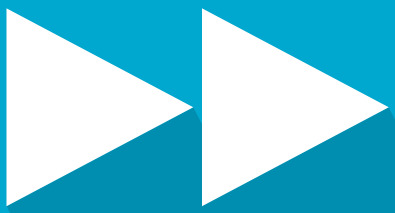
NHS
University Hospital Southampton
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2017/18



incorporating the quality account 2017/18
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 2017/18

incorporating the quality account 2017/18

Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a) of the National Health Service Act 2006

TABLE OF CONTENTS

OVERVIEW AND PERFORMANCE REPORT

A word from the chairman and chief executive

Staff at UHS achieved some amazing things in 2017/18, a year in which the Trust faced the huge challenge of continuing to deal with rapidly rising demand for our services at a time when, like many hospitals, we were already under great pressure.

Perhaps the most obvious achievement was that the Care Quality Commission (CQC) rated UHS as **good** for the quality of care which it provides overall and **outstanding** for leadership. It is no coincidence that the results from our latest NHS staff survey were so positive. We were particularly pleased that our response rate had increased and that UHS staff rated us the fourth best nationally for staff recommending the hospital as a place to work or receive care. We are also the seventh best nationally for staff engagement and results show that our staff feel able to contribute fully towards improvements.

However, it's truly in times of adversity, such as that we experienced over the winter period, that you see teamwork and commitment shine through. On several occasions we supported our neighbouring hospitals by providing care to their patients.

We were also immensely proud of the way our staff pulled together during the days of thick snow with many staying on site overnight to ensure we had enough staff to care for our patients. Others stayed to look after stranded patients who were unable to get home. Staff with 4x4 vehicles collected colleagues for work and drove patients home. It was a monumental and incredibly uplifting effort from all.

Our staff have indeed continued to strive tirelessly to provide both the quality of care and the speed of access to treatment to which we aspire. We are confident that we have done the former but the rapid increase in patient numbers has at times made it difficult to achieve the latter. We are determined to improve our performance to achieve the standards our patients expect. We are encouraged by the terrific results we achieve in the NHS Friends and Family test, with patients overwhelmingly recommending UHS as a place to have their hospital care.

As the result of achieving our financial target for 2016/17 we became eligible for additional national cash incentive payments, which meant that in 2017/18 we were able to commit to the biggest capital investment programme the Trust has ever seen. As part of this programme we were able to address some of the areas of our estate that were highlighted as requiring improvement in a previous CQC report. We are delighted to say that we have again delivered our financial target for 2017/18 and will as a result be able to sustain a high rate of investment in upgrading our hospitals.

We have also recently been able to start work on a £5m project to build a new Children's Emergency Department as the result of generous support from the public for Southampton Hospital Charity and our partnership with the Murray Parish Trust without which the project would have been impossible. It will transform the environment in which our young patients are treated.

Sadly at the end of the year we waved goodbye to Fiona Dalton, our chief executive for the last four years, who took the opportunity of a lifetime to live and work in Vancouver where she will lead a major Canadian healthcare group. Fiona was a remarkable chief executive, both immensely liked and admired throughout UHS and she left with the goodwill and best wishes of everyone.

Peter Hollins
Chairman

David French
Interim chief executive officer

Overview of the Trust

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 11,454 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 2017/18 was more than £810m.

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.

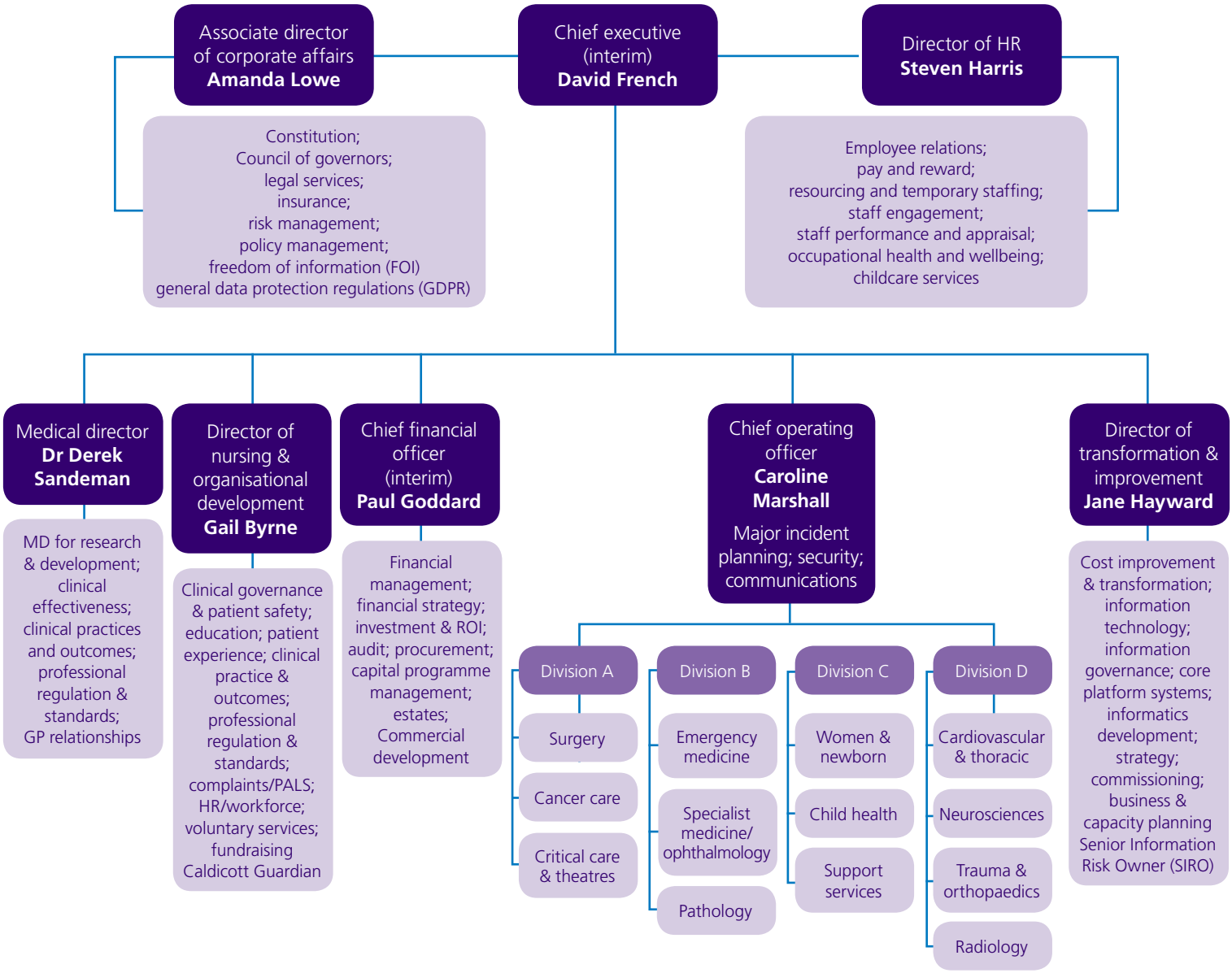
In the early half of the century, the site began to expand, including the opening of the school of nursing and the creation of the Wessex Neurological Unit. In 1971 a new medical school was opened in Southampton and the 1970s and 1980s saw a significant building programme encompassing the current footprint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

The way we're structured

Structure of the executive team

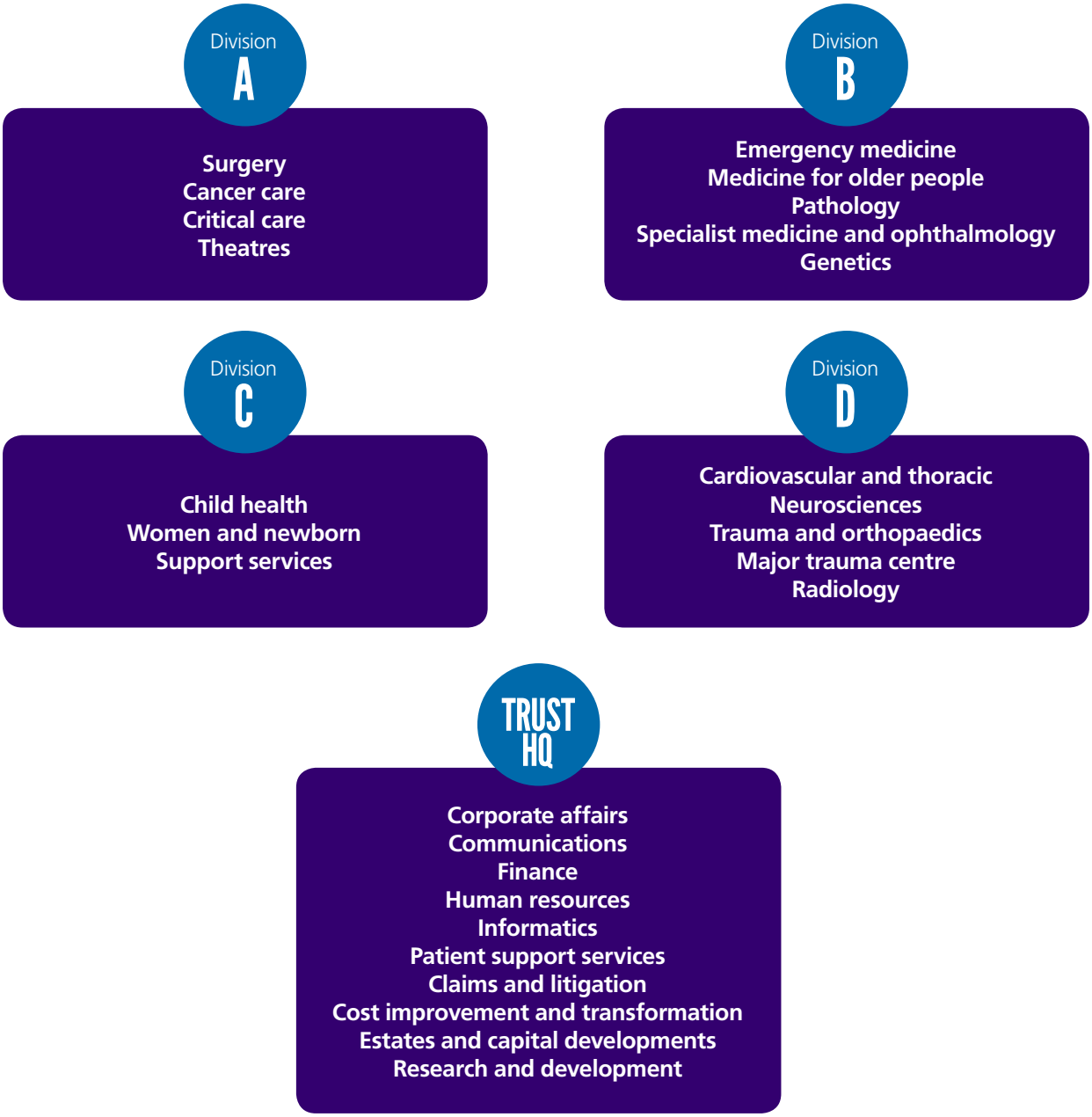


Structure of our services

Our services are split into five divisions and within each division there are care groups. Each division, with the exception of Trust headquarters, is led by a divisional management team consisting of:

- divisional clinical director (DCD)
- divisional director of operations (DDO)
- divisional head of nursing/professions (DHN)
- divisional research and development lead
- divisional finance manager
- divisional planning and business development (or strategy) manager
- divisional education lead
- division HR business partner
- divisional governance manager (DGM)

The diagram below outlines the five divisions and care groups/services within each. Each care group has a clinical lead, care group manager and matron/s for specific services as a minimum.



Our vision and values

Our Forward vision outlines who we are and what we stand for, as well as describing the current challenges we face and our priorities for the future. It also provides an in-depth review of our three Trust values, which are summarised below:

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

Our clinical teams will provide services to patients and are crucial to our success. We have launched a leadership strategy that ensures our clinical management teams are engaged in the day-to-day management and governance of the Trust.

Our growing reputation in research and development and our approach to education and training will continue to incorporate new ideas, technologies and greater efficiencies in the services we provide

Our priorities, key issues and risks

Our top eight priorities

1

Promote and live our values. We will:
- be clearer about the behaviours we expect from our staff
- recruit, train and promote people who demonstrably share our values in everything they do

2

Improve safety, quality and productivity. We will:
- Sign up to safety and deliver on our promises to patients as part of this campaign
- Focus on improving outcomes by measuring and publishing clinical outcomes for all specialties
- Focus on improving the whole patient experience, so that patients feel treated with compassion by all staff in every contact
- Develop the concept of excellent administrative care, organising our services well so that the patient journey runs smoothly
- Commit to productivity improvement across all areas
- Develop innovative solutions that allow us to deliver services more efficiently while making better use of our capacity

3

Our staff and education mission. We will:
- Attract the best staff by offering them a better deal and the best place to work
- Continue to invest in education and training opportunities for our staff including leadership development
- Ensure that our leaders and staff understand and deliver our equality and diversity agenda
- Prioritise excellent communication that allows the voice of our staff to be heard and acted on
- Focus on the staff of the future by developing our education and training capability for clinical and non-clinical staff
- Work with our local education providers to offer excellent education opportunities and bring high calibre people into healthcare roles in our hospitals

4

Become a hospital without walls. We will:
- Increase the number of patients we care for who are not inpatients within the hospital. Some of these will be cared for in another residential location or at home in partnership between ourselves and other organisations
- Be clear about services where we wish to provide end-to-end integrated care, and those where we wish to work with partners to integrate care across organisations
- Work with health and social care partners (public, private and third sector), where necessary using new organisational models, to ensure that patients are always cared for in the right setting
- Work more closely with general practices and support innovation being led by primary care

5

Specialised services. We will:

- Engage with commissioners to plan changes in service models according to national service specifications
- Continue to plan and manage the ongoing drift of sub-specialist work particularly in paediatrics and complex surgical services
- Maintain and develop the critical mass that is increasingly required to care for complex and specialist patients
- Work with Salisbury NHS Foundation Trust, the University of Southampton and other partners to play our part in the genomic revolution, building on the Genomic Medicine Centre and seeking to become a Genomics Central Laboratory Hub for the region
- Develop our clinical informatics ability to ensure that we can take advantage of new information available for the benefit of patients

6

Preventative care. We will:

- Continue to expand our screening programmes as national policy and commissioning intentions develop
- Take every opportunity to further support and improve the health of our staff
- Ensure that our clinical translational research programme, much of which is directly relevant to health promotion, accelerates translation of research into benefit for the local population

7

Discovery. We will:

- Develop a detailed plan to continue increasing the number of UHS patients who are offered access to clinical trials and maximise the impact of the research we undertake
- Work with the University of Southampton to submit a strong bid for the next round of Biomedical Research Centre / Biomedical Research Unit funding opportunities
- Support the University of Southampton to create an international centre for cancer immunology to accelerate the development of new immune therapies to treat cancer

8

All stages of life. We will:

- Continue to expand our paediatric services in partnership with community and local acute paediatrics and develop the physical infrastructure of a modern children's hospital as quickly as finances allow
- Continue to improve transition and the care of teenagers and young adults
- Develop elderly care services that are integrated across the acute and community sectors
- Continue to develop our end of life care

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 2018/19.

2

Capacity and occupancy, which impacts on patient flow and 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:

- developing band four posts and apprentices
- leveraging the 'Think UHS' recruitment brand
- continuing to recruit within Europe and further afield
- working with universities to increase student nurses
- 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.

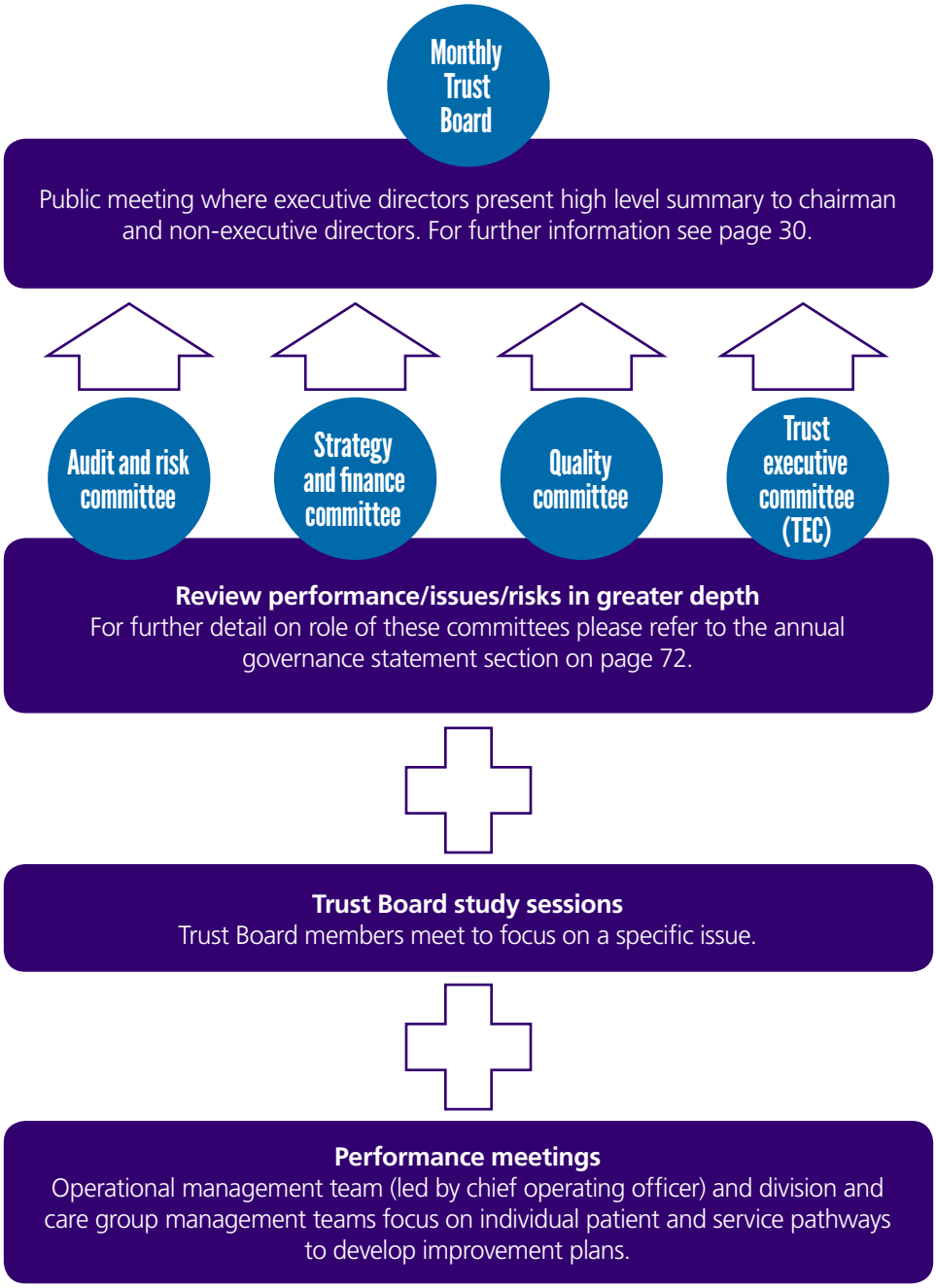
Performance report

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.

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.



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 2017/18 the format of the monthly report followed the five key Care Quality Commission (CQC) 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 – update on the previous month's performance written by the director of transformation and improvement.
- Trust overview – the top KPIs identified by Trust Board, RAG-rates for the previous 13 months
- Safe
- Effective
- Caring
- Activity
- Emergency department (ED)
- Referral to treatment (RTT/18 weeks)
- Cancer waiting times
- Flow
- Staffing (HR)
- Education and training
- Research and development
- Estates

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.

The emergency department, Activity and Flow section have several KPI's that are relevant to the key risk of **delivering the national access target**. Some of the KPI's are:

- Number of attendances
- Time to initial assessment
- Hospital red/black alerts
- Delayed transfers of care
- Non-elective length of stay

The Activity and Flow section have several KPI's that are relevant to the key risk of **capacity and occupancy**. Some of the KPI's are:

- Length of stay
- New referrals
- Number of attendances
- Bed occupancy
- Hospital red/black alerts

The Staffing (HR) section has several KPI's that are relevant to the key risk of Staffing. Some of the KPI's are:

- Staff turnover
- Nursing vacancies
- Friends and Family Test – percentage of staff who recommend UHS as a place to work

You can see full copies of the monthly report by visiting www.uhs.nhs.uk

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 2017/18 we continue to review the National Model Hospital data as it is published from NHS Improvement. The data and ability to compare our performance has helped to highlight areas of excellent practice and areas where there is potential to improve. The Trust now has a model hospital steering group which identifies potential improvement projects from the data and reports to transformation board.

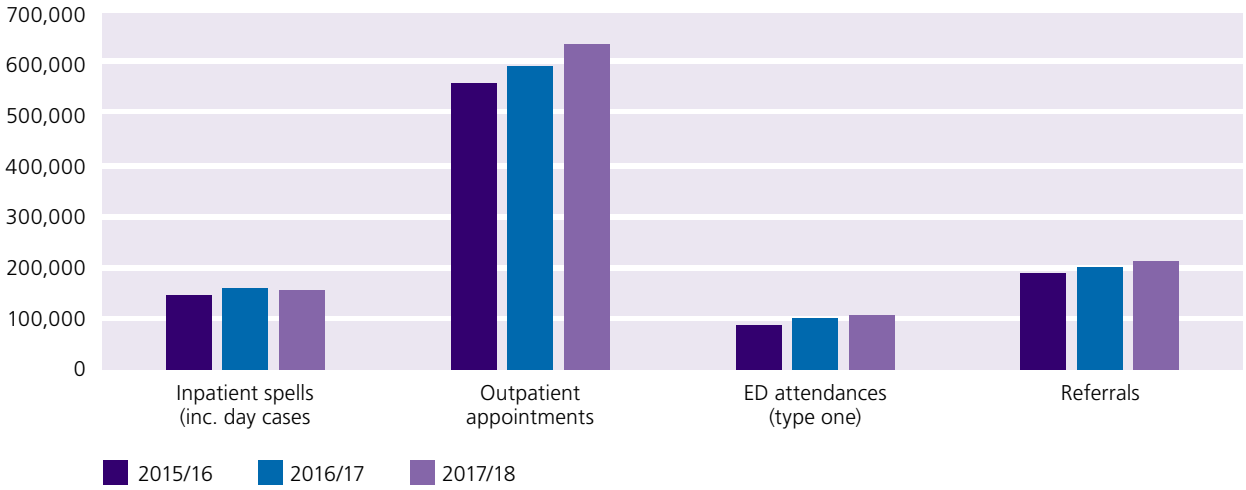
Detailed analysis and explanation of the development and performance of UHS

Activity, capacity and occupancy

Over the past three years we have seen significant increases in all types of activity. This is linked to demographic growth, new specialist techniques and services transferring from other providers including vascular services from Portsmouth. In addition, UHS now has responsibility for surgical services at Lymington.

The graph and table below demonstrate this increase in activity.

UHS growth in activity – 2015/16 to 2017/18



	2015/16	2016/17	2017/18	Increase 15/16 to 17/18
Inpatient spells (inc. day cases	146,066	155,780	154,224	5.6%
Outpatient appointments	562,972	596,621	624,083	10.9%
ED attendances (type one)	95,217	99,493	102,547	7.7%
Referrals	191,888	204,840	208,872	8.9%

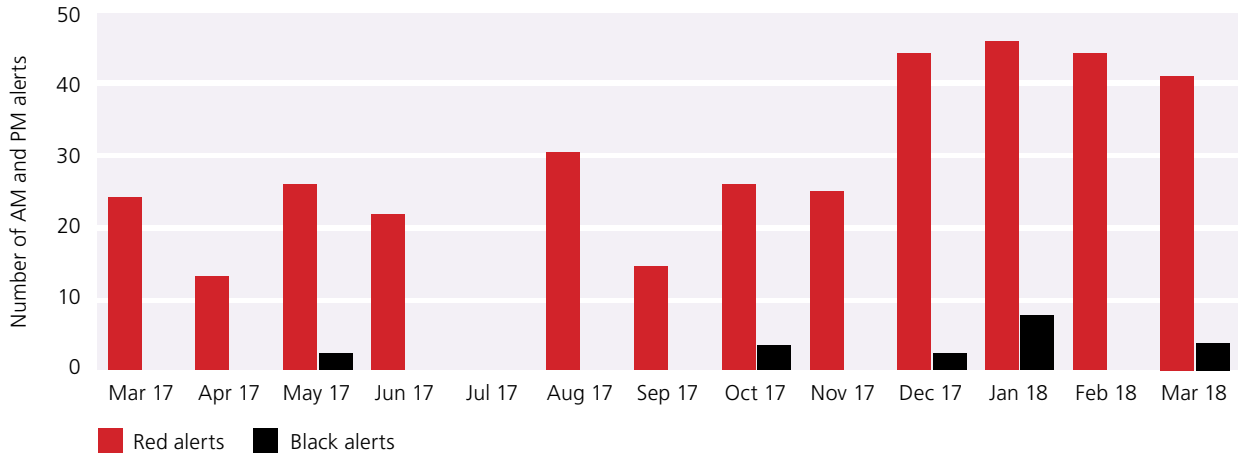
Hospital alert status

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 if actions are not taken several ambulances are likely to be delayed for long periods of time, stopping them from responding to 999 calls (this is based on a national definition of escalation).

Red alert is when the majority of the hospital is under significant operational pressure and is likely to include a mismatch between supply and demand of beds and/or there are no beds available, with patients waiting more than three hours in the emergency department, and patients with a clinical decision for admission but no bed identified for them to move to.

The Trust will undertake a wide range of actions in response to this, including the opening of additional overnight beds (usually within day wards), the redistribution of staff or bed capacity to support areas under most pressure, Trust-wide communication to request a focus on actions which will enable patients to be discharged or the admission avoided and the potential review of less urgent elective operations to maintain bed availability for patients with more urgent needs.

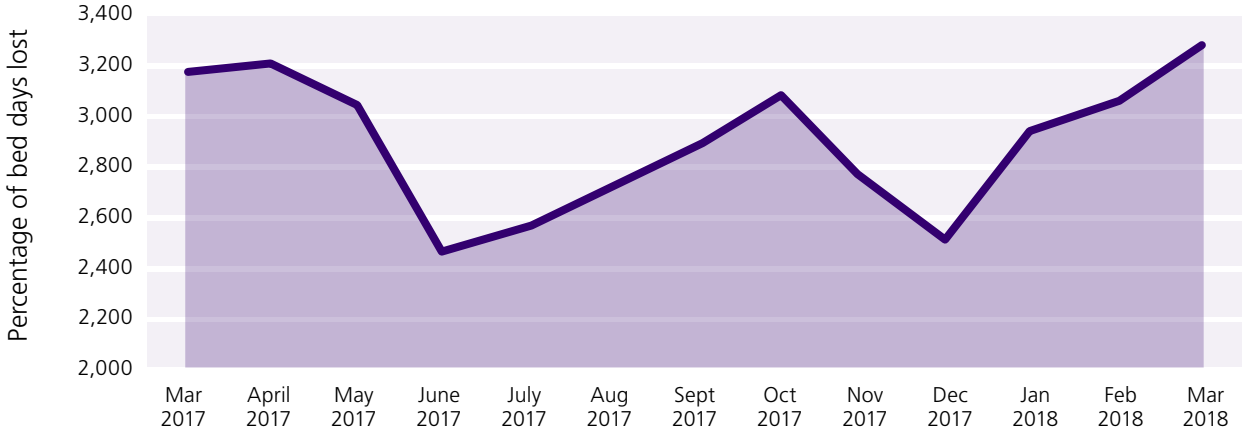
In 2015/16 a black alert was recorded seven times at the twice daily bed meetings. In 2016/17 this was increased to eleven and in 2017/18 this increased again to twenty. The chart below shows red and black alerts logged during 2017/18.



Contributing to this change has been an increase in length of stay (LoS) for elective patients linked to a more complex case mix and an increase in day cases.

The chart below shows the total bed days attributable to delayed transfers of care at UHS in 2017/18.

UHS delayed transfers of care 2017/18



Referral to treatment (18 weeks) performance

National target: 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 (incomplete pathways target).

How did we do?

UHS met the target in quarter one of 2017/18 but did not meet the target for the rest of the year. Achievement of this target in 2017/18 should be set against a rise in patient referrals, which highlights the increased demands being placed on the Trust. We have identified a reporting issue at our satellite outpatient clinics in Salisbury and are investigating the impact on referral to treatment reporting.

Emergency department (ED) performance

There are three types of emergency departments:

Type ONE

- ✓ 24 hour with full resuscitation facilities
- ✓ Consultant-led
- ✓ Designated accommodation for patients admitted via ED

Type TWO

- ✓ Single specialty emergencies (eye or dental)
- ✓ Consultant-led
- ✓ Designated accommodation

Type THREE

- ✓ Minor injuries/walk-in centres
- ✓ Doctor or nurse-led
- ✓ Can be routinely accessed without appointment
- ✓ May be co-located within an ED or sited in the community

We run all three types of departments and, in August 2017 we also took over the operation of Lymington Minor Injuries Unit and opened the Urgent Care Hub at Southampton General in October 2017. All three types are subject to the national target and are therefore reflected in our figures.

National target: The constitutional standard remains at 95% but a national recovery trajectory was agreed as:

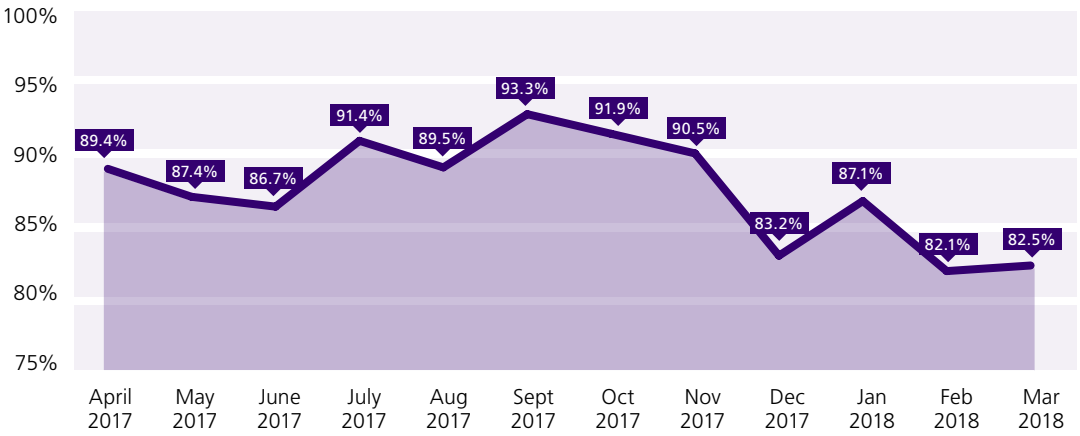
Patients should be treated and either admitted or discharged within four hours of arrival
85% achievement target set for April 17
90% achievement target in or before September 2017
95% achievement target by March 2018.

How did we do?

December 2017 was an extremely challenging month for emergency patients for the whole Hampshire and Isle of Wight area. UHS saw an increase in patients admitted to the Trust with influenza and, alongside our own bed pressures, we took ambulance diverts from other hospitals in order to maintain patient safety across Hampshire. Our Trust received formal letters of thanks from local commissioners and providers for the part we played during this difficult period.

The graph below shows our performance against the four hour target over the last year.

National 4 hour access target – UHS performance



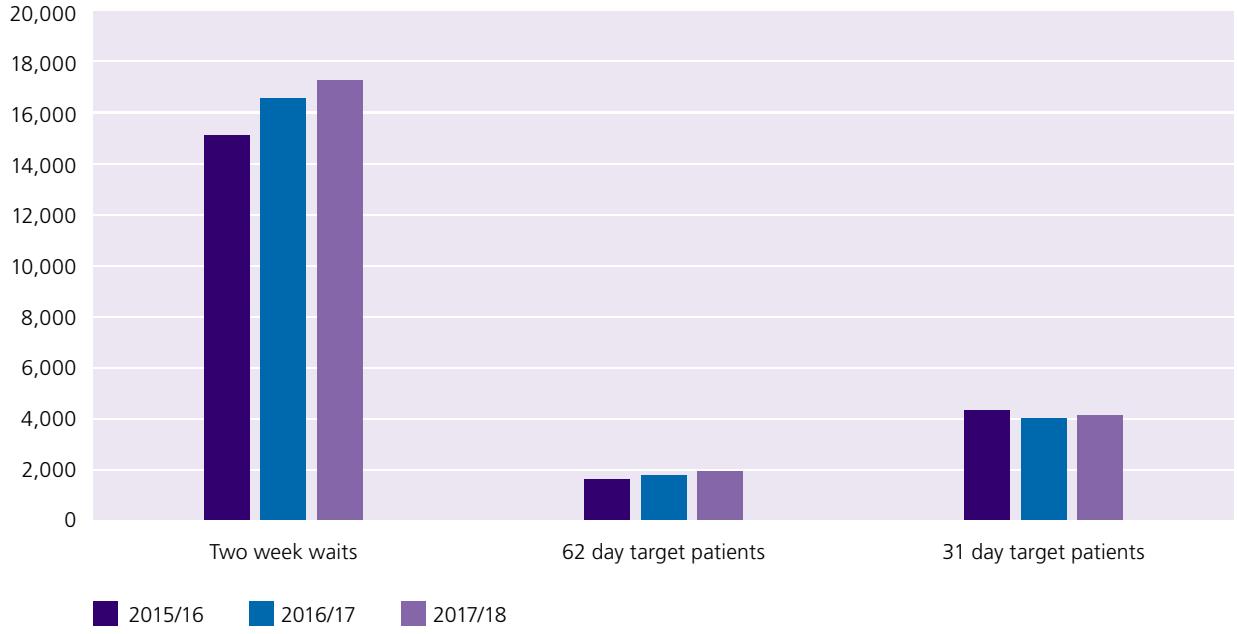
Cancer waiting times

There are ten separate cancer waiting times measures (below) 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 2017/18 the Trust met six of these measures.

Number	Measures	Achieved
1	a maximum one month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers	✘
2	a maximum 31-day wait for subsequent treatment where the treatment is surgery	✘
3	a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	✓
4	a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	✓
5	a maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers	✘
6	a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer	✓
7	a maximum 62-day wait for the first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	✓
8	a maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms	✓
9	a maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected	✘
10	A maximum 31-day wait (urgent GP referral to treatment) for first treatment for rarer cancers	✓

The number of patients referred under the two week wait urgent suspected cancer protocol seen within two weeks of their referral, rose by 5.2% in 2017/18. The chart overleaf shows the rise in demand for UHS cancer services over the past three years.

UHS growth in cancer actvity – 2015/16 to 2017/18



For staffing performance, please refer to page 61. For financial performance please see page 93.

David French Interim chief executive officer
24 May 2018

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.

Segmentation

During 2017/18 the Trust was confirmed as being placed within segment '2'. This segmentation information is the Trust's position as at 31 March 2018. 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	Q1	Q2	Q3	Q4
Financial sustainability	Capital service cover	2	2	2	1
	Liquidity	2	2	1	1
Financial sustainability	Income and expenditure margin	1	1	1	1
Financial sustainability	Distance from financial plan	1	1	2	1
	Agency spend	1	1	1	1
Overall scoring		1	1	1	1

Care Quality Commission ratings:

Overall rating for this trust	Are services at this trust safe?	Are services at this trust effective?	Are services at this trust caring?	Are services at this trust responsive?	Are services at this trust well-led?
					
Good	Requires improvement	Good	Outstanding	Requires improvement	Outstanding

The CQC inspected all key questions in four of the eight core services of surgery, critical care, end of life care and outpatient and diagnostic imaging and noted the Trust had a stable leadership team in place since their last inspection.

The previous inspection in 2015 had found safety of medicine and maternity services, along with responsiveness of urgent and emergency care and children's services 'required improvement'. At the 2017 inspection the following observation was made:

> **'At this inspection we saw significant improvement across the areas we inspected. There were improvements in surgery, critical care, end of life care and outpatients. Critical care is rated overall as 'Outstanding', with surgery, end of life care, and outpatients and diagnostic imaging as 'Good' overall. These services had been rated requires improvement in 2015. The improvements were in line with the trust's improvement plan and had been assisted by the trust board and executive leadership team'**

Professor Sir Mike Richards
Chief Inspector of Hospitals

Environmental matters

We recognise that the Trust's business has an impact on the environment. As a large hospital we undertake a wide range of activities and use a large amount of resources, for example:

- The Trust generates approximately 3,000 tonnes of waste yearly, half of which is clinical waste. If not properly treated this huge amount of waste can cause soil, water and air pollution depending on the disposal route.
- Due to the large number of visitors and deliveries we attract every day, traffic congestion is regularly experienced on and around the site, which impacts the air quality around the hospital.

We are committed to environmental sustainability and consider it as part of the business culture.
We acknowledge that reducing waste and minimising the consumption of scarce resources is consistent with financial sustainability. Our sustainability disclosure section on page 85 provides greater detail on the steps we are taking to reduce our activities' impact on the environment.

Social, community, anti-bribery 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. At University Hospital Southampton we value our reputation for top quality care and financial probity and conduct our business in an ethical manner.

The Bribery Act 2010 was introduced to make it easier to tackle the issue of bribery which is a damaging practice. Bribery can be defined as 'giving someone a financial or other advantage to encourage them to perform their duties improperly or reward them for having done so'.

To limit our exposure to bribery we have in place an Anti-Fraud, Bribery and Corruption Policy, a Standards of Business Conduct Policy and a Freedom to Speak Up (formerly Raising Concerns) Policy. These apply to all staff and to individuals and organisations who act on behalf of UHS. We also employ a local counter fraud specialist who will investigate, as appropriate, any allegations of fraud, bribery or corruption.

The success of our anti-bribery approach depends on our staff playing their part in helping to detect and eradicate bribery. Therefore, we encourage staff, service users and others associated with UHS to report any suspicions of bribery and we will rigorously investigate any allegations. In addition, we hold a register of interest for directors, staff, and governors and ask staff not to accept gifts or hospitality that will compromise them or the Trust.

The Board of Directors carries out its business in an open and transparent way. We are committed to the prevention of bribery as well as to combating fraud and expect the organisations we work with to do the same. Doing business in this way enables us to reassure our patients, members and stakeholders that public funds are properly safeguarded.

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.

ACCOUNTABILITY REPORT

Directors' report – the Trust Board

Board member			
Name	**Title**	**Biography**	**Declarations**
Fiona Dalton	Chief executive (until March 2018)	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.	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.
David French	Interim chief executive (chief financial officer until March 2018)	David joined the Trust in February 2016 and led on finance, procurement, estates and commercial development until March 2018, when he became interim chief executive officer. 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.	Non-executive director and chair of audit and risk committee, Vivid Housing Limited; Director, UHS Estates Limited, a wholly-owned subsidiary of UHSFT; Director, Southampton Commercial Estates Development Partnership (CEDP) Project Company Limited, a wholly-owned subsidiary of UHSFT; Member of Solent Acute Alliance
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.	Husband is a consultant surgeon in the Trust; Trustee of Naomi House Children's Hospice (until 10 February
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.	Director, UHS Estates Limited, a wholly-owned subsidiary of UHSFT; Father is mental health act manager, Southern Foundation Trust (voluntary position) (until 31 August 2017), member of assessment committee for Clinical Excellence Awards South and Public Health England (lay member) (until January 2018), a UHSFT simulated patient (voluntary position); Mother is a UHSFT simulated patient (voluntary position)
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.	Director of UHS Pharmacy Limited, a wholly-owned subsidiary of UHSFT; Daughter-in-law employed at UHSFT as medical support to department of innovation (from January 2017 – December 2017)
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.	Daughter is in an administration role at UHS (from July 2017)

Board member			
Name	**Title**	**Biography**	**Declarations**
Paul Goddard	Interim chief financial officer (from April 2018)	Paul joined the Trust in June 2007 as assistant director of finance and become the deputy director in December 2012. Paul has spent over 25 years in NHS finance having worked in many different organisations. A fellow of the Association of Chartered Certified Accountants, Paul became interim chief financial officer at UHS from April 2018.	Serves as a director of the Trust's wholly owned subsidiary company, UHS Pharmacy Limited. Sits on the Southampton Hospital Charity committee.
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.	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
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.	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
Dr Mike Sadler	Non-executive director	Mike joined UHS 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.	External clinical associate for PricewaterhouseCoopers; Member of the Advisory Board for xim (from 1 May)

Board member			
Name	**Title**	**Biography**	**Declarations**
Jenni Douglas-Todd	Non-executive director	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 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.	Managing director, Diversa Consultancy Limited; Member of the Judicial Conduct Investigative Office; Non-executive director, Hampshire Cricket Board; Trustee, National Association for the Care and Resettlement of Offenders (NACRO) (from 3 April 2017); Member of Regulatory Committee of the English Cricket Board (from 1 January)
Professor Cyrus Cooper	Non-executive director (from January 2018)	Cyrus Cooper is professor of rheumatology and director of the MRC Lifecourse Epidemiology Unit. He's also vice-dean of the faculty of medicine at the University of Southampton and professor of epidemiology at the Nuffield Department of Orthopaedics (rheumatology and musculoskeletal sciences, University of Oxford). He leads an internationally competitive programme of research into the epidemiology of musculoskeletal disorders, most notably osteoporosis. His key research contributions have been: • discovery of the developmental influences which contribute to the risk of osteoporosis and hip fracture in late adulthood • demonstration that maternal vitamin D insufficiency is associated with sub-optimal bone mineral accrual in childhood • characterisation of the definition and incidence rates of vertebral fractures • leadership of large pragmatic randomised controlled trials of calcium and vitamin D supplementation in the elderly as immediate preventative strategies against hip fracture. He is president of the International Osteoporosis Foundation, chair of the BHF Project Grants Committee, an emeritus NIHR senior investigator, and associate editor of Osteoporosis International. He has previously served as chairman of the Scientific Advisors Committee (International Osteoporosis Foundation), the MRC Population Health Sciences Research Network and the National Osteoporosis Society of Great Britain. He has also been president of the Bone Research Society of Great Britain and has worked on numerous Department of Health, European Community and World Health Organisation committees and working groups. Professor Cyrus has published extensively on osteoporosis and rheumatic disorders and pioneered clinical studies on the developmental origins of peak bone mass. In 2015, he was awarded an OBE for services to medical research.	Director and professor of rheumatology, Medical Research Council (MRC) Lifecourse Epidemiology Unit; Vice-Dean, Faculty of Medicine, University of Southampton; Professor of epidemiology, University of Oxford; President of the International Osteoporosis Foundation (IOF)

Board member			
Name	**Title**	**Biography**	**Declarations**
Jane Bailey	Non-executive director (from January 2018)	In 1985, Jane joined the pharmaceutical company Glaxo as a management trainee, having graduated from London University with a degree in environmental science and pharmacology. Here she rose to senior commercial vice president, gaining experience of a broad range of disease areas across different regions of the world. She specialised in leading global research and development teams in the formation of strategies to bring new medicines to patients. She also worked to ensure that the medicines developed were supported by robust evidence demonstrating their clinical and cost effectiveness. In delivering this she gained extensive experience of leading large diverse teams across a complex global organisation. For five years, Jane ran her own strategy development consultancy, working across a breadth of healthcare organisations. In 2017 Jane gained an MSc in public health, with distinction, at King's College, London University. Her studies focused on how to ensure the public are engaged in development of healthcare services and how social theories can help inform effective disease prevention and management.	Director of Healthwatch Portsmouth.
Catherine Mason	Non-executive director (from March 2018)	Catherine's career has spanned roles in consumer goods, transport and healthcare. She has worked in marketing for blue chip companies, run public transport in Northern Ireland as the group chief executive of Translink and was managing director of NATS services business, the leading provider of air traffic control services, before moving into private healthcare in 2016.	Nil.
Professor Iain Cameron	Non-executive director (until December 2017)	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.	Member of UK Clinical Research Collaboration Board; Dean, Faculty of Medicine and member, University Executive Board, University of Southampton; Board member, Wessex Academic Health Sciences Network; Trustee, Wessex Medical Trust; Joint chair, University Hospital Southampton/ University of Southampton Joint Research Strategy Board; Non-executive director of the Medical and Dental Defence Union of Scotland (MDDUS) (from 28 April 2017)
Lynne Lockyer	Non-executive director (until February 2018)	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 Primary Care Trust 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.	Board member\trustee of the Brendoncare Foundation
Dr David Price	Non-executive director (until December 2017)	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. 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.	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

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.

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 is available for public inspection.

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, 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 57.

Development of the Board

The Board held monthly study sessions during 2017/18 where strategic issues, along with emerging issues, were discussed.

Meetings of the Board

The Board meets once a month in public, with the exception of the months of August and December. Additional private meetings with only the Board present 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. The audit and risk committee meets five times a year and quality committee meets six-weekly. The remuneration and appointment committee meets at least four times per year, with additional meetings held as required. The strategy and finance committee meets monthly. The frequency of each committee meeting is set out in each committee's terms of reference which are reviewed annually.

The performance of individual Board members is reviewed as set out on page 56 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.

Board meeting attendance record 2017/18

Board member	27 Apr	23 May Extra CS	1 Jun	28 Jun	27 Jul	Aug No meeting held	27 Sep	28 Oct	30 Nov	21 Dec	1 Feb	1 Mar	29 Mar
Peter Hollins Chair	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Simon Porter Non-executive director (Senior independent director and deputy chair)	✔	✔ telecon	✔	✔	✔ (OS only)		✔	✔	✗	✔	✔	✔	✔
Iain Cameron Non-executive director (until 18/12/17)	✔	✔	✔	✔	✔		✔	✔	✗	✔ (non voting)			
Lynne Lockyer Non-executive director (until 28/2/18)	✔	✗	✔	✔	✔		✔	✔	✔	✔	✔		
David Price Non-executive director (until 31/12/17)	✔	✔ telecon	✔	✔ (OS only)	✗		✔	✔	✔ (OS only)	✔			
Mike Sadler Non-executive director	✔	✔ telecon	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Jenni Douglas-Todd Non-executive director	✔	✔ telecon	✔	✔	✔		✔	✔	✔	✔	✔ (OS only)	✔	✔
Jane Bailey Non-executive director (from 1/1/18)											✔	✔	✔
Cyrus Cooper Non-executive director (from 1/1/18)											✔	✗	✔
Catherine Mason Non-executive director (from 1/1/18)												✔	✔
Fiona Dalton Chief executive officer (until March 2018)	✔	✗	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
David French Chief Financial Officer (until March 2018)	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Derek Sandeman Medical Director	✔	✔	✗	✔	✔		✔	✔	✔	✔	✔	✔	✔
Gail Byrne Director of nursing and organisational development	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✗	✔
Caroline Marshall Chief operating officer	✔	✗	✔	✔	✔		✗	✗	✗	✗	✔	✔	✔
Jane Hayward Director of transformation and improvement	✔ (OS only)	✔	✔	✔	✔		✔	✔	✔	✔	✔ (OS only)	✔	✗

Telecon = telephone conference
OS only = open session only

Well-led framework

The Board of UHS is responsible for all aspects of leadership within the organisation. The Board has a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that high quality, sustainable care is provided.

In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice and should look to identify the areas of the Trusts, leadership and governance that would benefit from further targeted development work to secure and sustain future performance. NHS Improvement require all trusts to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework.

The Board engaged KPMG to carry out an externally facilitated, developmental review of our leadership and governance using the well-led framework. The review concluded in September 2017 with KPMG confirming that "there are sufficient arrangements in place to ensure that University Hospital Southampton NHS Foundation Trust (the 'Trust') is well-led. Our view is that the Trust is high performing against each domain."

The review consisted of:
- Review of documents and Trust governance structures to support compliance with each domain of the well-led framework
- Consideration of the Board's self-assessment undertaken in July 2017
- Interviews with Board members and other key members of Trust staff
- Observation of Trust Board, Board committees and other key governance meetings
- Appraisal of Board governance, including committee structures and Board to ward assurance

In addition to this, the Trust was subject to an unannounced CQC inspection in January 2017 to conduct a follow-up inspection of issues previously highlighted within surgery, critical care, end of life care and outpatient and diagnostic imaging services. The improvements found at this inspection resulted in an overall rating of 'Outstanding' for the well-led domain.

The findings of both reviews accurately reflect the content and findings outlined within the 2017/18 Annual Report and Quality Account.

Audit and risk committee

The audit and risk committee is a non-executive committee of the Trust Board. 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. All of which supports the achievement of the Trust's objectives.

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 2017/18.

- 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 verbally 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.

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 page 27.

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 2017 and March 2018 in relation to matters covered in this annual report.

Member	15 May	17 July	16 Oct	15 Jan	19 Mar
Simon Porter Senior independent director and deputy chair Chair of audit and risk committee	✔	✔	✔	✔	✔
David Price Non-executive director (until 31/12/17)	✔	✗	✔		
Mike Sadler Non-executive director	✔	✔	✔	✗	✗
Jane Bailey Non-executive director (from 1/1/18)				✔	✔

External auditors

The external audit contract is currently held by KPMG LLP (from 1 January 2018). The contract is for three years with the option to extend for a further two years. Appointment of the external auditor was approved by the Council of Governors at an additional meeting held on 14 November 2017. KPMG regularly report to and attend the audit and risk committee, enabling the committee to monitor their performance. The statutory audit fee for 2017/18 was £57,773 plus VAT and for UHS Pharmacy Ltd and UHS Estates Ltd was £7,900 plus VAT. The quality audit fee for 2017/18 was £9,075 plus VAT. The non-audit services provided by KPMG LLP totalled £33,000 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 VAT team, and is residual work relating to projects it was dealing with prior to 2016/17. This team has no role in the external audit of the Trust. The Trust has now changed VAT advisers and this cost should be minimal in future years.

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 page 123 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

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 below.

Better payment practice code	Expected Sign	Actual 31/03/2018 YTD Number	Actual 31/03/2018 YTD £'000
Non NHS			
Total bills paid in the year	+	84,837	342,899
Total bills paid within target	+	81,266	326,248
Percentage of bills paid within target	%	95.8%	95.1%
NHS			
Total bills paid in the year	+	3,525	40,105
Total bills paid within target	+	2,959	36,424
Percentage of bills paid within target	%	83.9%	90.8%
Total			
Total bills paid in the year	+	88,362	383,004
Total bills paid within target	+	84,225	362,672
Percentage of bills paid within target	%	95.3%	94.7%

Statement as to the disclosures to auditors

So far as the Board is aware, there is no relevant audit information of which the Trust's auditor is unaware and all steps have been taken in order to be aware of any relevant audit information and to establish that the Trust's auditor is aware of that information, in connection with preparing the audit report.

Disclosures

In accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18 and the 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
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.
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 remuneration17 committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.
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.
N/A	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.
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.
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.
N/A	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated
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.
N/A	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.
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.
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.
N/A	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. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)
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.
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.

Code provision	Requirement
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). See also ARM paragraph 2.93.
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.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (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.
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.
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: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • 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 • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.
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.
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.
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.
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.
N/A	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • 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.
N/A	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.
A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery
A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance
A.1.6	The board should report on its approach to clinical governance.

Code provision	Requirement
A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement (Monitor) for advising the board and the council and for recording and submitting objections to decisions.
A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.
A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.
A.4.2	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.
A.5.2	The council of governors should not be so large as to be unwieldy.
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.
A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.
A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.
A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.
A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.
B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.
B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.
B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).

Code provision	Requirement
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.
B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.
B.5.4	Committees should be provided with sufficient resources to undertake their duties.
B.6.3	The senior independent director should lead the performance evaluation of the chairperson.
B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.
B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.12.
C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.
C.1.4	a) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.
C3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.
C3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.
C3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.
C3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.

Code provision	Requirement
B.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
D1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.
D1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.
D1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.
D2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.
D2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.
E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.
E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.

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 Quality Improvement Framework (QIF) with priorities set against the CQC outcomes of well-led, safe, responsive, effective and caring. The QIF is a tool to engage and communicate with staff and patients about transformation projects to improve the quality of care. 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 priorities are informed from information gathered from patient surveys, complaints and concerns, safety incidents and national and local quality initiatives. These improvement priorities are published as part of the annual quality account, which can be found on page 136. A rolling programme of monitoring and review of progress is undertaken at each meeting of the quality committee.

To ensure that quality is embedded 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 to support the implementation of the vision and move to a future organisational state of excellence.

During the past year we have been progressing our stated aim "to be much clearer about the behaviours we expect from our staff". A consultation process took place with staff across the Trust to identify and describe the behaviours associated with each value that we expect all staff to demonstrate. We have now published a series of 'behavioural statements' endorsed by the Trust Board.

Following an inspection in December 2014, the Care Quality Commission (CQC) gave us an overall rating of 'Requires Improvement'. The CQC returned in January 2017 to conduct a follow up inspection of issues previously highlighted within surgery, critical care, end of life care and outpatient and diagnostic imaging services. The improvements found at this follow up inspection resulted in an overall rating of 'Outstanding' for the caring and well-led domains. In addition to this, the Trust achieved an improved overall rating of 'Good'.

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 above, there is a 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. The committee routinely considers performance against a broad range of qualitative indicators including (but not limited to):

- Integrated performance report
- Access performance (including emergency department and referral to treatment)
- Delayed transfers of care (DToC)
- Never events/ serious untoward incidents
- Complaints
- Emergency re-admissions
- Clinical outcomes

The Trust has established an integrated medical examiners group (IMEG) to review all deaths.

The quality governance disclosures should be read in conjunction with information provided in our quality account on page 136.

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.

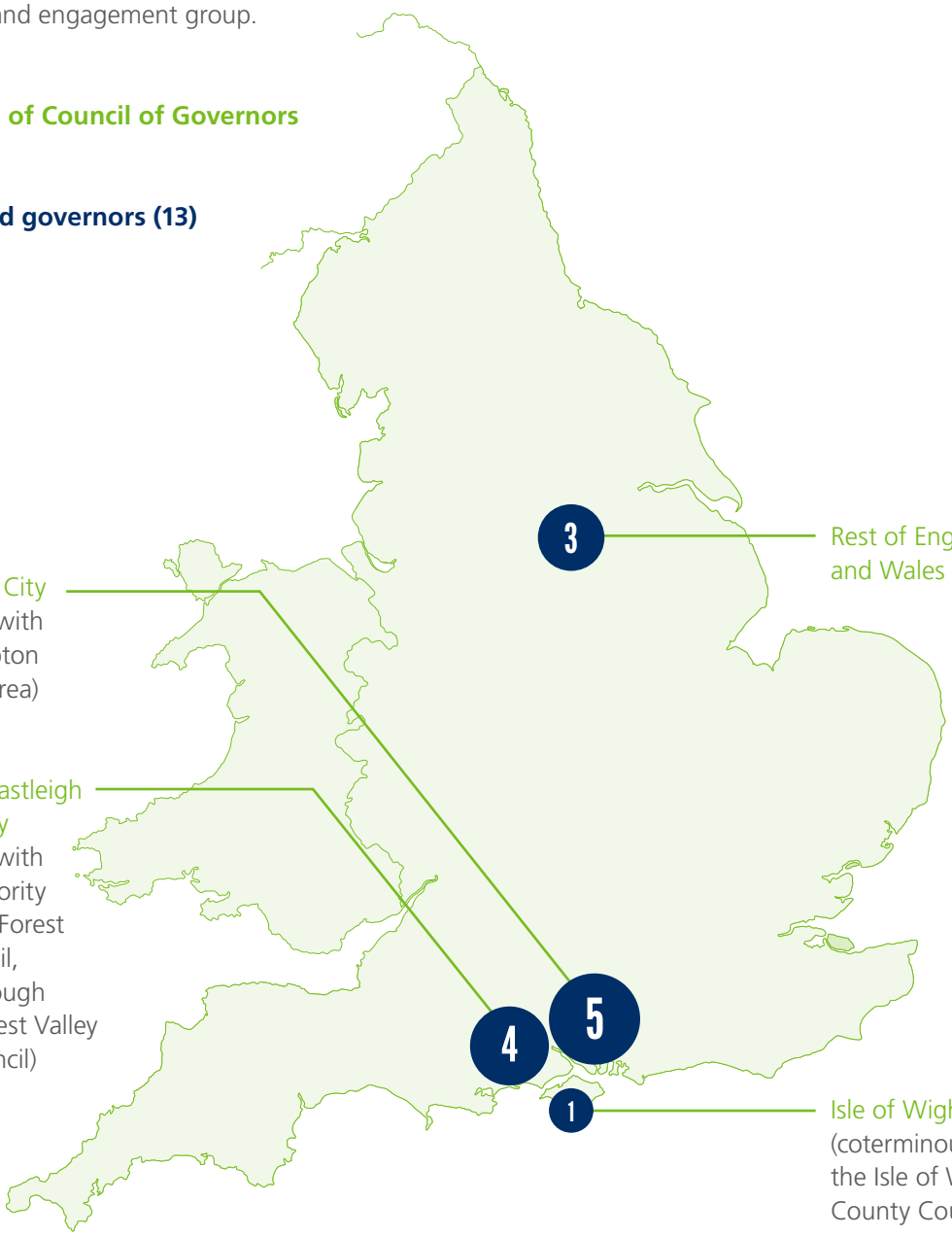
Council of Governors

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.

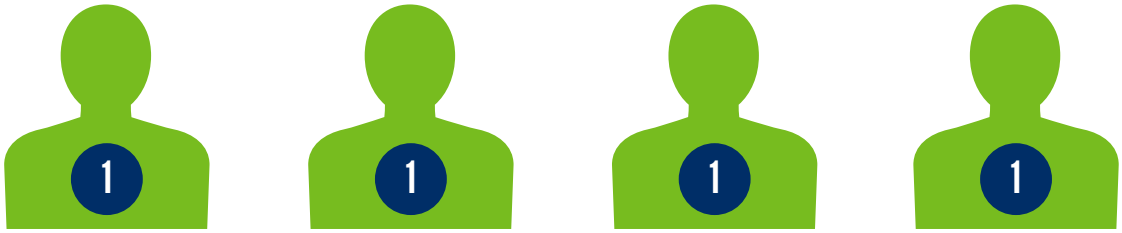
The Council of Governors is made up of 13 publicly elected governors, four elected staff governors, and six appointed governors. The governors serve a three year term of office. The Council has five working groups – governors' nominations committee, staff experience group, strategy group, patient experience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

Composition of Council of Governors

Public elected governors (13)



Staff elected governors (four)



Medical practitioners and dental staff

Nursing and midwifery staff

Other clinical staff

Non-clinical and support staff

Appointed governors (six)

NHS Southampton City Clinical Commissioning Group — 1

NHS West Hampshire Clinical Commissioning Group — 1

Hampshire County Council — 1

Southampton City Council — 1

Business South — 1

University of Southampton — 1

In addition to the elected Governors, two under-21 representatives have been appointed to the Council from University of Southampton and Richard Taunton Sixth Form College.

During 2017/18 there were a number of changes to the Council:

1. Three governors stepped down during 2017/18. These included two governors from Southampton City and one from New Forest, Eastleigh and Test Valley.
2. Five governors reached the end of their terms in 2017/18. Of these, two were at the end of their second term (Hampshire County Council and Staff - medical and dental) and three at the end of their first term (Staff - other clinical) and two governors from New Forest, Eastleigh and Test Valley). Of those reaching the end of their first term, one (Staff- other clinical) decided not to stand for re-election.
3. Elections for six seats took place in August 2017 with elected governors taking up their roles from October 2017. Of these, four were newly elected governors and two were re-elected to a second term.
4. Southampton City Council put forward a nomination for a replacement for a governor who stepped down in 2016. The new governor started in November 2017.
5. Appointed governors for West Hampshire Clinical Commissioning Group and Business South stepped down in January 2017. New governors were appointed and started in September 2017.

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.

Statutory responsibilities of the Council of Governors

- 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.

Constitutional duties of the Council of Governors

- 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.

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 overleaf.

Elected public members:

Pamela Ashurst, Southampton City Centre (until 27/6/17): Nil

Sylvia Wyatt, Southampton City Centre (until 6/10/17): Husband is professor Jeremy Wyatt, director of Wessex Institute/professor of Digital Healthcare, University of Southampton

Robert Chambers, Southampton City Centre: Employed as commissioner at Southampton City Clinical Commissioning Group; Wife is consultant geriatrician at UHS

Anthony Havlin, Southampton City Centre: Clerk to Education Admissions and Exclusions Panel; Trustee Treasurer, The Veracity Recreation Ground Trust

Edward Chaney, Southampton City Centre (until 3/1/18): Nil

Diane Eldridge, Southampton City Centre (from 1/10/17): Nil

Councillor Sue Blatchford, Southampton City Centre (from 1/10/17): Southampton City Council: Councillor

Heather Parsons, New Forest, Eastleigh and Test Valley (until 30/09/17): Director of Where There's a Will charity which supports the general intensive care unit patients and their families at UHS.

Bryan Bird, New Forest, Eastleigh and Test Valley (until 2/2/18): Nil

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

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.

Reuben Pengelly, New Forest, Eastleigh and Test Valley (from 1/10/17): Employee of University of Southampton; Wife employed by UHS.

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; part of the communications team representing Healthwatch and membership at St Mary's Hospital, Isle of Wight

Richard Goldsmith, Rest of England & Wales: Nil

John Haydon, Rest of England & Wales: Nil

Bob Purkiss, Rest of England & Wales: Nil

Elected staff members:

Brian Birch, Medical and dental (until 30/9/17): Receives honoraria to speak at, chair and attend meetings or liaises/receives educational material from representatives of various pharmaceutical companies; Acts as paid advisor (ad hoc) to Janssen; Serves as alternate vice-chair on the Hampshire B Research Ethics Committee; Conducts private practice involving treating patients at the Wessex Nuffield Hospital and The Spire Hospital. Max Jonas, Medical and dental (from 1/10/17): Nil

Tina Baker, Nursing and midwifery: Nil

Amanda Turner, Non-clinical and support: Nil

Annette Purkis, Other clinical (until 30/9/17):

Emil Bica, Other clinical (from 1/10/17): Nil

Appointed under 21 representatives:

Aimen Maksoud, Nil

Lorner Cotter, Nil

Appointed stakeholder members:

Joan Wilson, Southampton City Clinical Commissioning Group (CCG) (until 1/6/17): Nil

Mark Kelsey, Southampton City Clinical Commissioning Group (CCG) (from 1/10/17): Clinical chair, Southampton CCG

Ellen McNicholas, West Hampshire Clinical Commissioning Group (CCG) (from 1/10/17): Employed as director of quality and nursing at West Hampshire CCG.

Dr Michelle Cowen, University of Southampton: Director of Learning in Practice, University of Southampton, Faculty of Health Sciences.

Councillor Sue Blatchford, Southampton City Council: Nil

Councillor Andrew Gibson, Hampshire County Council (until 29/6/17): Nil

Councillor Keith Mans, Hampshire County Council (from 1/10/17): Councillor, Hampshire County Council

Shirley Anderson, Business South (from 1/10/17): Nil

Council of Governors' attendance record 2017/18

Governor	Meeting attendance					
	11 July 2017	10 October 2017	1 November 2017 (Extra)	14 November 2017 (Extra)	16 January 2018	13 March 2018
Peter Hollins Chair	✓	✓	✓	✗	✓	✓
Simon Porter Senior independent director/ deputy chair	✓	✓	✗	✓	✓	✓
Rose Wiltshire Elected, Isle of Wight	✓	✓	✗	✓	✓	
John Haydon Elected, Rest of England and Wales	✓	✓	✓	✗	✓	✗
Richard Goldsmith Elected, Rest of England and Wales	✗	✗	✓	✓	✓	✗
Bob Purkiss Elected, Rest of England and Wales	✗	✗	✓	✓	✓	
Pamela Ashurst Elected, Southampton City (until 27/06/17)						
Sylvia Wyatt Elected, Southampton City (until 6/10/17)	✗					
Rob Chambers Elected, Southampton City	✓	✗	✗	✓	✗	✓

Governor	Meeting attendance					
	11 July 2017	10 October 2017	1 November 2017 (Extra)	14 November 2017 (Extra)	16 January 2018	13 March 2018
Edward Chaney Elected, Southampton City (until 3/1/18)	✓	✓	✗	✗		
Tony Havlin Elected, Southampton City	✓	✗	✓	✗	✗	✓
Diane Eldridge Elected, Southampton City (from 01/10/17)		✓	✓	✗	✗	✗
Bryan Bird Elected, New Forest, Eastleigh and Test Valley (until 2/2/18)	✓	✓	✓	✓	✓	
Andrew Grapes Elected, New Forest, Eastleigh and Test Valley	✓	✓	✓	✓	✓	✓
Heather Parsons Elected, New Forest, Eastleigh and Test Valley (until 30/09/17)	✓					
Anne Murphy Elected, New Forest, Eastleigh and Test Valley	✓	✗	✓	✗	✓	✓
Reuben Pengelly Elected, New Forest, Eastleigh and Test Valley (from 01/10/17)		✗	✗	✓	✓	✓
Brian Birch Elected, medical and dental staff (until 30/09/17)	✓					
Max Jonas Elected, medical and dental staff (from 01/10/17)		✗	✓	✓	✓	✗
Tina Baker Elected, nursing and midwifery staff	✗	✗	✗	✓	✓	✓
Annette Purkis Elected, other clinical staff (until 30/09/17)	✗					
Emil Bica Elected, other clinical staff (from 01/10/17)		✓	✗	✓	✓	✓
Amanda Turner Elected, non-clinical and support staff (from 01/10/17)	✓	✓	✓	✓	✓	✓
Ellen McNicholas Appointed, West Hampshire CCG (from 01/10/17)		✓	✗	✗	✓	✓
Joan Wilson Appointed, Southampton City CCG (until 01/06/17)						
Mark Kelsey Appointed, Southampton City CCG (from 01/10/17)		✓	✗	✗	✓	✓
Cllr Andrew Gibson Appointed, Hampshire City Council (until 29/06/17)						
Cllr Keith Mans Appointed, Hampshire County Council (from 01/10/17)		✓	✗	✗	✓	✓

Governor	Meeting attendance					
	11 July 2017	10 October 2017	1 November 2017 (Extra)	14 November 2017 (Extra)	16 January 2018	13 March 2018
Cllr Sue Blatchford Appointed, Southampton City Council	✓	✓	✓	✓	✓	✓
Michelle Cowen Appointed, University of Southampton	✓	✓	✗	✗	✓	✓
Shirley Anderson Appointed, Business South (from 01/10/17)		✓	✓	✗	✓	✓
Aimen Maksoud Under 21 representative (from 01/04/17)	✗	✗	✗	✗	✓	✗
Lorna Cotter Under 21 representative (from 04/07/17)	✓	✓	✗	✗	✗	✓

In 2017/18 the Council of Governors considered a number of items including:
- Membership engagement
- Performance of the Trust
- Updates on the Well-Led review
- Review of the draft Quality Account including Patient Improvement Framework
- Updates on non-executive director (NED) recruitment and proposed changes to the NED terms and conditions
- Review of the Care Quality Commission Report following January 2017 inspection.

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' nomination 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' nomination committee met on five occasions during 2017/18 and considered the following topics:
- Non-executive director appraisals, including appraisal of the Trust Board chair
- Non-executive director recruitment for 2017/18
- Non-executive director appointments for 2017/18
- Annual review of non-executive director pay and terms and conditions

Governor elections

Governor elections were held in August 2017 for four constituencies: Southampton City (one seat), New Forest, Eastleigh and Test Valley (three seats), Staff – medical and dental (one seat) and Staff – other clinical (one seat). Six newly appointed governors started in their roles from 1 October 2017.

September 2018 will bring an end to the term of office for two elected governors. Plans are being developed to run elections throughout the summer with a view to appointing to all vacancies by 1 October 2018. 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	3,052
New Forest, Eastleigh and Test Valley	3,661
Rest of England and Wales	1,365
Isle of Wight	811
Out of Trust area	6

Age range	Number
16	1
17-21	30
22+	8,501
Not known	363

Ethnicity	Number
White	8,064
Mixed	41
Asian/Asian Black	242
Black/Black British	89
Other (inc Chinese)	65
Not stated	394

Engagement with members

Engaging with and offering opportunities for members to interact with the Trust and Council of Governors remains key to the development of the Trust's plans. We are achieving this through a programme of activities both within the hospital and externally by utilising existing events such as Southampton Mela Festival as well as creating our own external opportunities. In the past year we have held six members' evenings at the hospital which has given members a unique chance to find out more about the goings on within a major acute NHS trust.

Membership levels have reduced naturally, but work is being done around creating further incentives for members, including target groups we know we need to develop further, by both the membership manager and Council of Governors. The annual members meeting in September 2017 bought UHS together with partners from South Central Ambulance Service and Hampshire and Isle of Wight Air Ambulance to show attendees what happens during a major trauma event. Attendees also received information on Trust news and finances.

We continue to develop relationships with healthcare colleagues and the community to help reach and hear the views of as many people as possible. The annual hospital open day at Southampton General Hospital was a success and by including the governors within a treasure trail they were able to meet and speak with members of the public who otherwise may not have been aware of their function and role within the Trust. 2018 sees us continuing to focus on engagement and recruitment with many more exciting events, such as celebrating 70 years of the NHS, to come.

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 asked to present on a wide range of topics.

Examples of topics covered during 2017/18 include:

- Patient complaints
- Patient survey results
- Patient experience strategy
- Equality and diversity
- Results of the National Cancer Survey
- Update on the UHS volunteer scheme
- Review of Council of Governors' effectiveness
- 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 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. In addition, council members hold a private meeting with the non-executive directors on a quarterly basis.

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, four governors claimed expenses totalling £1,017.54.

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

Interim chief executive officer
24 May 2018

Annual remuneration statement

Executive changes

The executive team have remained substantively the same during 2017/18. However due to long term illness of Caroline Marshall (chief operating officer), Andrew Asquith (deputy chief operating officer), covered the position until 1 March 2018.

New non-executive directors

David Price left the Trust on 31 December 2017 and was replaced by Jane Bailey on 1 January 2018.

Professor Iain Cameron reached the end of his second term of three years and left the Trust on 31 December 2018. Due to the Trust's continuing close links with the University of Southampton, Professor Cyrus Cooper was appointed as non-executive director commencing 1 January 2018.

Lynne Lockyer finished her second term and was replaced by Catherine Mason on 1 March 2018.

All appointments of non-executive directors were approved by the Council of Governors in line with UHS constitution.

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 2017.

Specific pay changes

Following salary benchmarking information provided by NHS Improvement during February 2017, the remuneration and appointment committee reviewed the salaries of existing executive directors. Most salaries benchmarked appropriately against information provided by NHSI, at either below or around the medium salary for large acute NHS trusts of £500m turnover or greater.

However it was noted that the chief executive's salary was significantly below the lower quartile of comparator trusts. In consideration of the excellent performance of UHS and the substantial contribution made by the CEO the remuneration committee agreed to seek approval from NHSI to increase salary. Following the approvals procedure this was agreed and the salary of Fiona Dalton was increased to £211,090 from 1 April 2017.

It should be noted that the increase was non-pensionable and Fiona chose to donate all of the increase to charity.

Senior managers' remuneration policy

The table below sets out a description of the remuneration package for senior managers:

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 performance related pay for its executive directors at present. In the current financial context this is seen as the right way to operate.

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 for COO position	£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 appointment 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. The Trust uses the NHS Improvement benchmarking information as its primary guide.

Salaries in excess of the pay received by the prime minister

The remuneration and appointment 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).

The salaries of executive directors are outlined on page 58. 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	Approximate time commitment	Fee type payable	Amount
Chair	2.5 days per week	Annual fee	£47,275
Senior independent director (SID)	4 days per month	Annual fee Additional annual payment for SID role	£13,181 £2,500
Non-executive director (NED)	4 days per month	Annual fee	£13,181
Chair of audit and risk committee	1 day 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

Changes to non-executive director pay

Current non-executive directors (NEDs) are able to claim reasonable expenses incurred in conducting their duties (travel and so on).

In October 2017 the Council of Governors agreed that the existing arrangements be phased out and the structure of NED remuneration be aligned more closely with that of other UHS staff. Specifically;

- NEDs are only able to claim travel expenses for costs incurred that are not part of normal travel from home to UHS.
- NED mileage for travelling to Southampton General Hospital is replaced with a flat sum to be consolidated into NED salaries. In 2016/17 total travel to work expenses paid to claimant NEDs averaged £766 each. It is therefore proposed that this amount be incorporated into salaries for newly-appointed NEDs raising them to £14,000.

The car parking charge to NEDs continue to be levied monthly to preserve parity with other UHS staff.

The three new NEDs appointed since this time have been recruited on these new terms. All existing NEDs will transition to the arrangement from 1 April 2018.

Interim chief executive officer
24 May 2018

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 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 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 attendance record

Board member	Apr 27	July 27	Sept 27 Extra	Jan 16	Feb 1	Mar 1	Mar 29 Extra
Peter Hollins Chair	✓	✓	✓	✓	✓	✓	✓
Simon Porter (senior independent director and deputy chair)	✓	✓	✓	✓	✓	✓	✓
Iain Cameron non-executive director (until 18/12/17)	✓	✓	✓				
Lynne Lockyer non-executive director (until 28/2/18)	✓	✓	✓	✓	✓		
David Price non-executive director (until 31/12/17)	✓	✗	✓				
Mike Sadler non-executive director	✓	✓	✓	✗	✓	✓	✓
Jenni Douglas-Todd non-executive director	✓	✓	✗	✓	✗	✓	✓
Jane Bailey non-executive director (from 1/1/18)				✓	✓	✓	✓
Cyrus Cooper non-executive director (from 1/1/18)				✗	✓	✗	✓
Catherine Mason non-executive director (from 1/3/18)						✓	✓

How is executive performance assessed?

The remuneration and appointment 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 and appointment 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?

The Trust does not operate performance bonus schemes. The chief executive has terms which can take back a proportion of salary in the event of substantial and or sustained under-performance of duties.

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.

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 three governors and the chair. The chief executive and 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 is a member 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	Chairman	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).	31 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).	1 March 2018
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	31 December 2019
Mike Sadler	Non-executive director	1 September 2014	31 August 2020
Jenni Douglas-Todd	Non-executive director	1 April 2016	31 March 2019
Jane Bailey	Non-executive director	1 January 2018	1 January 2021
Catherine Mason	Non-executive director	1 March 2018	1 March 2021
Professor Cyrus Cooper	Non-executive director	1 January 2018	1 January 2021

Payments for loss of office during 2017/18

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

Remuneration of senior managers 2017/18

	2017-18					
Name and title	**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**
Mr A Asquith	125-130	n/a	n/a	n/a	70-72.5	195-200
Ms J Bailey	0-5	n/a	n/a	n/a	n/a	0-5
Ms G Byrne	135-140	n/a	n/a	n/a	125-127.5	260-265
Prof I Cameron	5-10	n/a	n/a	n/a	n/a	5-10
Prof C Cooper	0-5	n/a	n/a	n/a	n/a	0-5
Ms F Dalton	210-215	n/a	n/a	n/a	50-52.5	260-265
Mr D French	165-170	n/a	n/a	n/a	47.5-50	215-220
Ms J Hayward	140-145	n/a	n/a	n/a	37.5-40	180-185
Mr P Hollins	45-50	n/a	n/a	n/a	n/a	45-50
Ms Lockyer	10-15	n/a	n/a	n/a	n/a	10-15
Ms C Mason	0-5	n/a	n/a	n/a	n/a	0-5
Dr C Marshall	185-190	n/a	n/a	n/a	20-22.5	205-210
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	15-20	n/a	n/a	n/a	n/a	15-20
Ms J Douglas-Todd	10-15	n/a	n/a	n/a	n/a	10-15
Dr D Sandeman	200-205	n/a	n/a	n/a	32.5-35	230-235

Prof Cameron left the Trust on 31 December 2017.
Prof Cyrus Cooper and Jane Bailey commenced with the Trust on 1 January 2018.
Ms Catherine Mason commenced with the Trust on 1 March 2018.
Mr Andrew Asquith covered the role of chief operating officer due to the absence of Caroline Marshall.
The salary increase to Fiona Dalton's pay was non-pensionable and Fiona chose to donate all of the increase to charity.

Comparison with 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

Pension benefits of senior managers

	2017-18						
Name	**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 2018 (bands of £5000)**	**Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5000)**	**Cash equivalent transfer value at 31 March 2018**	**Cash equivalent transfer value at 31 March 2017**	**Real increase in Cash equivalent transfer value**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr A Asquith	2.5-5	5-7.5	30-35	70-75	443	379	30
Ms G Byrne	5-7.5	17.5-20	45-50	145-150	1062	870	90
Ms F Dalton	2.5-5	0-2.5	50-55	115-120	743	671	32
Mr D French	2.5-5	0-2.5	25-30	0-5	309	260	23
Ms J Hayward	2.5-5	0-2.5	55-60	155-160	1077	975	46
Dr C Marshall	0-2.5	5-7.5	65-70	200-205	1571	1445	55
Dr D Sandeman	0-2.5	5-7.5	70-75	210-215	1658	1516	63

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.

Figure for 2016/17 are show in brackets

- The banded remuneration of the highest paid director for the year to 31 March 2018 was £210k-£215k (£195k - 200k). This was 7.2 (6.8) times the median remuneration of the workforce which was £29.1k (£29.0k).
- The banded remuneration of the chief executive for the year to 31 March 2018 was £211.1k (£191.0k). This was 7.2 (6.6) times the median remuneration of the workforce which was £29.1k (£29.0k).
- For the year no (six) employees received remuneration in excess of the highest paid director.
- Remuneration ranged from £15.4k to £211.1k (£15.2k to £259.7k).

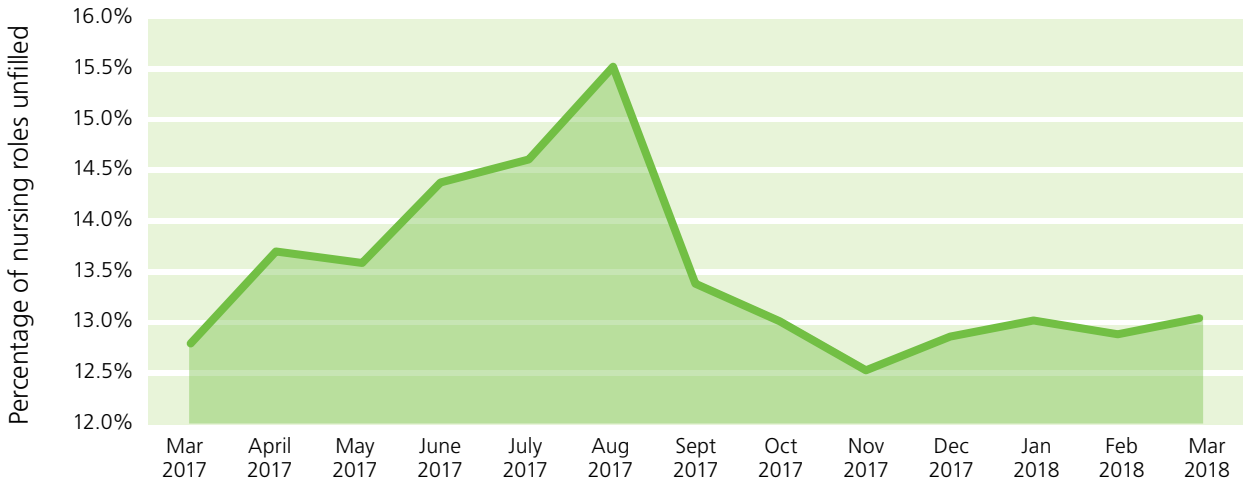
David French,
interim chief executive officer
24 May 2018

Staffing report

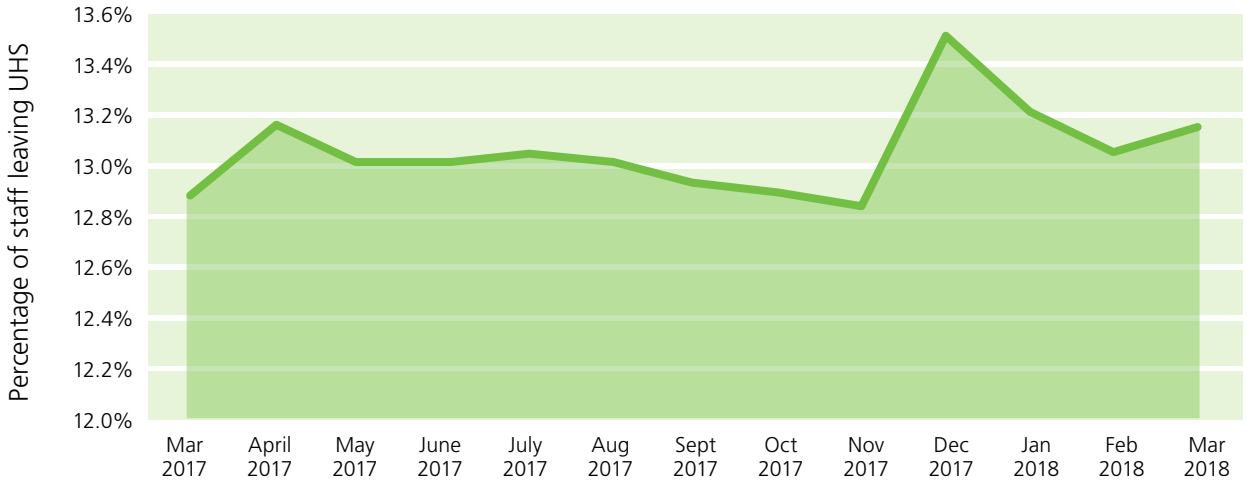
Performance

In 2017/18 recruitment remained steady including the annual surge for newly qualified recruitments in September. Nursing vacancy rates and staff turnover in 2017/18 are shown in the charts below.

UHS nursing vacancies 2017/18



UHS staff turnover (rolling 12 months) 2017/18



We employ in excess of 11,400* 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.
*Total number of permanent, bank, fixed term and honorary contract staff.

Table 1:
Staff employed as at 31 March 2018

Staff Group	FTE	Headcount
Additional professional scientific and technical	332.80	377
Additional clinical services	1,658.98	1,912
Administrative and clerical	1,617.36	1,840
Allied health professionals	508.07	590
Estates and ancillary	410.46	449
Healthcare scientists	280.33	302
Medical and dental	634.95	671
Nursing and midwifery registered	3,039.69	3,473
Grand Total	**8,482.63**	**9,614**

Average number of staff employed during 2017/18

Staff Group	FTE	Headcount
Additional professional scientific and technical	323.6	369
Additional clinical services	1,591.5	1,840
Administrative and clerical	1,573.8	1,799
Allied health professionals	496.8	576
Estates and ancillary	408.2	445
Healthcare scientists	273.8	296
Medical and dental	617.6	654
Nursing and midwifery registered	2,992.4	3,417
Grand Total	**8,277.8**	**9,394**

Table 2:
Staff employed through bank, fixed term and honorary contracts as at 31 March 2018

Staff Group	FTE	Headcount
Additional professional scientific and technical	16.22	22
Additional clinical services	69.25	102
Administrative and clerical	207.09	306
Allied health professionals	17.46	37
Estates and ancillary	12.40	35
Healthcare scientists	16.40	22
Medical and dental	793.23	1,196
Nursing and midwifery registered	78.83	120
Grand Total	**1,210.89**	**1,840**

Average number of staff engaged through bank, fixed term and honorary contracts during 2017/18

Staff Group	FTE	Headcount
Additional professional scientific and technical	14.1	21
Additional clinical services	70.1	127
Administrative and clerical	189.8	291
Allied health professionals	13.9	52
Estates and ancillary	19.8	43
Healthcare scientists	15.9	23
Medical and dental	786.2	1,168
Nursing and midwifery registered	91.2	132
Grand Total	**1,200.9**	**1,857**

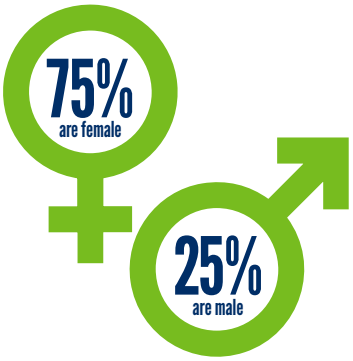
Staffing costs

	Group		Trust	
	Year ended 31 March 2018 Total £000	Year ended 31 March 2017 Total £000	Year ended 31 March 2018 Total £000	Year ended 31 March 2017 Total £000
Salaries and wages	**350,852**	336,253	**350,534**	335,965
Social security costs	**36,190**	34,670	**36,165**	34,649
Apprenticeship levy	**1,740**	0	**1,737**	0
Pension cost - Employers contributions to NHS Pensions	**42,293**	40,491	**42,287**	40,491
Pension cost - other contributions	**18**	17	**18**	10
Temporary staff - external bank	**19,394**	9,748	**19,394**	9,748
Temporary staff - agency/contract staff	**11,610**	13,964	**11,606**	13,964
NHS Charitable funds staff	**882**	355	**0**	0
Recoveries from Other bodies in respect of staff cost netted off expenditure	**(9,253)**	(3,485)	**(9,253)**	(3,485)
Total Net Staff Costs	**453,726**	432,013	**452,488**	431,342
Employee Expenses - Staff	**451,699**	430,933	**451,343**	430,617
NHS Charitable funds: Employee expenses	**882**	355	**0**	0
Total Employee benefits excluding capitalised costs	**452,581**	431,288	**451,343**	430,617

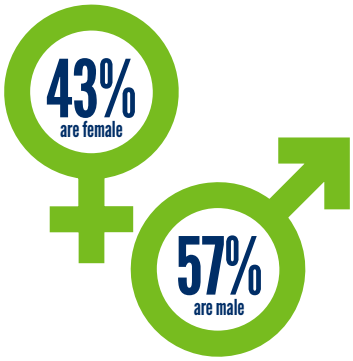
Gender equality

Our workforce is predominantly female, and the Trust is well represented by senior female leaders in executive director positions – you can find the gender breakdown of our staff below.

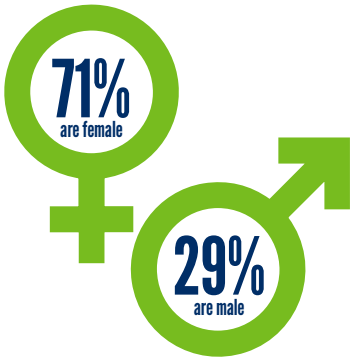
UHS workforce



Chair and Non-executive directors



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.

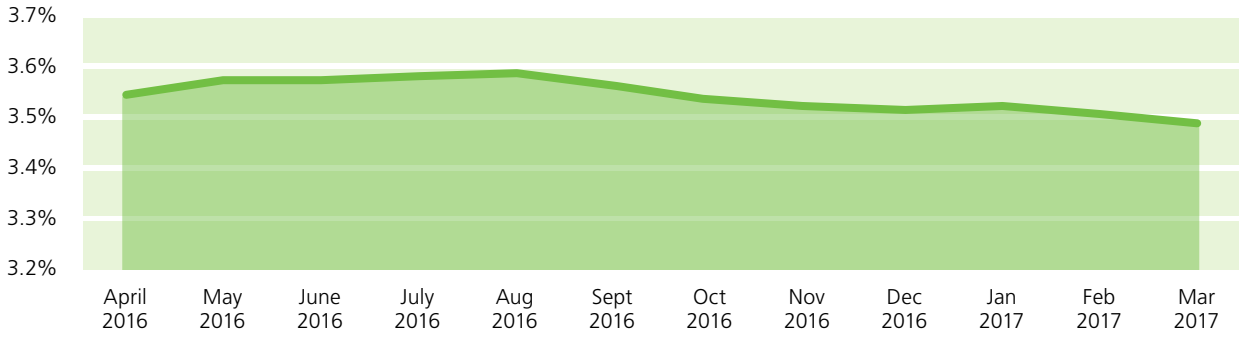
UHS has worked as one of the exemplar sites for NHS England's Healthy Workplace project. Our 'Live well and inspire' programme has promoted and delivered a range of activities, which include providing health checks for all staff. We have also installed a mini health check machine in the front entrance of Southampton General Hospital, which has proven extremely popular with both staff and the public.

Each staff member's 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.

In 2017 the absence management policy was revised to increase the levels of support provided and also take a more robust approach to the management of persistent absence.

UHS sickness rate (12 month rolling)



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.

A number of initiatives have been established in partnership 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, which has been made a permanent position, 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.

Experience of disabled staff remains a key concern for the Trust as a result of the 2017 staff survey results. This will continue to be a key area of focus for UHS.

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.

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

Freedom To Speak Up

All NHS trusts are required by the NHS Contract (2016/17) to nominate a Freedom to Speak Up Guardian and implement the minimum standards set out by NHS Improvement.

In 2016, UHS initially appointed Gail Byrne (director of nursing) and Steve Harris (director of HR) as its two Freedom to Speak up Guardians. The national FTSU office has published further recommendations, in line with the Francis review on implementation of FTSU, which encourages the executive director responsible for patient safety to oversee the raising concerns agenda with another person acting as the guardian.

In responding to these recommendations, in October 2017 UHS appointed Christine Mbabazi to the role of Freedom to Speak up Guardian. Christine focuses 2.5 days per week on this role, and also works as a lead for Equality and Diversity reporting to the Head of EDI.

Prior to the publication of requirements for FTSU, UHS had developed a strong culture of raising concerns, with particular reference to patient safety. Following the Francis Review in 2013, UHS took the following steps:

- Set up a Whistleblowing helpline manned by senior managers in 2014.
- Introduced an electronic incident management and reporting system with a campaign to increase levels of reporting called 'Safety in Numbers'.
- Launched a campaign called 'silence harms speak out' in 2013.

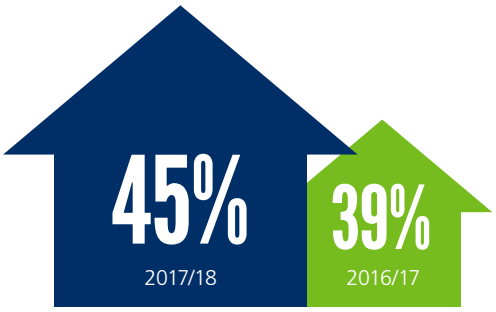
The annual staff survey results place UHS in the top 20% of acute Trusts with respondents feeling confident to raise concerns. The CQC, during its inspection in 2017, noted a strong culture of staff being able to raise concerns and being listened to appropriately.

UHS will continue to embed the FTSU guardian recommendation, continue to engage with the national and regional networks and provide reports to the Trust Board on issue being raised.

Responding to the staff annual attitude survey

The NHS has seen an extremely challenging year in terms of finances, staffing and performance. or the first time in seven years, overall NHS average staff engagement in the acute sector has fallen. However, UHS staff engagement has remained high.

Participation rates



Response rates are in line with NHS acute averages.

Things to celebrate:

3.95

UHS staff engagement has remained consistently high (3.95) compared to the NHS average (3.79). Overall, staff engagement fell from 3.81 to 3.79 in the acute sector.

NO.7

UHS is ranked number seven in acute Trusts, and is now the third best university teaching hospital.

NO.1

UHS is ranked as the best in the south for recommendation as a place to work and be treated.

NO.2

UHS is ranked second in good communication between senior managers and staff.

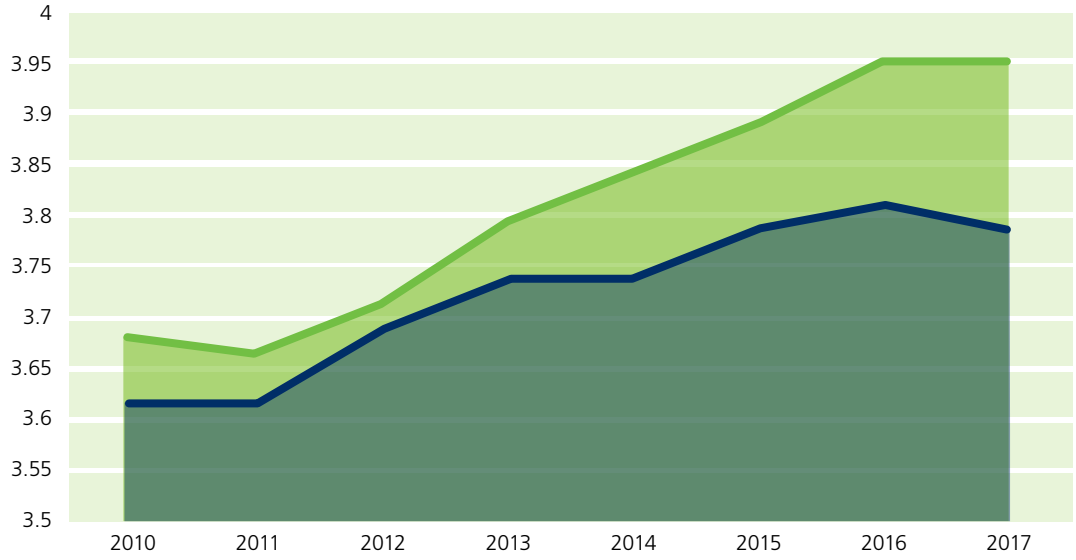
TOP 20%

Out of 32 key findings, UHS is in the top 20% of acute trusts in 18 areas. It is also above average in nine key finding areas.

UHS has seen statistically significant improvements in the following areas:

- quality of non-mandatory training, development and learning.
- percentage of staff experiencing bullying and harassment, which has dropped from 23% to 21%.

UHS engagement score v acute average



Ranked scores

Top/ bottom	Area	KF no	Key finding	Result	Acute average
Top 5 ranking score	Errors and incidents	31	Staff confidence and security in reporting unsafe clinical practice	3.83	3.65
	Errors and incidents	30	Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.87	3.73
	Working patterns	15	Percentage of staff satisfied with the oportunities for flexible working patterns	59%	51%
	Managers	6	Percentage of staff reporting good communication between senior management and staff	44%	33%
	Job satisfaction	1	Staff recommendation of the organisation as a place to work or receive treatment	4.05	3.75
Bottom 5 ranking score	Violence, harassment and bullying	27	Percentage of staff/colleagues reporting most recentexperience of harassment, bullying or abuse	44%	45%
	Equality and diversity	20	*Percentage of staff experiencing discrimination at work in the last 12 months	12%	12%
	Violence, harassment and bullying	22	*Percentage of staff/colleagues experiencing physical violence from patients, relatives or the public in the last 12 months	15%	15%
	Violence, harassment and bullying	24	Percentage of staff/colleagues reporting most recent experience of violence	68%	66%
	Errors and incidents	29	Percentage of staff/colleagues reporting errors, near misses or incidents witnessed in the last month	91%	90%

Areas of challenge

- Whilst showing some improvements in scores for Black and Minority Ethnic staff (BME), they remain lower in the Workforce Race Equality measures (WRES).
- Experience of staff who have stated that they have a disability still reported consistently lower acoss most metrics.
- Administration and clerical staff (excluding corporate HQ functions) report a significantly lower level of staff engagement than the UHS average.
- Whilst staff experiencing violence, abuse, bullying and harassment from patients and service users is not a national outlier, it is still a significant cause for concern.
- Number of appraisals being carried out has fallen from 89% to 87%. Also, whilst UHS remains in the top 20% of trusts for quality of appraisals, less than 40% of staff reported that the appraisal helped their job and left them feeling valued.
- Over 500 free text comments were submitted. The key themes of concern included dissatisfaction with pay, pressures due to staffing levels, and equality issues relating to disability.

Moving forward

Area of focus	Key actions	Measure of improvement
Appraisal quality	• Launch and embed the new values based appraisal system for Bands 1 - 8b. • Roll out improved training focused on quality of conversation. • Focus on areas of low performance in quality and quantity through HR business partners.	An increase in appraisals completed on ESR to 90% by 31 March 2019. An increase in the 2018 staff survey with staff reporting an increase in quality of appraisal.
Equality and diversity	• Continue to deliver the WRES action plan focusing particularly on: - Improvements in recruitment process and feedback to candidates. - Increasing engagement with BME staff on WRES and actions. • Work closely with the LID network to deliver improvements in: - Management of staff with disabilties and long term conditions (such as application of absence policy). - Further increase in speed and effectiveness of reasonable adjustments. - Delivering improvements in opportunites for career progression for disabled staff.	Improvement in WRES scores in 2018 staff survey. Improvements in results in disabled staff in 2018 survey results.
Violence and aggression	• Deliver progress in reductions in violence and aggression and support for staff through the violence and aggression steering group.	Improvements in the number of staff experiencing violence, aggression and harassment to below the national NHS average.
Quality improvement	• Continue with the Trust's quality improvement (QI) programme to increase staff ability to contribute to change and improvement in workplace systems and processes.	Staff reporting an increase to 80% in 'ability to contribute to improvements in work area' in the 2018 survey results.
Communication	• Ensure that each care group and department has a minimum level of digital and face-to-face communication, to ensure a two way dialogue and that key messages can be cascaded.	Increase in staff reporting effective communication from senior managers to 50% in the 2018 results.
Administration and clerical	• Establish a task and finish group to form corporate actions to improve the scores for this group.	Improvements in staff engagement for this group from 3.81 to 3.90.
Local action planning	• Ensure local plans to address key areas of concern in each divison/care group through HRBP's. • Wellbeing assessments to be carried out locally in areas where staff report high levels of stress.	Local improvements and targets as per local action plans.

Staff friends and family survey results

Staff experience is of great importance to UHS and in 2017 the friends and family test results showed that UHS was fourth best nationally for our proportion of staff saying that they would recommend the hospital as a place to work or to receive care.

UHS Friends and Family Test 2016 and 2017

Percentage of staff who recommend UHS as a place to work

Expenditure on consultancy

The Trust spent £53,000 on external consultancy during 2017/18.

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 established a process for dealing with potential off-payroll workers and contracts which has been reviewed by the Trust's tax advisers and is compliant with HMRC requirements under IR35.

Table 1: For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2018	Nil
Of which… No. that have existed for less than one year at time of reporting	Nil

Staff exit packages

The tables below outlines staff exit packages in line with the prescribed guidance for Foundation Trust reporting.

Exit package band	Number of compulsory redundancies	Number of other departures	Total number of exit packages by cost band
<£10,000	0	2	2
£10,000 - £25,000	0	2	2
£25,000 - £50,000	0	2	2
£50,000 - £100,000	0	1	1
£100,000 -£150,000	0	0	0
£150,000 - £200,000	0	1	1
Total number of exit packages by type	0	8	8
Total resource costs	**0**	**368,887**	**368,887**

Non-compulsory departures payments

Type of exit	Agreement number	Total value
Voluntary redundancies including early retirement contractual costs	3	**279,724**
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	5	**89,163**
Exit payment following tribunal or court orders	0	**0**
Non-contractual payments requiring HMT approval	0	**0**
Total		**368,887**
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 National Health Service Act 2006 (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 Southampton NHS Foundation Trust and of its income and expenditure, items of other comprehensive income 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 the NHS Foundation Trust Annual Reporting 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;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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 them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and 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. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

David French, interim chief executive
24 May 2018

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 2018 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 accountability 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 'Freedom to Speak Up (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 and routinely considers performance against a broad range of qualitative indicators including (but not limited to):
  - Integrated performance report
  - Access performance (including emergency department and referral to treatment)
  - Delayed transfers of care
  - Never events/serious untoward incidents
  - Complaints
  - Emergency re-admissions
  - Clinical outcomes
  - Hospital standardised mortality rate

- **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 principle 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.

Operational risks scoring 15 or above are mapped to the corresponding priority within the Assurance Framework, this enables the Board and audit and risk committee to have oversight of emerging risks and issues which may impact on the achievement of the agreed priorities.

The audit and risk committee undertakes quarterly reviews of the levels of risk identified and the controls in place to manage them. In addition to this the committee has undertaken a rolling programme of detailed reviews of individual Board priorities and the corresponding risks. A summary of the principal governance risks (managed in year) is provided below. Given the strategic nature of these risks, these will continued to be managed within future years.

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 Quality Improvement Framework priorities. Clinical accreditation scheme established to ensure that clinical areas are meeting the required standards. Routine monitoring of patient feedback including Friends and Family test and compliments/complaints. Robust mechanisms in place for reporting all incidents and near misses. The Serious Incident Scrutiny Group (SISG) conduct detailed investigation of all serious incidents and onward reporting to Board. The Interim Medical Examiners Group (IMEG) conduct reviews of all unexpected deaths. Medical director and director of nursing oversight of all Never Events and onward reporting to Board. Patient outcomes, experience and safety reports are provided to the Trust executive committee, quality committee and Trust Board.

Principal risk	How they are managed / mitigated
Failure to maintain staffing levels that reflect the needs of patients and are sufficiently flexible to support variability in demand	Available funding reviewed as part of regular ward staffing reviews. E-rostering is in place for all ward staff and the Trust has a single centralised bank for medical and nursing staff (NHS Professionals). 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. Focused recruitment strategies (including overseas) have been developed for 'hot spot' areas. Strengthening availability of alternative routes into training through apprenticeship models. A staffing status report is presented to the Trust executive committee and Trust Board on a monthly basis providing assurance around staffing risks.
Failure to deliver national access targets (ED, Cancer, RTT)	Internal processes have been improved alongside improving responsiveness from wards. Escalation processes have been implemented for breaches as well as weekly reviews. 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. Pilot new models of care through STP such as virtual clinics, reduced follow-ups. Participation in national improvement programme on frailty and ambulatory emergency care. 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: 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. 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. Capacity plans have been developed with links to wider system capacity plans. Work continues with the local health social care network to reduce delayed discharges. Plan agreed to achieve DToC reduction by December 2017 partially achieved. Implementation of 'Home before Lunch'
Failure to deliver financial plan as agreed with NHS Improvement – £27.1m 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. Management controls in place to restrict the use of agency/interim staff. Regular contract reviews held with commissioners. Good progress on delivery of CQUINs. Finance and KPI report showing monthly and cumulative performance on STF metrics. 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. 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. Agreed strategic maintenance plan that prioritises infrastructure risks that have the highest impact and are most likely to fail. Trust Investment Group (TIG) reviews the prioritisation of and approves business cases. 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. The audit and risk committee receives a Data Quality Assurance Framework on an annual basis, highlighting risks to data quality and mitigation actions being taken.

The Trust has always had a range of sophisticated software tools in use, managed by the central IT team, that protect its sensitive data against unwanted access from both external and internal sources as part of targeted criminal activity, malicious damage or accidental loss.

The recent award from NHS Digital of additional cyber resilience funding for Major Trauma Centres, has enabled us to invest further in the latest generation of firewall and threat prevention solutions from the leading suppliers in the market place.

Significant investment has also been made to enhance security on increasingly popular mobile devices.

The Trust has an Information Governance Steering Group which oversees management of our data security arrangements, ensures our technical and risk management and reporting policies are updated on a regular basis and ensures our processes meet the requirements of the annual submission of the, Information Governance Toolkit audit, to the Department of Health.

There is mandatory, annual Information Governance training for all staff. Contracts of employment contain specific information on the legal duty and obligations to maintain the security of all sensitive data and make reference to the specific Trust policies on this subject.

There is communication via the Trust's briefing process, intranet articles and staff briefing emails regarding specific threats and current malicious activity.

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
- Annual members' meeting.

Well-led assessment

In-line with guidance published by NHS Improvement in June 2017 and the requirements of the Code of Governance, the Board engaged KPMG to carry out an externally facilitated, developmental review of our leadership and governance using the well-led framework.

The review concluded in September 2017 with KPMG confirming that "there are sufficient arrangements in place to ensure that University Hospital Southampton NHS Foundation Trust (the 'Trust') is well-led. Our view is that the Trust is high performing against each domain".

The findings of KPMG were consistent with the self assessment undertaken by the Board. There were no governance issues noted and eight low level recommendations raised.

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 child health, day surgery unit and surgical pathways and psychiatric/mental health pathways.

In March 2017 the Department of Health published National guidance on learning from deaths. From April 2017, the Trust was required to collect information on deaths, reviews, investigations and resulting quality improvements; and from Q3 of 2017/18, this information has been reported via a quarterly paper presented to the public board meeting. The Internal Medical Examiner Group (IMEG) has carried out 'hot' review of adult inpatient deaths since September 2014, progressively expanding its scope to include all adult inpatient deaths since June 2015 and more recently to include deaths in the emergency department.

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 Quality Improvement Framework (QIF) 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.

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 Quality Improvement Framework priorities and are governed by our Transformation Board, led by the chief executive. The CIP has delivered approximately £32m of efficiency in 2017/18, 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 financial performance 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 2017 to 31 March 2018 the Trust reported four Information Governance Serious Incident Requiring Investigation (IG SIRI) to the Information Commissioner.

One incident involved an unencrypted data stick being lost, which contained information about a number of members of staff. The Information Commissioners Office (ICO) investigated and did not take any regulatory action against the Trust. The second incident concerned letters with patient information being sent to an incorrect address; the ICO investigated but did not take any action against the Trust. The other two incidents concerned a nursing handover sheet being included in a patient's belongings and some patient letters being sent to an incorrect person. These are currently under ICO investigation.

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 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 an established 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.

The Trust has a designated Data Quality Group in place, chaired by the director of transformation, in her role as the executive lead for IT. 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 risk 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 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 2017 to 31 March 2018 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 to conduct a follow-up inspection of issues previously highlighted within surgery, critical care, end of life care and outpatient and diagnostic imaging services. The improvements found at this follow-up inspection resulted in an overall rating of 'Outstanding' for the caring and well-led domains. In addition to this, the Trust achieved an improved overall rating of 'Good'. See page 147.

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 risk 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.

Interim chief executive officer
24 May 2018

Voluntary disclosures

Equality, diversity and inclusion

UHS continued to drive the equality agenda during 2017/18. The three year Equality, Diversity and Inclusion strategy is currently being drafted and a number of consultation events involving staff, patients and partners have taken place. UHS is establishing itself as a Third Party Reporting Centre for Hate Crimes, providing a safe and supported environment for staff to report any discrimination or harassment they may experienced outside of working hours. UHS are promoting inclusion through participation in National Inclusion Week, providing a range of activities which seeks to raise awareness of the importance of inclusion in the workplace and the business benefits to having a diverse and included workforce.

Key equality areas that UHS focused on are as follows:

Race

Race continues to be a key national and international issue. The Trust published its third annual national Workforce Race Equality Standards (WRES) in July. The report indicated that whilst there is still considerable way to go before our workforce is truly equitable across race, progress is being made. BME and white staff are now equally as likely to enter disciplinary processes and access mandatory and non-mandatory training and CPD.

The Trust Board has 15% BME representation which reflects the local BME community. However, whilst there have been improvements in staff perception around equal opportunities for promotion and career progression, it does remain lower for BME staff.

Additionally, BME staff continue to report higher incidences of bullying, harassment and discrimination than their white counterparts. Appropriate governance arrangements are in place to monitor the action plan to address racial inequality within the workforce.

UHS are participating in the WRES Frontline Staff Forum to support the national development of the next stages of WRES. The head of equality, diversity and inclusion has also been selected to participate in the first WRES Experts programme.

UHS partnered with national development experts to deliver a bespoke programme designed to promote local BME talent, specifically aimed at mid grades such as bands six and seven. This programme was very well received and plans are being developed to consider how this inspired cohort of staff can be developed into coaches, role models and EDI project leads. A second programme is planned for 2018/19. Additionally, the Board received EDI training from the same experts and this training is to be extended to senior managers.

UHS is currently developing its plans to mark the Windrush 70th Anniversary, using this as theme for Black History Month in October.

Disability

Disability remains another key issue at UHS. The staff survey results continue to indicate that staff declaring a disability perceive a poor experience working at UHS. However, the staff Long-term Illness and Disability Group (LID) has seen an increase in membership and continues to drive improvements for staff with disabilities. For example, the production of two Top Ten Tips guides, one aimed at managers supporting staff with disabilities, the second to highlight to staff with disabilities the support available and how to access it, a review of the Managing Sickness and Absence Policy and numerous estates access improvements.

UHS also supported three staff to participate in the Leadership Academy Programme, a programme designed specifically for junior/middle managers, who want to progress in their careers and have a disability or long term health condition. UHS are negotiating with Disability Rights UK to host delivery of this programme in-house to afford more staff this opportunity.

The Access Group continues to identify and prioritise estates related access issues, some of these include the Changing Places Toilet (currently being registered with the national Changing Places organisation), improving provision of hearing loops, installation of electronic doors and improvements to uneven surfaces.

UHS renewed its status as a Disability Confident Employer and is beginning work towards achieving Disability Confident Leader status within the next 18 months.

The Trust is also preparing for the forthcoming introduction of the Workforce Disability Equality Standards (WDES) later this year. The WDES is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant organisations to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.

Lesbian, Gay, Transgender, Bisexual (LGTB)

The Trust has an online LGBT group which provides peer support for LGBT colleagues and provides a voice for LGBT issues within the Trust. In August 2017 UHS again participated in the annual Southampton Pride Event. Its stand was well attended providing useful information about services, in addition to ensuring a platform to promote UHS as a good employer in Southampton.

A Transgender Patient Pathway Policy has been drafted and is currently being reviewed by local Gender Identity Issues charity Chrysalis, ahead of final policy approval.

Faith

UHS developed a multi-faith chaplaincy team, with chaplains from a number of Christian denominations, Muslim and Humanist faiths. A number of faith based celebrations were delivered throughout the year by the chaplaincy team, such as Eid lunch, Christmas carol service.

Governance and oversight

The director of nursing chairs the Trust's Equality, Diversity and Inclusion 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.

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 a Trust-wide staff awareness campaign promoting sustainability. To embed our sustainability ambitions, we will be putting together a Sustainable Development Management Plan (SDMP) in the near future 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. According to a report published in 2016 by the Sustainable Development Unit, an 11% carbon reduction was achieved by the NHS between 2007 and 2015. The carbon reduction target has been updated and the new goal for the NHS is to reach a 27% reduction by 2020.

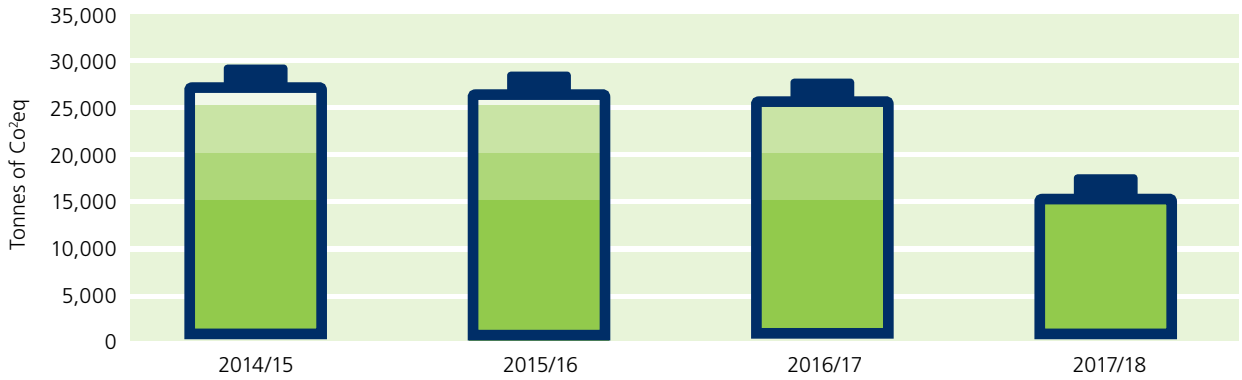
NHS England has identified the key areas or 'carbon hotspots' across the healthcare service where we should prioritise our carbon reduction activities to help protect the wellbeing of the UK population.

Energy consumption

For the year 2017/18 we used 38,866,480 kilowatt hours of electricity. Although this represents a 2.1% increase in consumption compared to the previous year, we've seen an important drop in the carbon emission equivalent. The 57% drop in the CO2e on one hand can be explained by a reduction in the use of natural gas, but on the other hand there has been a review of the Green House Gases (GHG) conversion factors for the year 2016 (-11%) and for 2017(-15%). The reduction in the conversion factors is a reflection of the fuel mix in todays UK electricity market. For example, low carbon electricity made up over half of the UK's supply, with coal plants closing or converting into biomass.

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

Carbon emissions - energy use



CO2eq is the standard unit for measuring carbon footprints

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

The Trust will invest £2.6m in energy efficiency schemes including replacing single glazed windows with high performance double glazed units, improving roof insulation, changing light fittings, waste heat recovery measures, introducing new BMS system controls in theatres, improvements to steam mains thermal insulation and the 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 two years ago with the purchase of an anaerobic digester system. The idea was to use catering food waste from the lunch time meal to generate biogas in order to generate renewable electricity. Unfortunately, despite our best efforts to keep the plant operational; it had to be shut down. We are, however, exploring the options for running the plant with natural gas only.

In addition we are 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.

Sustainability awareness campaign

During this year the Trust also embarked on a major staff awareness and engagement programme in sustainability. The Trust now has a sustainability champion group under the name of the 'Green Guardian Network' of about 80 enthusiastic staff. 2017 was a year packed with activities, among which were a series of lunchtime seminars for staff intended to provide an overview of sustainability in healthcare and how the Trust is undertaking its statutory duties in delivering carbon emissions reductions. It aimed to provide insight into how change in clinical care practice could deliver resource efficiencies whilst improving patient (and staff) outcomes. We registered a turnout of more than 60 participants during the lunchtime seminar. The lunchtime seminar content has been compiled and added on the Trust virtual learning portal under the course title 'Sustainability in Healthcare' and every staff member is encouraged to take the course on a voluntary basis.

Another successful activity this year was the Green Ward Completion (GWC). The GWC is a clinical engagement programme run by the Centre for Sustainable Healthcare (CSH) for NHS trusts wishing to improve their environmental sustainability and reduce their carbon footprint. Healthcare workers who participate are supported to design an innovative project in their unit or ward that will bring social and financial benefits alongside carbon reductions from resource efficiency. This year, four teams entered the competition. Team leaders for the projects included Clare Tull, senior sister from urology, Kat Macfarlane, staff nurse from acute medical unit, Vanessa Harradon, sister from cardiac intensive care unit and Annette Purkis, head of therapies from the therapy department.

Last September the Acute Medical Unit was pronounced the winner and presented with a certificate and £500 prize money to invest in their project or another sustainable initiative. The table below provides detail on the annual savings available to the Trust from the 2017 Green Ward Competition projects when projects are fully implemented and ongoing. This list is not exhaustive as there are other carbon and cost savings which could not be captured in the time available. Furthermore, these carbon and cost savings will increase if the projects are scaled up across wards.

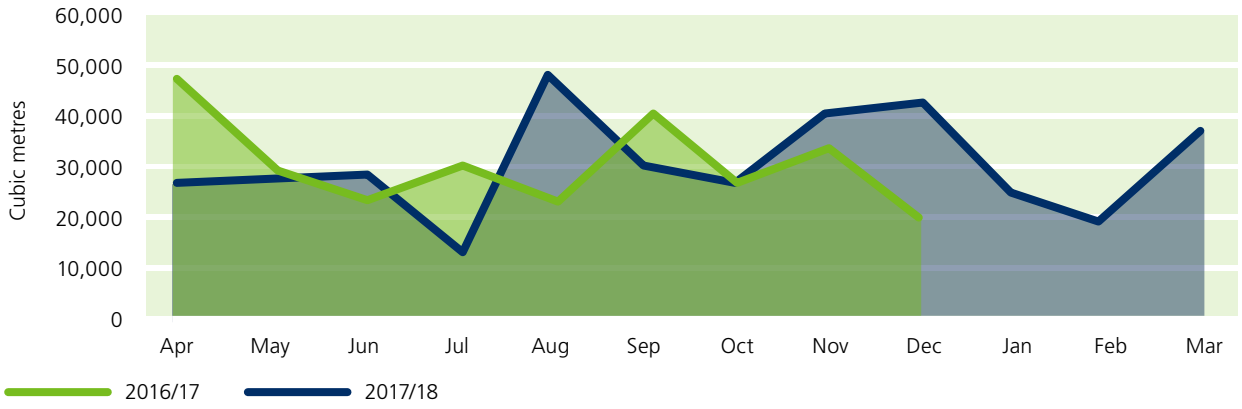
Project	Carbon	Money
Urometre Choice	3,082.17 kg CO2e	£10,061
Reducing duplicate ordering of medication	11,180 kg CO2e	£26,000
Eat, drink, move	25,63.58 kg CO2e	£166 (current) £12,934 (potential)
Early mobilisation project	8,950 kg CO2e	£47,500
Totals	**25,775.75 kg CO2e**	**£83,727 - £96,495**

Moving forward, the next challenge will be to calculate the potential savings from these projects if they were rolled out on every unit where applicable and also start a second GWC at UHS.

Finite resource use – water

The Trust used 354,488m3 of water this year, which equates to 342,804Kg of Co2 equivalents. This means a 5% increase in water use, despite the ongoing steam leak repairs that have been carried out throughout the year. We will continue to encourage individuals to reduce water wastage and report water leakages in order to improve our water efficiency.

SGH and UHS water use

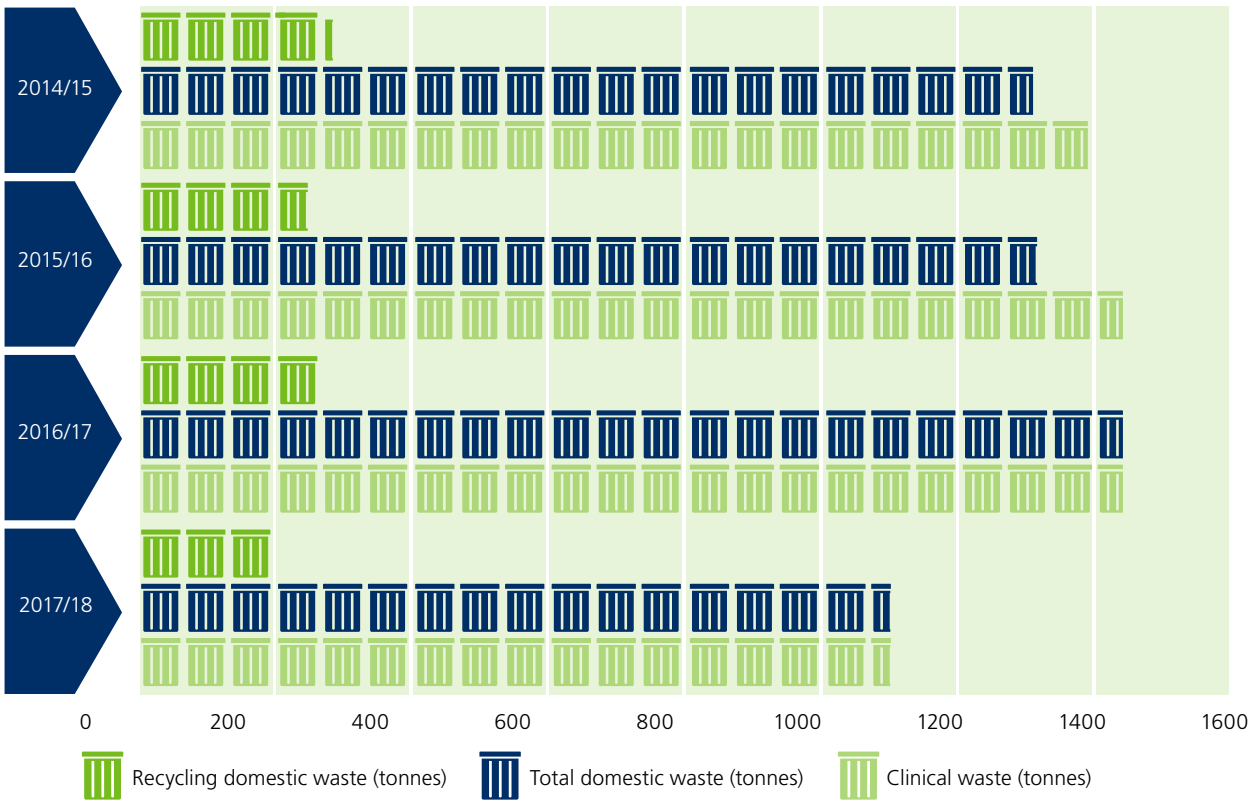


Waste management

Waste management is a core principle 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.

We have noticed an increase in the number of staff-led recycling initiatives and this is likely to positively impact next year's waste performance.

The waste data only includes waste data up to Q3 2017/18. 2,414 tonnes of waste was generated, which was equivalent to 24,827.4 kg CO2e.



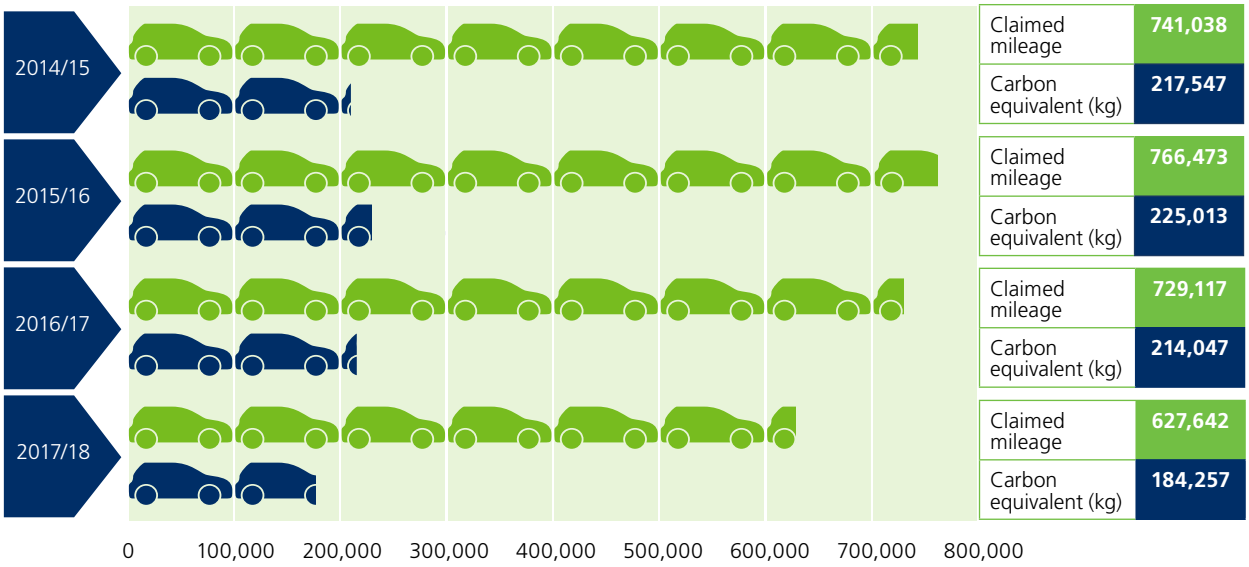
Sustainable travel

We are committed to improve the local air quality and improve the health of our community by promoting active travel to our staff. We will continue to encourage staff to use public transport and/or bikes with the aim to reduce our carbon (CO2e) reduction and improve staff wellbeing.

Compared to 2016/17 we have seen a 13% reduction in the amount of claimed mileage. This drop may be linked with the introduction of a new system which allows greater control and processes claims according to the Agenda for Change expenses claiming policy.

The trust encourages cycle to work and offer cycle to work scheme purchase for staff and organises regular Dr bike clinics and discounts on adult cycling lessons.

UHS travel emissions



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.

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 £1.722m, 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:

1.056m	262k	186k	147k	71k
for the purchase of equipment	for patient welfare and amenities	for staff education	for research	for staff welfare and amenities

SHC's major projects this year included:

- In partnership with the Murray Parish Trust, to raise **£2 million** towards the creation of a new children's emergency and trauma department
- Raising **£150,000** to complete the appeal to refurbish and remodel the Piam Brown children's cancer ward
- Raising **£50,000** for a new neonatal ambulance

The total raised for the benefit of the Trust's patients by SHC since its re-launch in 2008 now stands at £23.9m.

For more information about SHC visit www.southamptonhospitalcharity.org

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

The Charlotte Francis May Foundation

The League of Friends of Southampton Eye Unit

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. This programme started in 2017 and the Trust is now benefiting from the national investment.

As part of our electronic patient record programme, 2017 saw further extension of digitisation and went live with an Electronic Document Management System (EDMS) in Princess Anne Hospital in October. The scanning of documents is not the end point, but the start of a process that takes us through to direct digital data entry. Temperature, blood pressure and respiratory rate are now collected by mobile devices in nearly 50 wards and an assessment is ongoing regarding the introduction of fluid balance.

The Clinical Handover and Record of Treatment System used routinely by doctors on wards is now being developed into an outpatient list which will help the EDMS programme too and help the Trust move away from some old software.

The digital display of the ward 'white board' was successfully rolled out into medicine and elderly care before the winter, and this has proved a very popular project with staff who have continued to come forward with ideas for its use. For hospital control, it also provides a vital tool for management.

My Medical Record

The My Medical Record system supporting patients online is live for multiple organisations. Test results and letters are now routinely sent into this record, and the registered users have more than doubled to 9,000 in the past year. To support this growth and multiple user sites along with the security the system has been moved into the Microsoft Cloud.

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.

You can find out more about the informatics projects that are driving quality improvements on page 144 of the quality account.

Leading research into better care

You can find detailed information on our developments in research on page 147 of our quality account.

Investing for the future

The Trust continues to invest in our hospital sites with a programme of refurbishment and creating additional capacity where required.

Investments in 2017/18 have included:

- Relocation of the endoscopy washer disinfectors to G level North Wing
- The opening of the new Hybrid theatre on F level North Wing
- The completion of phase one of the E4 refurbishment programme
- The anaerobic digester has been brought into operation
- The completion of an building of an additional Linac bunker located within car park 9. The first patients were treated in early 2018 which enabled us to replace the existing machines
- Completion of the refurbishment of theatres 8 and 9
- The creation of an additional six side rooms in neurology
- Completion of phase one of the refurbishment of F1 ward
- The creation of a new safe space for patients in the emergency department
- The replacement of the washer disinfectors within sterile services
- Refurbishment of nuclear medicine on D level
- The creation of two additional surgical high dependency beds
- The opening of the new multi-storey car parking facility
- Improvements to customer parking have been completed
- The completion and opening of all four floors within Minerva House (support accommodation)
- Support for the completion of the University Cancer Centre for Immunology
- Continued investment in information technology
- Continued investment in the replacement of radiology equipment
- Continued investment in the infrastructure of the site through the strategic maintenance programme, creating a new decontamination unit for endoscopy and related services
- We have worked in conjunction with Maggie's charity to plan to build a new Maggie's centre

Investments planned for 2018/19 include:

- The continuation of the radiology equipment replacement programme
- The continued investment in information technology with external funding for an electronic document management system
- Building of the children's emergency department commenced in May 2018
- The creation of a new adult resus area which will facilitate improvements to the current majors area
- The creation of phase two of the refurbishment programme for F1 and E4 wards
- The refurbishment of four theatres in Princess Anne Hospital
- The creation of a new procedure room in West Wing
- The continuation of the detailed design to expand general ICU
- Creation of additional capacity for the neonatal department at Princess Anne
- The creation of a dedicated GP streaming suite by the emergency department to improve the flow of patients through the emergency department.
- The creation of a new theatre on E level centre block
- The creation of a larger GP hub next to the emergency department
- The creation of additional capacity in neurology for IAT medical thrombectomy
- The establishment of a new staff park and ride facility
- Continue to work with Maggie's charity to build the new Maggie's centre

ANNUAL ACCOUNTS

Statement from the chief financial officer

Despite a significant proportion of the NHS suffering with unprecedented financial pressures in 2017/18, I am pleased to report that the Trust has had a successful year, delivering a surplus of £41.1m.

Both income and expenditure were higher than expected due to continued growth in clinical activity, particularly over the winter months where emergency admissions were at their peak. During this period the Trust incurred higher pay costs in overtime and sometimes agency spend to ensure the highest quality of care is maintained for our patients. During the time of the severe bad weather the Trust provided overnight accommodation to some staff that put their patients first and stayed on the premises overnight. I would like to recognise this resilience, flexibility and compassion not only over the winter but across the whole year where our staff continue to go above and beyond to provide the best care they can in sometimes challenging situations.

The Trust had set a challenging efficiency target for 2017/18 of £32m which we overachieved by £1.8m by the year end, which is testament to the relentless drive to focus on improvement and transformation that so many of our staff are focussed on.

The Trust divested from its share of the highly successful Complete Fertility Centre to a major international private sector fertility company who are ideally placed to invest and develop the offering to patients.

The NHS has continued the funding arrangements where if trusts are able to achieve patient access and financial performance measures, they are rewarded with additional resources which can be invested in improved facilities and clinical services. As the Trust has delivered its financial target and the majority of the emergency access target for the year, we were awarded additional NHS funding of £27m in 2017/18. This finance will be used to fund a significant capital investment programme in 2018/19; as well as increased investment in IT infrastructure, we will refurbish some older operating theatres and modernise ward accommodation, as well as expanding neonatal facilities.

It should be noted that if the £27m were excluded from our results, the Trust would have generated a surplus of £14m which is less than 2% of annual turnover and was reliant on an element of one off benefits. The target set by the regulator for next financial year is £29m, including additional national funding of £25m. Whilst this net target is smaller than that achieved in 2017/18 it will continue to be a challenge to deliver with the anticipated cost pressures and the expectation of efficiency improvements of £32m.

The Trust has a strong track record of clinical and financial performance which is evidenced by the current level of cash reserves. The excellent results in 2017/18 mean we are in a position to be positive about achieving the plans we have set for 2018/19. Although these plans are reliant on continued efficiencies I am consistently humbled in how our staff continue to come up with innovative ideas with energy and enthusiasm which is inspirational.

Paul Goddard
Interim chief financial officer

Foreword to the accounts

These accounts for the period to 31 March 2018, 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.

David French
Interim chief executive
24 May 2018

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

Report on the audit of the financial statements.

1. Our opinion is unmodified

We have audited the financial statements of University Hospital Southampton NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Consolidated Statement of Comprehensive Income, Group and Trust Statement of Financial Position, Group and Trust Statement of Changes in Taxpayers Equity and Group and Trust Statement of Cash Flows and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and

- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Group financial statements as a whole	£15.2m (2016/17:£14.8m) 2% (2016/17: 2%) of total income from operations	
Coverage	100% (2016/17: 100%) of group assets, income and expenditure	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of NHS and non-NHS income	◀▶

Key: ◀▶ Risk level unchanged from prior year

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below the key audit matter (unchanged from 2017), in arriving at our audit opinion above, together with our key audit procedures to address this matter and our findings ("our results") from those procedures in order that the Trust's Council of Governors as a body may better understand the process by which we arrived at our audit opinion. The matter was addressed, and our results are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently is incidental to that opinion, and we do not provide a separate opinion on these matters.

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of land and buildings (£323.1 million; 2016/17: £302.4 million) Refer to page 32 (Audit and Risk Committee Report), page 108 (accounting policy) and page 126 (financial disclosures	**Subjective valuation:** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation, such as the condition of the asset. In particular the basis requires an assumption as to whether the replacement asset would be situated on an alternative site, with a potentially significant effect on the valuation. Between full valuations the Trust carries out an annual review to determine whether there are indications of impairment of assets due to reductions in market value, the clear consumption of economic benefits or a reduction in service potential. There is a risk that assets which have been impaired are carried at a value that is greater than their recoverable amount. For 2017/18 an interim "desk-top" revaluation of all of the land and buildings, which did not involve the physical inspection of the assets, was undertaken by an external valuer. There is a risk that the valuation may not reflect the current use or condition of the assets. **Accounting treatment** Consideration is also required as to whether revaluation gains and impairment losses are processed through other operating income/expense, or recognised in other comprehensive income. This treatment could have significant impact on the reported surplus or deficit for the year	**Our procedures included:** **Assessing valuer's credentials:** We assessed the scope, qualifications and experience of the Trust's valuer to verify that they were appropriately experienced and qualified to undertake the valuation; **Assessing valuer's credentials:** We inspected the instructions sent to the valuers to confirm that they were compliant with the requirements of the Group Accounting Manual to generate an appropriate valuation; **Methodology choice:** We considered the overall methodology of the external valuation performed to identify whether the approach was in line with industry practice; **Test of detail:** We agreed the accuracy of the estate data provided to the valuer to complete the desktop valuation by reconciling it to accounting records and re-performing measurements of a sample of assets; **Benchmarking assumptions:** We critically assessed the assumptions used by management to assess the carrying value of assets against BCIS all in tender price index and industry norms; **Accounting analysis:** We confirmed that accounting for valuation changes had been completed correctly in line with the requirements of the Group Accounting Manual; and **Test of detail:** 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 receive future benefits. **Our findings** **We found the resulting valuation of land and buildings to be balanced.**

	The risk	Our response
NHS and non-NHS income (£811.1 million; 2016/17: £761.8 million) Refer to page 32 (Audit and Risk Committee Report), page 106 (accounting policy) and page 120 (financial disclosures)	**Subjective estimate:** Of the Group's reported total income, £657.0 million (2016-17: £620.9m) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). Two CCGs and NHS England make up 81.0% of the Group's income. Income is contracted based on expected levels of activity and standard tariff prices for procedures, however the actual income for the year is based on the actual levels of activity completed during the year. Other performance based income is received from NHS Improvement (via local CCGs). This results in estimates being required at the year end. The Group reported total income of £130.0m (2016-17: £120.4million) from other activities. Much of this income is contracted from NHS and non-NHS bodies under contracts that indicate when income will be received; on delivery, milestones, or periodically. There is a risk that NHS and non-NHS income are not recognised in the correct period. **Accounting treatment:** In 2017/18 the Trust received strategic transformation funding (SF) from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. There is a risk that the Trust may not qualify for the amount accrued for in the financial statements.	**Our procedures included:** **Tests of details:** • For the three largest commissioners of the Group and Trust's activity we agreed that signed contracts were in place and that invoices had been issued in line with these contracts; • We inspected invoices for material income in the month prior to and following 31 March 2018 to determine whether income was recognised in the correct accounting period and in accordance with the amounts billed; • We agreed the levels of over and under performance reported to the records held on the Group and Trust's activity system. • We assessed the outcome of the agreement of balances exercise with CCGs and other NHS bodies. Where there were mismatches over £300k we challenged management's assessment of the level of income they were entitled to and the receipts that could be collected; • 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; • We tested material non-NHS income balances by agreeing a sample of income transactions through to supporting documentation and/or cash receipts. **Our findings** **We found the resulting estimates of NHS and non-NHS income to be balanced.** **The results of our testing of the accounting treatment of the transformation funding found no errors in the income recognised. The accounting treatment was appropriate.**

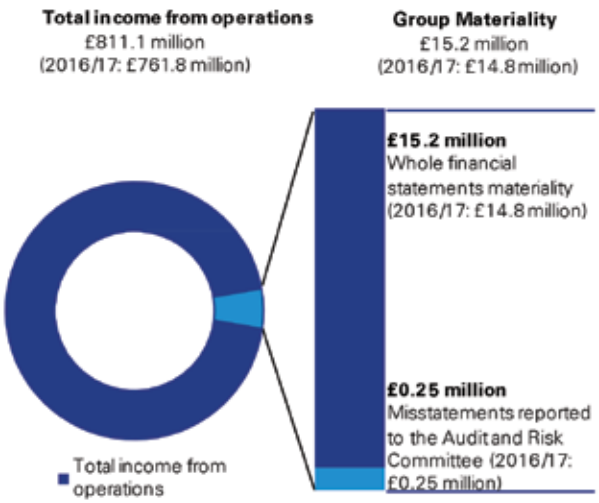
3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £15.2 million (2016/17: £14.8 million), determined with reference to a benchmark of income from operations (of which it represents approximately 2% (2016/17: 2%)). We consider operating income to be more stable than a surplus - or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £15.2 million (2016/17: £14.8 million), determined with reference to a benchmark of income from operations (of which it represents approximately 2% (2016/17: 2%)).

We agreed to report to the Audit and Risk Committee any corrected and uncorrected identified misstatements exceeding £250,000 (2016/17: (£250,000), in addition to other identified misstatements that warranted 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. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report
In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures
We are required to report to you if:
- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit and Risk Committee does not appropriately address matters communicated by us to the Audit and Risk Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities
Accounting Officer's responsibilities
As explained more fully in the statement set out on page 71, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. A fuller description of our responsibilities is provided on the FRC's website at www.frc.orq.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS
We have nothing to report on the statutory reporting matters
We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') 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 1 0(3) of the National Health SeNice Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources.

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the 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 the 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 the 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 (C&AG) in November 2017, as to whether the Trust had 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 and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

We did not identify any significant risks.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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.

CERTIFICATE OF COMPLETION OF THE AUDIT

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.

Neil Thomas
for and on behalf of KPMG LLP (Statutory Auditor) Chartered Accountants
15 Canada Square, Canary Wharf, London E14 5GI
25 May 2018

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

		Group		Trust	
		Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	NOTE	**£000**	£000	**£000**	£000
Operating income from patient care activities	**3.1**	**681,070**	641,364	**681,070**	641,364
Other operating income	**3.1**	**130,017**	120,445	**124,870**	117,110
Operating income from continuing operations		**811,087**	761,809	**805,940**	758,474
Operating expenses of continuing operations	**4**	**(761,284)**	(729,926)	**(758,912)**	(726,729)
OPERATING SURPLUS *		**49,803**	31,883	**47,028**	31,745
Finance income	**8**	**217**	217	**146**	76
Finance expenses	**9**	**(2,834)**	(2,835)	**(2,834)**	(2,835)
PDC Dividends payable		**(6,959)**	(6,313)	**(6,959)**	(6,313)
NET FINANCE COSTS		**(9,576)**	(8,931)	**(9,647)**	(9,072)
Total gains/ (losses)		**3,647**	(4,092)	**3,685**	(4,409)
SURPLUS FOR THE YEAR		**43,874**	18,860	**41,066**	18,264
Revaluations	**11**	**544**	105	**544**	104
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**44,418**	18,965	**41,610**	18,368

* Adjusting for items such as charitable income and costs, losses on disposal and donated assets, the surplus for NHS performance reporting purposes amounted to £41.153m (2016/17: £20.439m)

The notes on pages 105 to 135 form part of these accounts.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AT 31 MARCH 2018

		Group		Trust	
		31 March 2018	31 March 2017	31 March 2018	31 March 2017
	NOTE	£000	£000	£000	£000
Non-current assets					
Intangible assets	12	12,948	7,685	12,948	7,685
Property, plant and equipment	13	323,149	302,351	319,080	299,969
Investment Property	14.1	125	108	0	0
Investments in joint ventures and associates	15	1	0	1	0
Other Investments	14.2	2,997	3,052	3,441	3,441
Trade and other receivables	17	3,492	3,564	8,877	3,564
Total non-current assets		342,712	316,760	344,347	314,659
Current assets					
Inventories	16	16,219	15,198	15,624	14,717
Trade and other receivables	17	81,379	64,011	80,720	63,482
Cash and cash equivalents	19.1	56,600	35,963	51,202	33,196
Total current assets		154,198	115,172	147,546	111,395
Current liabilities					
Trade and other payables	20	(83,231)	(77,515)	(79,997)	(74,705)
Borrowings	21	(9,848)	(10,479)	(9,848)	(10,479)
Provisions	23.1	(626)	(2,139)	(626)	(2,139)
Other liabilities	22	(15,527)	(16,126)	(15,527)	(16,126)
Total current liabilities		(109,232)	(106,259)	(105,998)	(103,449)
Total assets less current liabilities		387,678	325,673	385,895	322,605
Non-current liabilities					
Trade and other payables	20	(751)	(783)	(6,518)	(2,885)
Borrowings	21	(54,422)	(48,688)	(54,422)	(48,688)
Provisions	23.1	(2,885)	(2,924)	(2,885)	(2,924)
Other liabilities	22	(14,924)	(11,078)	(14,924)	(11,078)
Total non-current liabilities		(72,982)	(63,473)	(78,749)	(65,575)
Total assets employed		314,696	262,200	307,146	257,030
Financed by					
Taxpayers' equity					
Public Dividend Capital		203,929	195,423	203,929	195,423
Revaluation reserve		25,478	24,872	25,478	24,872
Income and expenditure reserve		78,176	37,130	77,739	36,735
Charitable fund reserves		7,113	4,775	0	0
Total taxpayers' equity		314,696	262,200	307,146	257,030

The financial statements on pages 101 to 135 were approved by the Board on 24 May 2018 and signed on its behalf by:

David French
Interim chief executive
24 May 2018

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2018

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 2017	**4,775**	**195,423**	**24,872**	**37,130**	**262,200**
Surplus for the year	**2,338**	**0**	**0**	**41,536**	**43,874**
Revaluations - property, plant and equipment	**0**	**0**	**544**	**0**	**544**
Public Dividend Capital received	**0**	**8,506**	**0**	**0**	**8,506**
Other reserve movements	**0**	**0**	**62**	**(490)**	**(428)**
Taxpayers' and Others' Equity at 31 March 2018	**7,113**	**203,929**	**25,478**	**78,176**	**314,696**
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' Equity at 31 March 2017	4,775	195,423	24,872	37,130	262,200

Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2017	**195,423**	**24,872**	**36,735**	**257,030**
Surplus for the year	**0**	**0**	**41,066**	**41,066**
Revaluations - property, plant and equipment	**0**	**544**	**0**	**544**
Public Dividend Capital received	**8,506**	**0**	**0**	**8,506**
Other reserve movements	**0**	**62**	**(62)**	**0**
Taxpayers' and Others' Equity at 31 March 2018	**203,929**	**25,478**	**77,739**	**307,146**
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

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

		Group		Trust	
		Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	NOTE	**£000**	£000	**£000**	£000
Operating surplus		**49,803**	31,883	**47,028**	31,745
Operating surplus		**49,803**	31,883	**47,028**	31,745
Depreciation and amortisation	**12/13.1**	**21,296**	20,457	**21,243**	20,424
Impairments	**11**	**(484)**	(1,334)	**(484)**	(1,334)
Non-cash donations/grants credited to income		**(1,236)**	(2,271)	**(1,236)**	(2,271)
(Increase) in Trade and Other Receivables	**17**	**(17,607)**	(7,071)	**(22,857)**	(5,791)
(Increase) in Inventories	**16**	**(1,021)**	(321)	**(907)**	(320)
Increase/(decrease) in Trade and Other Payables	**20**	**6,529**	(3,954)	**4,015**	(5,234)
Increase in Other Liabilities	**22**	**3,247**	7,394	**3,247**	7,394
(Decrease) in Provisions	**23**	**(1,559)**	(320)	**(1,559)**	(320)
NHS Charitable Funds - other movements in operating cash flows		**0**	(28)	**0**	0
NET CASH GENERATED FROM OPERATIONS		**58,968**	44,435	**48,490**	44,293
Interest received	**8**	**217**	217	**146**	76
Purchase of intangible assets	**12**	**(7,270)**	(3,559)	**(7,270)**	(3,559)
Purchase of Property, Plant and Equipment	**13**	**(24,488)**	(15,275)	**(16,569)**	(13,096)
Sales of Property, Plant and Equipment	**10**	**47**	0	47	0
Receipt of cash donations to purchase capital assets		**1,240**	2,271	**1,240**	2,271
Investment in subsidiary		**0**	0	**(1)**	(2,549)
Cash from disposals of business units and subsidiaries *	**10**	**3,700**	0	**3,700**	0
Net cash (used in) investing activities		**(26,554)**	(16,346)	**(18,707)**	(16,857)
Public dividend capital received		**8,506**	3,466	**8,506**	3,466
Loans repaid to the Department of Health	**21**	**(4,922)**	(4,927)	**(4,922)**	(4,927)
Other loans repaid	**21**	**(171)**	(162)	**(171)**	(162)
Capital element of finance lease rental payments		**(5,641)**	(4,933)	**(5,641)**	(4,933)
Capital element of Private Finance Initiative Obligations		**(353)**	(333)	**(353)**	(333)
Interest paid	**9**	**(553)**	(701)	**(553)**	(701)
Interest element of finance lease	**9**	**(2,181)**	(1,983)	**(2,181)**	(1,983)
Interest element of Private Finance Initiative obligations	**9**	**(107)**	(126)	**(107)**	(126)
PDC Dividend paid		**(6,355)**	(6,339)	**(6,355)**	(6,339)
Net cash (used in) financing activities		**(11,777)**	(16,038)	**(11,777)**	(16,038)
Increase in cash and cash equivalents		**20,637**	12,051	**18,006**	11,398
Cash and Cash equivalents at 1 April		**35,963**	23,912	**33,196**	21,798
Cash and Cash equivalents at 31 March		**56,600**	35,963	**51,202**	33,196

*Cash from disposals of business units relates to the sale of Complete Fertility

The notes on pages 105 to 135 form part of these accounts.

Notes to the accounts

Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2017-18, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

The Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 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.

1.3 Basis of consolidation

In addition to the Trust itself, the Trust has consolidated into its group accounts the following entities: Southampton Hospital Charity, UHS Pharmacy Limited and UHS Estates Limited. The Trust and subsidiary accounts are prepared separately and then inter-group transactions are manually netted off.

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 2018 was £4.390m (unrestricted) and £2.723m (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 2018 was £1.432m and its gross assets at 31 March 2018 totalled £2.213m. UHS Estates Ltd provides building management services to the Trust for buildings that the company develops. It now operates Minerva House (staff support offices) and Compton House (radiotherapy bunker) and is due to develop several more buildings in 2018/19. Its turnover for the period ended 31st March 2018 was £0.498m and its gross assets at 31 March 2018 totalled £9.882m.

Entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where subsidiaries' accounting policies are not aligned with the Trust or where the subsidiaries' accounting dates are not coterminous. The amounts consolidated are drawn from the financial statements of Southampton Hospital Charity, UHS Pharmacy Ltd and UHS Estates Ltd. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

1.4 Joint arrangements

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust has one joint venture, Southampton CEDP LLP, which is a commercial partnership with Partnering Solutions (Southampton) Limited for undertaking various developments, the latest of which related to a new multi-storey car park which opened in 2017/18. The Trust accounts for its joint venture 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 £2k) in the year to 31st December 2017.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

1.6 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Trust.

1.7 Revenue

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue 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. At the year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued and agreed with the commissioner.

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.

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.

Revenue 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.

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.

1.8 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 Schemes. These schemes are unfunded, defined benefit schemes that covers NHS employers, general practices and other bodies allowed under the direction of Secretary of State in England and Wales.The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other expenses

Other operating expenses are recognised when and to the extent that the goods or services have been received. They are 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.

Government grants are grants from Government bodies other than income from commissioners or NHS Trusts 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.

1.9.1 Value Added Tax

Most of the activities of the Trust are outside the scope of value added tax (VAT). 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.

1.9.2 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 2018.

1.10 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;
- 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.

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.

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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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. Current values in existing use are determined as follows:

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided. The site used for the Trust's valuation is adjacent to the M27. The Trust's valuers are RICS registered valuers and partners of Gerald Eve LLP. A desktop revaluation has been carried out at 31 March 2018. The last full revaluation was undertaken at 31 March 2015.

In addition, as part of preparation for the sale of the Complete Fertility service a valuation of the equipment used in the service was undertaken by Charterfields Surveyors. They also are RICS registered valuers.

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.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation

Freehold land, assets under construction or development, investment properties and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.11 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Trust as lessee

Finance leases

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

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.

The Trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.15 Private Finance Initiative (PFI) transactions

PFI transactions that 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.

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 Assets, liabilities and finance costs
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 current value in existing use.

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 initial 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.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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 cost.

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.

Other assets contributed by the Trust to the operator
Other assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.16 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of sale 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 £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for 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;
- 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 intangible asset and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Measurement
Intangible assets acquired separately are recognised initially at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

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

1.17 Inventories
Inventories are valued at the lower of cost and net realisable value,using the weighted average cost method.

1.18 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.19 Financial assets and liabilities
Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss, held to maturity investments, available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value, other than impairment losses, taken to Other Comprehensive Income. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition.

Impairment
At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have 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 expenditure.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

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

Financial liabilities
Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:
- the amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets, and
- the premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 Provisions

The Trust recognises a provision when it has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016-17: positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016-17: negative 2.70%) for expected cash flows up to and including 5 years;
- A medium term rate of negative 1.85% (2016-17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years;
- A long term rate of negative 1.56% (2016-17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

Clinical negligence costs

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

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 23.3 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 NHS Resolution 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.

1.21 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and would normally be required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. However, the Trust (along with other NHS organisations) has been granted an exemption from the requirements of managing and trading allowances.

1.22 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

Contingent liabilities are not recognised, but are disclosed at note 24, unless the possibility of a payment is remote.

A contingent asset is a possible asset arising from past events whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the Trust's control.

Contingent assets are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.23 Public dividend capital (PDC)

Public dividend capital is a type of public sector equity finance, which represents the Department of Health's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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 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, (iii) any PDC dividend balance receivable or payable and (iv) Sustainability & Tranformation Fund incentive receivable balances in 2016/17 and 2017/18. 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. The PDC dividend calculation is based upon the Trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

1.24 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise.

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. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

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 the Statement of Comprehensive Income 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.

1.25 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.

1.26 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.

1.27 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.28 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed. 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 2018 is £5.955m, and for finance leases £54.016m.

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. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the tables below.

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	71
Dwellings	45	45
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. From 2015/16, the Trust has adopted a basis of valuation for building assets which excludes VAT from the cost of rebuilding assets.

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 2018 was £6.137m (see note 18.1).

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 2018 was £3.511m (see note 23.2).

Key sources of estimation uncertainty

There are no key assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.29 Accounting Standards that have been issued but not adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

Change published	Financial year for which the change first applies / comment
IFRS 9 Financial Instruments	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
IFRS 15 Revenue from contracts with customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 22 Foreign Currency Transactions and Advance Consideration	Application required for accounting periods beginning on or after 1 January 2018.
IFRIC 23 Uncertainty over Income Tax Treatments	Application required for accounting periods beginning on or after 1 January 2019.

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.

No detailed work reviewing contracts under IFRS 15 has been undertaken as yet in anticipation of additional guidance being received for NHS contracts. The Trust has maintained comprehensive records of both operating and finance leases and reviews all such arrangements on a monthly basis, so the preparatory work for IFRS 16 is expected to be less onerous.

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 2018	Year ended 31 March 2017
	£000	£000
Division A	**173,376**	163,835
Division B	**150,970**	143,972
Division C	**137,286**	132,251
Division D	**158,747**	153,887
Total Divisions	**620,379**	593,945
Adjustment for income included above	**65,089**	66,855
Headquarters and corporate costs	**52,483**	46,882
Total Operating Expenses excl charity	**737,951**	707,682
Depreciation, amortisation, impairments etc	**20,812**	19,123
Charitable expenditure and running costs	**2,521**	3,121
Total Operating Expenses incl charity	**761,284**	729,926

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 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Income from patient care activities				
Elective income	**129,813**	120,929	**129,813**	120,929
Non elective income	**186,662**	149,318	**186,662**	149,318
Outpatient income	**23,036**	22,056	**23,036**	22,056
Follow up outpatient income	**46,350**	48,499	**46,350**	48,499
A & E income	**17,383**	15,577	**17,383**	15,577
Other NHS clinical income	**267,870**	274,802	**267,870**	274,802
Private patient income	**5,825**	5,892	**5,825**	5,892
Other clinical income	**4,131**	4,291	**4,131**	4,291
Total income from patient care activities	**681,070**	641,364	**681,070**	641,364
Other operating income				
Research and development	**21,606**	21,555	**21,606**	21,555
Education and training	**35,449**	36,408	**35,449**	36,408
Cash donations for the purchase of capital assets - received from other bodies	**1,236**	2,270	**1,236**	2,270
Charitable and other contributions to expenditure - received from other bodies	**566**	536	**566**	536
Non-patient care services to other bodies	**12,615**	14,115	**12,285**	14,073
Sustainability and Transformation Fund income	**27,308**	20,237	**27,308**	20,237
Rental revenue from operating leases	**37**	34	**37**	34
NHS Charitable Funds: Incoming Resources excluding investment income	**4,779**	3,293	**0**	0
Other Operating Income:				
Car parking	**3,659**	3,730	**3,659**	3,730
Staff accommodation rentals	**47**	46	**47**	46
Crèche services	**1,468**	1,430	**1,468**	1,430
Clinical excellence awards	**4,055**	4,098	**4,055**	4,098
Other	**17,192**	12,693	**17,154**	12,693
Total other operating income	**130,017**	120,445	**124,870**	117,110
TOTAL OPERATING INCOME	**811,087**	761,809	**805,940**	758,474

Of total Operating Income of £811.087m, £657.011m was for commissioner requested services (2016/17: £620.912m), and £154.076m was for non-commissioner requested services (2016/17: £140.897m). 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 £30.201m (2016/17: £33.774m). Of the income above £2.7m related to the Complete Fertility service. Following the discontinuation of the service and transfer to a third party £1.6m of this income and the associated costs will no longer be incurred by the Trust. There is no impact on service provision.

3.2 Operating lease income

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Rental revenue from operating leases - minimum lease receipts	**37**	34	**37**	34
Future minimum lease payments due on leases of buildings and equipment expiring				
- later than five years:	**1,216**	1,043	**1,216**	1,043

3.3 Analysis of income from activities by source

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
NHS Foundation Trusts	**435**	458	**435**	458
NHS Trusts	**160**	108	**160**	108
NHS England	**335,339**	319,712	**335,339**	319,712
Clinical Commissioning Groups	**324,407**	301,200	**324,407**	301,200
Local Authorities	**1,020**	915	**1,020**	915
Non NHS: Private patients	**5,825**	5,892	**5,825**	5,892
Non-NHS: Overseas patients (non-reciprocal)	**570**	723	**570**	723
NHS injury scheme (was RTA)	**2,541**	2,653	**2,541**	2,653
Devolved administrations and Channel Islands	**10,773**	9,703	**10,773**	9,703
Total income from activities	**681,070**	641,364	**681,070**	641,364

3.4 Overseas visitors

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
Income recognised this year	**570**	723	**570**	723
Cash payments received in-year (relating to invoices raised in current and previous years)	**644**	455	**644**	455
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**158**	156	**158**	156
Amounts written off in-year (relating to invoices raised in current and previous years)	**18**	67	**18**	67

3.5 Fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m (Group and Trust)

	Year ended 31 March 2018	Year ended 31 March 2017
	£000	£000
Group and Trust		
Income	**5,127**	5,160
Full cost	**(4,368)**	(3,903)

This relates to income from car parking and nursery fees. All surplus income is reinvested in services.

4 Operating expenses

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**15,067**	13,527	**15,067**	13,527
Purchase of healthcare from non-NHS and non-DHSC bodies	**13,866**	13,570	**13,866**	13,570
Staff and executive directors costs	**452,581**	431,288	**451,343**	430,617
Non-executive directors	**143**	145	**143**	145
Supplies and services – clinical (excluding drugs costs)	**84,248**	86,903	**84,248**	86,903
Supplies and services - general	**18,403**	18,225	**18,187**	18,051
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**95,012**	94,501	**96,017**	95,467
Inventories written down (net including drugs)	**0**	61	**0**	61
Consultancy	**53**	112	**53**	112
Establishment	**3,354**	3,229	**3,336**	3,206
Premises - business rates collected by local authorities	**3,039**	2,280	**3,018**	2,261
Premises - other	**19,886**	18,035	**19,805**	17,968
Transport (business travel only)	**325**	278	**325**	278
Transport - other (including patient travel)	**2,099**	1,568	**2,095**	1,565
Depreciation	**19,022**	18,503	**18,969**	18,470
Amortisation	**2,274**	1,954	**2,274**	1,954
Impairments net of (reversals)	**(484)**	(1,334)	**(484)**	(1,334)
Increase/(decrease) in impairment of receivables	**1,571**	705	**1,571**	705
Change in provisions discount rate	**40**	302	**40**	302
Audit fees payable to the external auditor:				
Audit services - statutory audit	**66**	66	**58**	58
Other auditor remuneration (payable to external auditor only)	**33**	106	**84**	63
Charitable fund audit	**8**	9	**0**	0
Internal audit - non-staff	**105**	105	**105**	105
Clinical negligence - amounts payable to NHS Resolution (premium)	**14,033**	10,022	**14,033**	10,022
Legal fees	**899**	431	**899**	407
Insurance	**629**	593	**629**	593
Research and development - non-staff	**6,847**	5,355	**6,847**	5,355
Education and training - non-staff	**1,447**	1,902	**1,447**	1,902
Operating lease expenditure (net)	**1,419**	1,099	**1,403**	1,083
Redundancy costs - non-staff	**416**	106	**416**	106
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS ba	**1,095**	1,068	**1,095**	1,068
Car parking and security	**713**	674	**713**	674
Other losses and special payments - non-staff	**7**	19	**7**	19
Other services (e.g. external payroll)	**804**	1,160	**804**	1,160
Other NHS charitable fund resources expended	**1,631**	2,757	**0**	0
Other	**633**	602	**499**	286
TOTAL	**761,284**	729,926	**758,912**	726,729

Of the operating expenses above £2.5m related to the Complete Fertility service. Following the discontinuation of the service and transfer to a third party approximately £1.4m of these costs will no longer be incurred by the Trust. There is no impact on service provision.

4.1 Group other audit remuneration

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
Other auditor remuneration paid to the external auditor is analysed as follows:				
Audit-related assurance services	**9**	9	**9**	9
All taxation advisory services not falling within item 3 above;	**10**	97	**61**	54
All other non-audit services	**14**	0	**14**	0
Total	**33**	106	**84**	63

4.2 Group and Trust losses and special payments

	Year ended 31 March 2018		Year ended 31 March 2017	
	Cases by number and value			
Losses and special payments paid out in the year were as follows:	**Number**	**£000's**	Number	£000's
Losses of cash	**0**	**0**	14	7
Bad debts and claims abandoned	**185**	**41**	204	154
Damage to buildings, property etc. (including stores losses) due to:	**0**	**0**	12	39
Total Losses	**185**	**41**	230	200
Ex gratia payments	**32**	**13**	33	7
Total Special Payments	**32**	**13**	33	7
Total Losses and Special Payments	**217**	**54**	263	207

5.1 Employee expenses

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	Total £000	Total £000	**Total £000**	Total £000
Salaries and wages	**350,852**	336,253	**350,534**	335,965
Social security costs	**36,190**	34,670	**36,165**	34,649
Apprenticeship levy	**1,740**	0	**1,737**	0
Pension cost - Employers contributions to NHS Pensions	**42,293**	40,491	**42,287**	40,491
Pension cost - other contributions	**18**	17	**18**	10
Temporary staff - external bank	**19,394**	9,748	**19,394**	9,748
Temporary staff - agency/contract staff	**11,610**	13,964	**11,606**	13,964
NHS Charitable funds staff	**882**	355	**0**	0
Recoveries from Other bodies in respect of staff cost netted off expenditure	**(9,253)**	(3,485)	**(9,253)**	(3,485)
Total Net Staff Costs	**453,726**	432,013	**452,488**	431,342
Employee Expenses - Staff	**451,699**	430,933	**451,343**	430,617
NHS Charitable funds: Employee expenses	**882**	355	**0**	0
Total Employee benefits excluding capitalised costs	**452,581**	431,288	**451,343**	430,617

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 31st March 2018 (in their capacity as directors) totalled £1,047k (2016/17 £1,262k). 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 31st March 2018 totalled £134k (2016/17 £130k). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was 6 (2016/17 6).

5.2 Average number of employees (WTE basis)

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	Total Number	Total Number	**Total Number**	Total Number
Medical and dental	**1,398**	1,369	**1,398**	1,369
Administration and estates	**1,955**	1,828	**1,955**	1,828
Healthcare assistants and other support staff	**1,827**	1,673	**1,827**	1,673
Nursing, midwifery and health visiting staff	**3,435**	3,402	**3,435**	3,402
Scientific, therapeutic and technical staff	**944**	913	**944**	913
Healthcare science staff	**448**	451	**448**	451
Other	**132**	136	**121**	125
Total	**10,139**	9,772	**10,128**	9,761
Number of Employees (WTE) engaged on capital projects	**29**	18	**29**	18

5.3 Early retirements due to ill health

From April 2017 to March 2018 there were 5 (Apr 2016- Mar 2017:4) early retirements from the organisation agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements is £264k (Apr 2016- Mar 2017: £258k). 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 2018		Year ended 31 March 2017	
£10,001 - £25,000	**1**	**21**	3	54
£25,001 - 50,000	**1**	**48**	6	227
£50,001 - £100,000	**1**	**80**	3	223
£150,001 - £200,000	**1**	**150**	0	0
Total	**4**	**299**	12	504

5.5 Exit packages: other (non-compulsory) departure payments - 2017/2018

	Number of other departures Number	Value of other departures £000	Number of compulsory redundancies Number	Value of compulsory redundancies £000
	Year ended 31 March 2018		Year ended 31 March 2017	
<£10,000	0	0	3	17
£10,000 - £25,000	3	61	1	14
£25,001 - £50,000	1	28	3	107
£50,001 - £100,000	0	0	1	68
Total	4	89	8	206

6 Pensions

Past and present employees are covered by the provisions of the NHS Pension Schemes.

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 2018, is based on valuation data as 31 March 2016, updated to 31 March 2018 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 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 2018 the Trust had 91 members in NEST (31st March 2017: 69) and had made total contributions for 2017/18 of £12k (2016/17: £9k).

7.1 Operating leases

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017 (Restated)
	£000	£000	**£000**	£000
Minimum lease payments	**1,419**	1,099	**1,403**	1,083

7.2 Arrangements containing an operating lease

	Year ended 31 March 2018			Year ended 31 March 2017		
	£000	**£000**	**£000**	£000	£000	£000
Group	**Buildings**	**Plant & Machinery**	**Total**	Buildings	Plant & Machinery	Total
Future minimum lease payments due:						
- not later than one year;	**248**	**252**	**500**	258	296	554
- later than one year and not later than five years;	**687**	**318**	**1,005**	868	122	990
- later than five years.	**4,450**	**0**	**4,450**	4,656	0	4,656
Total	**5,385**	**570**	**5,955**	5,782	418	6,200
Trust						
Future minimum lease payments due:						
- not later than one year;	**248**	**245**	**493**	258	280	538
- later than one year and not later than five years;	**687**	**318**	**1,005**	868	115	983
- later than five years.	**4,450**	**0**	**4,450**	4,656	0	4,656
Total	**5,385**	**563**	**5,948**	5,782	395	6,177

7.3 Interest on late payments

There was no interest incurred on late payments in 2016/17 or 2017/18.

8 Finance revenue

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
Interest on bank accounts	**99**	76	**99**	76
Interest on other investments / financial assets	**0**	0	**47**	0
NHS charitable fund investment income	**118**	141	**0**	0
Total	**217**	217	**146**	76

9 Finance expenditure

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
Capital loans	**493**	629	**493**	629
Interest on other loans	**47**	57	**47**	57
Interest on finance lease obligations	**2,181**	1,985	**2,181**	1,985
PFI finance costs	**106**	126	**106**	126
Total interest expense	**2,827**	2,797	**2,827**	2,797
Unwinding of discount on provisions	**7**	38	**7**	38
Total Finance expenses	**2,834**	2,835	**2,834**	2,835

10 Other gains and losses

	Group		Trust	
	Year ended 31 March 2018	Year ended 31 March 2017	**Year ended 31 March 2018**	Year ended 31 March 2017
	£000	£000	**£000**	£000
Gains on disposal of property, plant and equipment	**47**	0	**47**	0
Gains on disposal of intangible assets	**3,700**	0	**3,700**	0
Losses on disposal of property, plant and equipment	**(62)**	(4,409)	**(62)**	(4,409)
Total gains/(losses) on disposal of assets	**3,685**	(4,409)	**3,685**	(4,409)
Fair value gains/(losses) on charitable fund investments & investment properties	**(38)**	317	**0**	0
Total other gains/(losses)	**3,647**	(4,092)	**3,685**	(4,409)

The gain on disposal of intangible assets relates to the sale of Complete Fertility.

11 Impairments

Group and Trust	Year ended 31 March 2018			Year ended 31 March 2017		
	Net impairment	Impairments	Reversals	Net impairment	Impairments	Reversals
	£000	£000	£000	£000	£000	£000
Changes in market price	(484)	0	(484)	(1,334)	0	(1,334)
Total Impairments	(484)	0	(484)	(1,334)	0	(1,334)

All of the amount above was credited (2016/17 £0.484m credited) to the Statement of Comprehensive Income. There was no impairment charged to the Revaluation reserve, however there was a revaluation of £0.544m (2016/17: £0.105m) credited to the Revaluation reserve.

12 Intangible assets

	Movements for year ended 31 March 2018		Movements for year ended 31 March 2017	
	Software licences (purchased)	Total	Software licences (purchased)	Total
Group and Trust	£000	£000	£000	£000
Valuation/Gross Cost at 1 April	17,603	17,603	15,000	15,000
Additions - purchased / internally generated	7,519	7,519	3,096	3,096
Additions - assets purchased from cash donations / grants	18	18	0	0
Disposals	(829)	(829)	(493)	(493)
Valuation/Gross cost at 31 March	24,311	24,311	17,603	17,603
Amortisation at 1 April	9,918	9,918	8,350	8,350
Provided during the year	2,274	2,274	1,954	1,954
Disposals	(829)	(829)	(386)	(386)
Amortisation at 31 March	11,363	11,363	9,918	9,918
Net Book Value at 31 March	12,948	12,948	7,685	7,685

13.1 Property, plant and equipment 2017/18

	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 2017	31,031	242,772	1,305	7,259	103,043	686	6,234	24	392,354
Additions - purchased	0	10,149	0	4,880	4,436	13	1,966	0	21,444
Additions - leased	0	10,967	0	0	5,221	0	0	0	16,188
Additions - grants / donations of cash to purchase assets	0	65	0	119	906	118	14	0	1,222
Reclassifications	0	4,781	0	(7,182)	2,191	(6)	218	(2)	0
Revaluations	0	706	53	0	0	0	(69)	0	690
Disposals	0	0	0	0	(7,790)	(19)	(261)	0	(8,070)
Valuation/Gross cost at 31 March 2018	31,031	269,440	1,358	5,076	108,007	792	8,102	22	423,828
Accumulated depreciation at 1 April 2017	0	23,243	54	0	62,828	435	3,425	18	90,003
Provided during the year	0	8,593	27	0	9,331	88	981	2	19,022
Reversal of impairments credited to operating expenses	0	(484)	0	0	0	0	0	0	(484)
Reclassifications	0	0	0	0	(99)	(6)	105	0	0
Revaluations	0	148	0	0	0	0	0	(2)	146
Disposals	0	0	0	0	(7,773)	(19)	(216)	0	(8,008)
Accumulated depreciation at 31 March 2018	0	31,500	81	0	64,287	498	4,295	18	100,679

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, other than £44k relating to disposal of Fertility services assets which was part of the sale of Complete Fertility; of the remainder 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.

13.2 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 - government granted	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 expenses	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

13.3 Property, plant and equipment - other entities in Group

	Movements for year ended 31 March 2018			Movements for year ended 31 March 2017		
	Buildings excluding dwellings	Information Technology	Total	Buildings excluding dwellings	Information Technology	Total
Of the movements above, the following relate to UHS Pharmacy Ltd:	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	115	86	201	110	86	196
Additions - purchased	0	15	15	5	0	5
Valuation/Gross cost at 31 March	115	101	216	115	86	201
Accumulated depreciation at 1 April	38	62	100	22	45	67
Depreciation provided during the year	16	17	33	16	17	33
Accumulated depreciation at 31 March	54	79	133	38	62	100

	Movements for year ended 31 March 2018			Movements for year ended 31 March 2017
	Assets Under Construction and Payments on Account	Plant & machinery	Total	Assets Under Construction and Payments on Account
Of the movements above, the following relate to UHS Estates Ltd:	£000	£000	£000	£000
Valuation/Gross cost at 1 April	2,281	0	2,281	0
Additions - purchased	1,725	0	1,725	2,281
Reclassifications	(2,401)	2,401	0	
Valuation/Gross cost at 31 March	1,605	2,401	4,006	2,281
Accumulated depreciation at 1 April	0	0	0	0
Depreciation provided during the year	0	20	20	0
Accumulated depreciation at 31 March	0	20	20	0

These additions relate to Radiotherapy equipment.

13.4 Property, plant and equipment financing

	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & machinery	Transport equipment	Information Technology	Furniture & fittings	Total
Net book value at 31 March 2018	£000	£000	£000	£000	£000	£000	£000	£000	£000
Group									
Owned	31,031	200,534	1,277	4,852	17,336	26	3,786	4	258,846
Finance Lease	0	8,070	0	0	24,052	84	0	0	32,206
On-balance-sheet PFI contracts	0	3,544	0	0	0	0	0	0	3,544
Donated	0	25,792	0	224	2,332	184	21	0	28,553
NBV Total at 31 March 2018	31,031	237,940	1,277	5,076	43,720	294	3,807	4	323,149
Net book value at 31 March 2017									
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
Of the balance above, the following relates to UHS Pharmacy Ltd:									
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 31 March 2018	0	61	0	0	0	0	22	0	83
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 31 March 2017	0	77	0	0	0	0	24	0	101
Of the balance above, the following relates to UHS Estates Ltd:									
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 31 March 2018	0	0	0	1,605	2,381	0	0	0	3,986
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 31 March 2017	0	0	0	2,281	0	0	0	0	2,281

None of the balance relates to the Trust charity.

14.1 Investments property

	Group		Trust	
	Movements for year ended 31 March 2018	Movements for year ended 31 March 2017	Movements for year ended 31 March 2018	Movements for year ended 31 March 2017
	£000	£000	£000	£000
Carrying value at 1 April	108	108	0	0
Additions	17	0	0	0
Carrying value at 31 March	125	108	0	0

14.2 Other Investments/financial assets (non-current)

	Group		Trust	
	Movements for year ended 31 March 2018	Movements for year ended 31 March 2017	Movements for year ended 31 March 2018	Movements for year ended 31 March 2017
	£000	£000	£000	£000
Carrying value at 1 April	3,052	2,707	3,441	891
Additions	0	28	0	2,550
Fair value gains (taken to I&E)	0	317	0	0
Fair value losses (for assets held at FV through I&E)	(55)	0	0	0
Carrying value at 31 March	2,997	3,052	3,441	3,441

15 Investments in joint ventures and associates

The Trust has a 50% share in Southampton CEDP LLP. Its share of the accumulated surpluses were £1k in year and cumulatively and as these are accounted for using the equity method these are shown as an investment in the Statement of Financial Position.

16 Inventories

	Group			Trust		
	Drugs	Consumables	Total	Drugs	Consumables	Total
	£000	£000	£000	£000	£000	£000
Current						
Carrying Value at 31 March 2017	**3,400**	**11,798**	**15,198**	**2,919**	**11,798**	**14,717**
Carrying Value at 31 March 2018	**3,423**	**12,796**	**16,219**	**2,828**	**12,796**	**15,624**

17 Trade and other receivables

	Group		Trust	
	Total 31 March 2018	Total 31 March 2017	**Total 31 March 2018**	Total 31 March 2017
	£000	£000	**£000**	£000
Current				
Trade receivables	**58,759**	34,795	**58,610**	34,793
Accrued income	**2,976**	5,538	**2,974**	5,697
Provision for impaired receivables	**(6,137)**	(5,564)	**(6,137)**	(5,564)
Prepayments (revenue) (non-PFI)	**15,394**	16,753	**15,359**	16,750
PDC dividend receivable	**0**	311	**0**	311
VAT receivable	**2,581**	1,577	**2,149**	1,232
Other receivables	**7,765**	10,267	**7,765**	10,267
NHS charitable funds: trade and other receivables	**41**	334	**0**	(4)
Total Current	**81,379**	64,011	**80,720**	63,482
Non-Current				
Other receivables	3,492	3,564	**8,877**	3,564
Total Non-Current	**3,492**	3,564	**8,877**	3,564
Total Trade and other Receivables	**84,871**	67,575	**89,597**	67,046

The Trust non-current receivable relates to a loan to UHS Estates Ltd

18.1 Provision for impairment of receivables

	Group		Trust	
	Movements for year ended 31 March 2018	Movements for year ended 31 March 2017	**Movements for year ended 31 March 2018**	Movements for year ended 31 March 2017
	£000	£000	**£000**	£000
At 1 April	**5,564**	5,400	5,564	5,400
Increase in provision	**5,160**	4,755	5,160	4,755
Amounts utilised	**(998)**	(541)	(998)	(541)
Unused amounts reversed	**(3,589)**	(4,050)	(3,589)	(4,050)
At 31 March	**6,137**	5,564	**6,137**	5,564

18.2 Analysis of impaired receivables

	Group		Trust	
	Receivables 31 March 2018	Receivables 31 March 2017 (Restated)	**Receivables 31 March 2018**	Receivables 31 March 2017 (Restated)
Ageing of impaired receivables				
0 - 30 days	**4,259**	1,843	**4,259**	1,843
60-90 days	**0**	229	**0**	229
90- 180 days	**166**	902	**166**	902
over 180 days	**1,712**	2,590	**1,712**	2,590
Total	**6,137**	5,564	**6,137**	5,564
Ageing of non-impaired receivables past their due date				
0 - 30 days	**12,218**	10,891	**12,167**	10,864
30-60 Days	**1,772**	1,557	**1,772**	1,557
60-90 days	**1,344**	1,208	**1,344**	1,208
90- 180 days	**2,035**	530	**2,034**	530
over 180 days	**5**	81	**0**	81
Total	**17,374**	14,267	**17,317**	14,240

19.1 Cash and cash equivalents

	Group		Trust	
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
Total cash balance	**56,600**	35,963	**51,202**	33,196
Cash at commercial banks and in hand	**5,441**	3,205 0	**43**	438
Cash with the Government Banking Service	**51,159**	32,758 0	**51,159**	32,758
Cash and cash equivalents as in SoFP	**56,600**	35,963	**51,202**	33,196

19.2 Third party assets held by the NHS Foundation Trust

Group and Trust	**31 March 2018**	31 March 2017
	£000	£000
Bank balances	**7**	6

20 Trade and other payables

	Group		Trust	
	Total	Total	**Total**	Total
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
Current				
Trade payables	**39,908**	39,070	**38,158**	38,563
Capital payables (including capital accruals)	**5,782**	7,304	**6,090**	5,095
Accruals (Revenue costs only)	**15,199**	16,254	**13,416**	16,165
Social Security costs	**4,994**	4,769	**4,994**	4,769
Other taxes payable	**4,551**	4,296	**4,551**	4,296
PDC dividend payable	**293**	0	**293**	0
Accrued interest on DH loans	**69**	81	**69**	81
Other payables	**11,949**	5,313	**11,940**	5,308
NHS Charitable funds: Trade and other payables	**486**	428	**486**	428
Total Current	**83,231**	77,515	**79,997**	74,705
Non-current				
Capital payables (including capital accruals)	**346**	378	**6,113**	2,480
Other payables	**405**	405	**405**	405
Total Non Current	**751**	783	**6,518**	2,885
Total Trade and other payables	**83,982**	78,298	**86,515**	77,590

An amount of £5.992m (2016/17 £5.706m) relating to outstanding pension contributions is included within amounts due to other related parties; this liability was due in April 2017.

21 Borrowings

	Group		Trust	
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
Current				
Capital Loans from Department of Health	**3,489**	4,922	**3,489**	4,922
Other Loans	**134**	127	**134**	127
Obligations under finance leases	**5,854**	5,078	**5,854**	5,078
Obligations under Private Finance Initiative contracts	**371**	352	**371**	352
Total Current	**9,848**	10,479	**9,848**	10,479
Non-current				
Capital Loans from Department of Health	**17,131**	20,620	**17,131**	20,620
Other Loans	**746**	923	**746**	923
Obligations under finance leases	**34,867**	25,096	**34,867**	25,096
Obligations under Private Finance Initiative contracts	**1,678**	2,049	**1,678**	2,049
Total Non Current	**54,422**	48,688	**54,422**	48,688
Total Borrowings	**64,270**	59,167	**64,270**	59,167

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

Original Advance Date	Original Loan	Balance outstanding at 31st March 2018	Balance outstanding at 31st March 2017	Interest Rate
	£000	£000	£000	%
November 2007	3,000	0	283	4.85%
March 2008	7,500	0	750	4.19%
September 2008	8,000	400	1,200	4.85%
September 2010	8,000	3,995	4,529	2.74%
October 2011	10,000	3,500	4,500	1.57%
September 2012	5,000	2,220	2,776	0.76%
June 2013	15,000	10,505	11,504	1.91%
Total balance outstanding		20,620	25,542	
Repaid in year		4,922		

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 £0.880m. £171k was repaid in year

22 Other liabilities

	Group		Trust	
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
Current				
Deferred income	**10,839**	13,514	**10,839**	13,514
Deferred grants	**4,688**	2,612	**4,688**	2,612
Total Current	**15,527**	16,126	**15,527**	16,126
Non-current				
Deferred income	**14,924**	11,078	**14,924**	11,078
Total Non-current	**14,924**	11,078	**14,924**	11,078
Total Other liabilities	**30,451**	27,204	**30,451**	27,204

23.1 Provisions for liabilities and charges

	Current	Current	**Non-current**	Non-current
Group and Trust	**31 March 2018**	31 March 2017	**31 March 2018**	31 March 2017
	£'000	£'000	**£'000**	£'000
Pensions- Early departure costs	**216**	216	**2,885**	2,924
Other legal claims	**399**	382	**0**	0
Restructurings	**11**	0	**0**	0
Other	**0**	1,541	**0**	0
Total	**626**	2,139	**2,885**	2,924

23.2 Movements in provisions for liabilities and charges 17/18

	Pensions- Early departure costs	**Other legal claims**	**Re-structurings**	**Other**	**Total**
Group and Trust	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
At 1 April 2017	3,140	382	0	1,541	**5,063**
Change in the discount rate	40	0	0	0	**40**
Arising during the year	140	170	11	0	**321**
Utilised during the year - cash	(212)	(23)	0	(1,541)	**(1,776)**
Reversed unused	(14)	(130)	0	0	**(144)**
Unwinding of discount	7	0	0	0	**7**
At 31 March 2018	**3,101**	**399**	**11**	**0**	**3,511**
- not later than one year;	216	399	11	0	**626**
- later than one year and not later than five years;	864	0	0	0	**864**
- later than five years.	2,021	0	0	0	**2,021**
Total	**3,101**	**399**	**11**	**0**	**3,511**

23.3 Clinical negligence liabilities

	31 March 2018	31 March 2017
Group and Trust	**£'000**	£'000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Foundation Trust	**274,049**	166,783

24 Contingent liabilities

	31 March 2018	31 March 2017
Group and Trust	**£'000**	£'000
Other	**88**	47

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

25.1 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 2018		Year ended 31 March 2017	
Group	**Income**	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
	0	**0**	0	0
Department of Health	**26,349**	**5**	26,123	0
Portsmouth Hospitals NHS Trust	**1,535**	**8,878**	1,411	3,734
NHS Resolution	**0**	**14,383**	0	10,376
NHS Southampton CCG	**139,847**	**0**	130,134	0
NHS West Hampshire CCG	**141,609**	**0**	126,284	0
NHS England	**374,411**	**0**	352,267	0
Health Education England	**37,174**	**0**	35,458	0
Solent NHS Trust	**1,396**	**1,467**	1,697	1,210
Southern Health NHS Foundation Trust	**2,858**	**4,582**	3,503	2,758
Hampshire Hospitals NHS Foundation Trust	**1,741**	**2,434**	1,965	2,062
Other NHS Bodies	**49,938**	**17,590**	49,193	15,760
	776,858	**49,339**	728,035	35,900

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**	**42,293**	0	40,491
National Insurance Fund	**0**	**37,930**	0	34,670
NHS Blood and Transplant	**215**	**7,227**	0	6,779
NHS Professionals	**0**	**23,017**	0	19,297
University of Southampton	**5,856**	**9,572**	6,408	9,499
Other government bodies	**2,012**	**597**	2,181	1,744
	8,083	**120,636**	8,589	112,480
Total value of transactions with related parties	**784,941**	**219,314**	736,624	148,380

The Group comprises the Trust, UHS Pharmacy Ltd, UHS Estates Ltd and Southampton Hospital Charity. The Trust has £558k (£364k at 31st March 2017) receivables with Southampton Hospital Charity. It has share capital of £841k (£841k at 31st March 2017), receivables of £3k (£20k at 31st March 2017) and payables of £141k (£0k at 31st March 2017) with UHS Pharmacy Ltd, and share capital of £2.6m (£2.599m at 31st March 2017), and receivables of £5.826m (£353k at 31st March 2017) and payables of £6.075m (£353K at 31st March 2017) with UHS Estates Ltd. Transactions with related parties are on a normal commercial basis. UHS Pharmacy Ltd made donations to Southampton Hospital Charity of £50k in 2017/18 (2016/17: £310k).

	At 31 March 2018		At 31 March 2017	
Group	**Receivables**	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Department of Health	**0**	**0**	320	0
Other NHS Bodies	**50,631**	**14,067**	31,826	8,455
Other government bodies	**4,744**	**21,110**	4,462	19,727
Total balances with related parties at 31 March	**55,375**	**35,177**	36,608	28,182

25.3 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 £0k (2016/17 £222k) and was charged £0k (2016/17 £14k) from its joint venture for services rendered. The Trust accounted for a Multi Storey Car Park built under the partnership as a finance lease in 2017/18.

26 Capital Commitments

	Group		Trust	
	Total	Total	**Total**	Total
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
Group and Trust	**£000**	£000	**£000**	£000
Property, Plant and Equipment	**16,005**	15,547	**16,005**	15,403
Intangible assets	**401**	55	**401**	55
Imaging Infrastructure Support Service	**20,072**	26,374	**20,072**	26,374
Total	**36,478**	41,976	**36,478**	41,832

The Imaging Infrastructure Support Service commitment relates to the purchase of new radiology equipment over the remaining 5 years of the contract.

27 Finance Lease obligations

	31 March 2018	31 March 2017
Group and Trust	**£000**	£000
Gross buildings lease liabilities	**20,756**	6,368
of which liabilities are due:	**0**	0
- not later than one year;	**1,714**	1,029
- later than one year and not later than five years;	**5,604**	3,211
- later than five years.	**13,438**	2,128
Finance charges allocated to future periods	**(5,639)**	(1,463)
Net buildings lease liabilities	**15,117**	4,905
- not later than one year;	**1,031**	684
- later than one year and not later than five years;	**3,607**	2,315
- later than five years.	**10,479**	1,906
Gross other lease liabilities	**33,260**	30,277
- not later than one year;	**6,364**	5,693
- later than one year and not later than five years;	**18,788**	18,679
- later than five years.	**8,108**	5,905
Finance charges allocated to future periods	**(7,656)**	(5,008)
Net other lease liabilities	**25,604**	25,269
- not later than one year;	**4,823**	4,394
- later than one year and not later than five years;	**15,690**	15,433
- later than five years.	**5,091**	5,442

28.1 On-SOFP PFI obligations

	Total	Total
	31 March 2018	31 March 2017
Group and Trust	**£000**	£000
Gross PFI liabilities	**2,293**	2,752
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.	**0**	459
Finance charges allocated to future periods	**(244)**	(351)
Net PFI obligation	**2,049**	2,401
- not later than one year;	**371**	352
- later than one year and not later than five years;	**1,678**	1,601
- later than five years.	**0**	448
	2,049	2,401

28.2 On-SOFP PFI commitments

Group and Trust	**Total 31 March 2018 £000**	Total 31 March 2017 £000
Commitments in respect of the service element of the PFI		
Within one year	**1,553**	1,526
2nd to 5th years (inclusive)	**6,210**	6,105
Later than five years	**0**	1,526
Total	**7,763**	9,157

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

28.3 Analysis of amounts payable to service concession operators (Group and Trust)

	Total for 31 March 2018	Total for 31 March 2017
	1,553	1,527
Unitary payment payable to service concession operator		
Consisting of:		
- Interest charge	**106**	126
- Repayment of finance lease liability	**352**	333
- Service element	**1,095**	1,068

29.1 Imaging infrastructure support service commitments

Group and Trust

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

	31 March 2018			31 March 2017		
	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;	**3,284**	**4,901**	**8,185**	3,210	4,791	8,001
- later than one year and not later than five years;	**13,136**	**19,604**	**32,740**	12,840	19,164	32,004
- later than five years.	**8,210**	**12,253**	**20,463**	11,235	16,769	28,004
Total	**24,630**	**36,758**	**61,388**	27,285	40,724	68,009

29.2 Other financial commitments

	Group		**Trust**	
	31 March 2018 £000	31 March 2017 £000	**31 March 2018 £000**	31 March 2017 £000
The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:				
not later than 1 year	**9,910**	17,167	**10,896**	17,167
after 1 year and not later than 5 years	**13,127**	18,654	**17,072**	18,654
paid thereafter	**22**	31	**24,168**	31
TOTAL	**23,059**	35,852	**52,136**	35,852

30 Post balance sheet events

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

31 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 2018 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.

31.1 Financial assets by category

	Group		Trust	
	Total	Total	**Total**	Total
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	Loans & Receivables £000	Loans & Receivables £000	**Loans & Receivables £000**	Loans & Receivables £000
Trade and other receivables (excluding non financial assets) - with NHS and DH bodies	**50,631**	31,910	**49,538**	31,910
Trade and other receivables (excluding non financial assets) - with other bodies	**14,268**	15,581	**20,885**	13,556
Cash and cash equivalents at bank and in hand	**56,600**	35,963	**51,202**	32,545
NHS Charitable funds: financial assets	**3,038**	3,052	**0**	0
Total	**124,537**	86,506	**121,625**	78,011

31.2 Financial liabilities by category

	Group		Trust	
	Total	Total	**Total**	Total
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
Borrowings excluding finance lease and PFI liabilities	**21,500**	26,592	**21,499**	26,592
Obligations under finance leases	**40,721**	30,174	**40,721**	30,174
Obligations under PFI, LIFT and other service concession contracts	**2,049**	2,401	**2,049**	2,401
Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies	**12,180**	6,615	**12,156**	6,615
Trade and other payables (excluding non financial liabilities) - with other bodies	**61,771**	62,618	**64,991**	62,430
Provisions under contract			**0**	
Total	**138,221**	128,400	**141,416**	128,212

31.3 Maturity of financial liabilities

	Group		Trust	
	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	£000	£000	**£000**	£000
In one year or less	**83,799**	79,712	**81,227**	79,524
In more than one year but not more than two years	**9,281**	9,239	**9,480**	9,239
In more than two years but not more than five years	**22,735**	23,126	**23,531**	23,126
In more than five years	**22,406**	16,323	**27,178**	16,323
Total	**138,221**	128,400	**141,416**	128,212

32 Limitation on auditor's liability

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

QUALITY ACCOUNT AND QUALITY REPORT 2017/18

CONTENTS

Chief executive's welcome

It is my pleasure to present the Quality Account for 2017/18. This has been a busy year for us at University Hospital Southampton NHS Foundation Trust. This report forms part of our requirement to account for both the quality of our services and the finances that we have managed.

It shows our quality improvements during 2017-18 and sets out how we maintain safe services and improve our standards. Our Board is accountable for the quality of all of the services we provide as a Trust and sets the strategic direction and the tone for the organisation. We believe that quality – the safety, effectiveness and experience of our services – has improved this year and that we have achieved this by providing high quality care, whenever and however we are needed, and by working in partnership with patients, supporting them to take an active role in their own health and wellbeing.

Despite increasing financial and capacity pressures on our services, and on the NHS as a whole, we have seen some significant improvements this year. Our staff have delivered real achievements in maintaining excellent clinical outcomes while reducing avoidable harm to patients, focusing on how we learn from mistakes and improve patient experience. I am particularly proud that we have delivered these improvements in the context of the significant challenges we have faced throughout the year to meet key national access standards and tackle long-standing pressures around demand, capacity and patient flow.

We could not have achieved this without all our staff and volunteers. We are proud that the latest annual survey of NHS staff shows UHS is the fourth highest Trust in the country for staff recommending the hospital as a place to work or receive care. We are also the seventh best nationally for staff engagement. Our staff report above average in: confidence in reporting unsafe practices; reporting errors, near misses and incidents; belief in the fairness of procedures for reporting errors, near misses and incidents; feeling able to contribute towards improvements at work. Most encouragingly, the results indicate staff are increasingly positive about working here which we recognise is critically important to the quality of care we provide.

The Care Quality Commission (CQC) inspected our core services in January 2017 and published their report in July 2017. The inspection covered surgery, out patients and diagnostic imaging, end of life care and critical care. Whilst some areas for improvement were identified, our overall rating improved from 'requires improvement' to 'Good' overall, with several areas rated as 'Outstanding' including our 'Well Led' domain. We are proud of this achievement but we believe we can still do better. Our ambition is for all our hospitals and services is to be rated as 'outstanding'. This drives our work in acting on the CQC's findings and recommendations.

We are almost unique in having such good quality of care alongside a strong financial performance. To my mind, these two things go hand in hand. If the quality is good, the finance naturally falls into place but if the money situation is bad, quality suffers because you can't afford to invest and improve. Sadly, being in financial balance is now an exception in the NHS with the majority of Trusts in financial deficit so money for investment and improvement just isn't there.

Currently, Trusts achieving their financial targets are eligible for additional national cash incentives. We achieved our financial target back in 2016/17 and could therefore commit to the biggest capital investment programme the Trust had ever seen. During the year we have refurbished several wards, expanded and upgraded the Surgical High Dependency Unit, and opened the new radiotherapy bunker. We also chose to replace every bed mattress in the hospital with new models which will drive us further towards our ambition of zero pressure sores.

The long standing issues with parking were eased with the opening of the new multi-storey car-park providing a much-needed additional 778 spaces. This has enabled us to increase parking capacity for staff, patients and visitors and has reduced queuing and congestion, both on and off-site, significantly. I would like to thank patients and visitors, staff and our residential neighbours for their patience for the significant inconvenience the queues and traffic congestion caused them.

Our investment in IT transformation continued, partly funded by national monies awarded through our recognition as a 'global digital exemplar'. This funding is enabling transformation in digital medical records and other large-scale projects as well as improving the quality of day-to-day equipment available for our staff.

We have also delivered our financial target for 2017/18 so this will bring more national money for investment. In allocating this to projects, we try to balance the need to maintain the existing estate, upgrade and expand clinical environments, buy new equipment and develop new services. It has been a real team effort at UHS and we are very grateful to everyone who contributed in so many different ways ranging from efficiencies such as cheaper deals for the consumable items we use, to attracting new staff to work here replacing expensive agency staff, to clinical pathways changes which allow our patients to go home earlier. These efficiencies have either allowed us to treat more patients for the same money or have actually improved the quality of care across the hospital.

In all cases though, despite having the financial budget available, we have been unable to recruit the staff we need to provide care. There is a national shortage of registered nurses and doctors in certain specialties. It's important we make UHS an attractive place to work so that people with skills in high demand choose UHS. We also rely heavily on colleagues from overseas and the effects of Brexit and the current immigration restrictions are proving troublesome both here and across the NHS. We do all we can to lobby government on the importance of being able to recruit staff with the right skills, values and motivation whether from Southampton, the UK, the EU or elsewhere in the world.

Our 2018/19 capital investment programme will be more than £50m and will help us to support a major expansion of general intensive care and major changes around the emergency department. We will also start construction of the new children's emergency and trauma department, which is kindly being funded by generous donations to Southampton Hospital Charity with financial match-funding from the government. This report shows how we performed against our 2017/18 priorities, then sets out our priorities for the coming year. Measures of quality and performance are, by their nature, less precise than our financial information, with less internal and external scrutiny than the financial information presented in our annual report and accounts. But I believe this report gives an accurate account of quality at UHS and I hope it will be read widely, by staff as well as by the people who use our services.

These accounts represent our commitment to ensuring that we continue to improve service user and carer experience, and to strengthening recovery-focused care and continuous quality improvement. We have made good progress and believe the quality priorities we have selected for this year will help us achieve our ambition to provide outstanding care for every service user.

I declare that to the best of my knowledge the information in this document is accurate.

David French,
Interim chief executive officer
24 May 2018

Our approach to quality assurance

Our approach to quality

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 have renamed the framework the quality improvement framework (QIF) in recognition of the fact that the 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 QIF 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.

The Trust remains responsive to the personal needs of our patients. Patient care and experience remains a key focus for improvement.

Survey question number	Question	Trust	Average
11+	Hospital: shared sleeping area with opposite sex	16%	8%
13	Hospital: staff did not completely explain reasons for changing wards at night	43%	46%
14	Hospital: bothered by noise at night from other patients	43%	38%
15	Hospital: bothered by noise at night from staff	23%	19%
16	Hospital: room or ward not very or not at all clean	2%	3%
17+	Hospital: did not always get enough help from staff to wash or keep clean	28%	29%
18+	Hospital: not always able to take own medication when needed to	39%	34%
19+	Hospital: food was fair or poor	44%	39%
20	Hospital: not always offered a choice of food	19%	20%
21+	Hospital: did not always get enough help from staff to eat meals	43%	37%
22	Hospital: did not get enough to drink	6%	6%

Our commitment to safety

In a large organisation, such as the NHS, things will sometimes go wrong and this will have an impact on all those involved. We recognise 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 processes 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.

We fully align our safety strategy to NHS England's 'Sign up to Safety' campaign to demonstrate our commitment to put patient safety first, continually learn, be honest and transparent, collaborate and support people to understand why things go wrong and how to put them right.

Duty of candour

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 are committed to being open and transparent to patients and their families and 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 our intranet 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 patients and families and keep them updated. Every patient (or their family) are contacted by letter following a moderate or high harm incident and are invited to ask any questions they would like answered as part of the investigation. We will also meet 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.

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. We have a Freedom to Speak Up policy and a Freedom to Speak up Guardian. Our staff survey shows that our staff consider UHS as above average in:

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Fairness and effectiveness of procedures for reporting errors, near misses or incidents			
	% agreeing/strongly agreeing with the following statements:			
Q12a	"My organisation treats staff who are involved in an error, near miss or incident fairly"	65	55	65
Q12b	"My organisation encourages us to report errors, near misses or incidents"	91	88	90
Q12c	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again"	75	69	75
Q12d	"We are given feedback about changes made in response to reported errors, near misses and incidents"	66	56	64
	Raising concerns about unsafe clinical practice			
Q13a	% saying if they were concerned about unsafe clinical practice they would know how to report it	96	95	96
	% agreeing/strongly agreeing with the following statements:			
Q13b	"I would feel secure raising concerns about unsafe clinical practice"	77	69	76
Q13c	"I am confident that the organisation would address my concern"	68	57	66

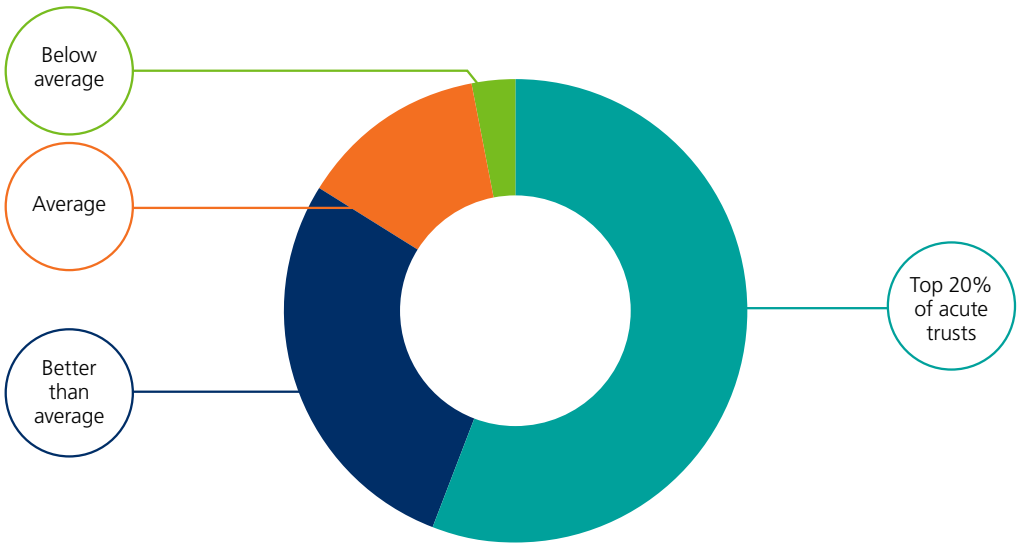
Our commitment to staff

UHS has a growing reputation as a top teaching hospital in the UK and overseas. It attracts candidates locally, nationally and internationally and is also one of the largest employers in Southampton. With 11,454 staff working in a diverse range of healthcare related fields, we believe the Trust offers an exciting and rewarding place to work. The Trust has also been awarded 'outstanding' by the CQC in the 'well-led' domain, attributed to a strong positive working culture that is well developed throughout the organisation.

To understand how staff feel about working for the Trust, and to continue to make improvements to our services, we use the results of the annual 'NHS Staff Attitude Survey' and 'Friends and Family Test' to consider how we perform against the pledges set out in the NHS constitution and against other similar acute trusts.

Out of the 32 key findings in the 2017 survey, the Trust was in the top 20% of acute trusts for 18 findings, nine were above average, four were average, and one was below average.

Staff survey 2017 – key findings

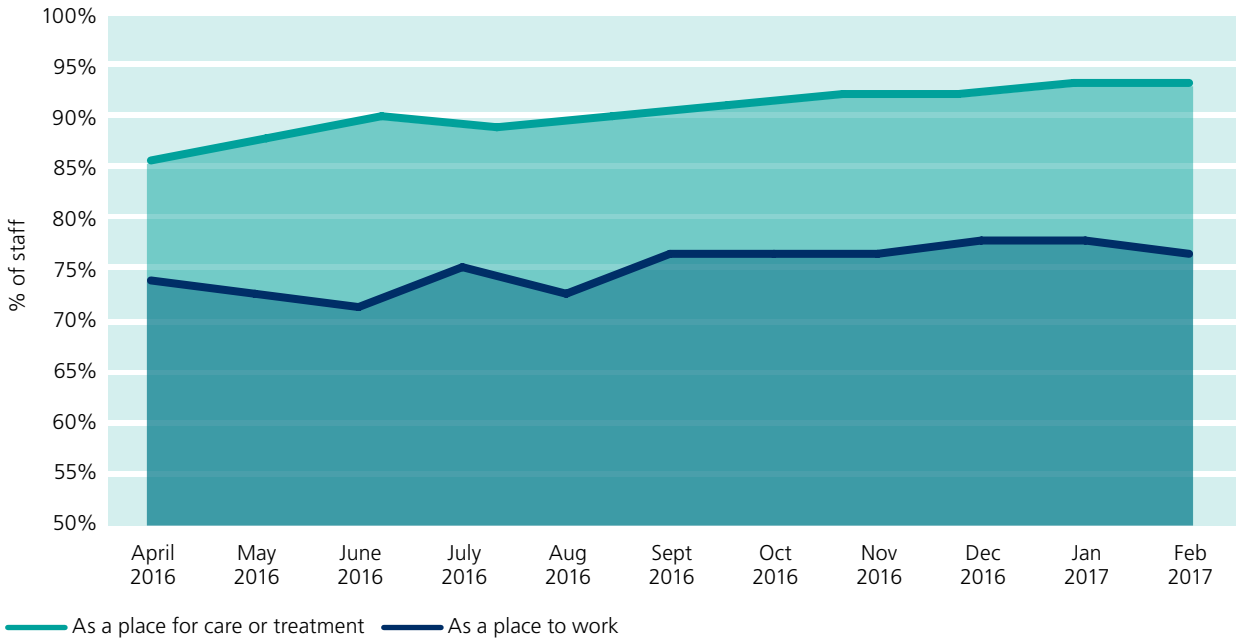


Our top five results were:

1. **KF31: Staff confidence and security in reporting unsafe clinical practice - 3.83 against a national average for acute trusts of 3.65.**
2. **KF30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents – 3.87 against a national average for acute trusts of 3.73.**
3. **KF15: Percentage of staff satisfied with the opportunities for flexible working patterns – 59% against a national average for acute trusts of 51%.**
4. **KF6: Percentage of staff reporting good communication between senior management and staff – 44% against a national average for acute trusts of 33%.**
5. **KF1: Staff recommendation of the organisation as a place to work or receive treatment – 4.05 against a national average for acute trusts of 3.75.**

The Friends and Family Test asks on a quarterly basis (except for Q3 when the annual survey is conducted) whether a member of staff would recommend the Trust as a place for care or treatment and whether a member of staff would recommend the Trust as a place to work. In the latest results from Q2 of 17/18, the Trust achieved a 93% result for question 1 (against an acute average of 81%), and a 76% result for question 2 (against an acute average of 64%). The Trust continues to improve in both areas as can be seen below:

Staff recommending UHS



To further improve supporting our staff in 2018/19, we are rolling out a behavioural framework called 'living our values' based on our three core values which are: patients first, working together, and always improving. The framework will also be used in our recruitment, 360 degree appraisal, performance management, and talent management initiatives and link with our leadership and management programmes and succession planning.

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 for every care group. We will use the feedback from the survey to support staff to improve the services we deliver and share our findings so that we can learn from our mistakes. This includes working with our Trade Union colleagues and networks to ensure views from all staffing groups are taken into account.

Some positive staff responses from the 2017 survey:

"I retired 5 years ago only for 3 weeks. Absolutely love working here with a great team of people and patients that are admitted"

"Proud and happy being part of this very prestigious organisation especially here in cardiovascular and thoracic. I always feel and treat my colleagues as second family members. Love this department especially the staff who are really working hard to make a difference to our patients' lives"

"I love my job and the team I work with, I am always supported and feel I can report any issues I am concerned about and it will be acted on accordingly"

"I love my job & I love working in ED!"

Our commitment to education and training

All of the developments outlined in the 2016/17 Quality Account concerning training, development and workforce have continued to be developed and embedded. Three examples of this are:

1. 'Learner reviews' (where learners in UHS meet with education leads to discuss their experience of learning during placements) are now fully embedded and being used to make changes in practice.
2. A number of 'trainer development master-classes' have been held and they are well attended and evaluated by participants.
3. Our in-house 'history taking and physical assessment' programme aimed at advancing practice in non-medical professions has been embedded.

Over the course of 2017/18 improvements have been made in the quality and focus of the e-learning modules available for statutory and mandatory subjects, including offering a greater variety e-learning modules for role specific subjects, which continues to increase the accessibility and ease of completion for staff.

We have successfully delivered our Inclusive Leadership programme; 48 participants (75% BAME) have explored their leadership potential and will now make a significant contribution to increasing the cultural competency and ultimately greater representation of diversity at senior management levels.

UHS continues to provide high quality learning environments and experiences for a range of learners. Following many changes across the education sector in health, UHS is working on a number of projects to support the continuation of quality placements. This includes reviewing models of support and revisiting education programmes delivered to nursing staff and procure nurse degree apprenticeship training with a plan to support up to fifty staff to start the programme in September 2018.

In occupational therapy we are now placing students from the University of Bournemouth, as well as working with Health Education England South to develop the pharmacy pre-registration training provision. Healthcare science has supported the introduction of new training programmes in gastrointestinal physiology and bioinformatics and work continues to scope apprenticeships for level 6 in healthcare science across all specialities. UHS continues to offer high quality placements to doctors in training. Improvements are evidenced in feedback from the national General Medical Council (GMC) survey. A visit by the GMC to the Trust, as part of their quality assurance visit to Health Education Wessex, commended the Trust on

> **"an organisational culture that identified and valued the importance of education and training to the wider organisation".**

These activities run alongside the UHS commitment to work with existing and new higher education partners. UHS have designed and delivered a team fellowship programme, both internally and on behalf of Health Education England (HEE) Wessex, which integrates quality improvement and leadership development in enabling participating teams to effect positive change in their service.

Our commitment to technology to support quality

UHS is committed to using modern technology to help improve the quality of care, safety and patient experience and is recognised as an exemplar site for IT global digital exemplar (GDE).

We are working in partnership with commissioning colleagues to plan and deliver a transformational programme of work using new technology to redesign outpatient services. The programme is overseen by our operational productivity transformation board (system level) and internal working group.

We have already introduced telephone follow-up, nurse led follow-up and patient triggered follow-up in six high volume specialties through the outpatient Commissioning for Quality and Innovation (Op CQUIN) in 2015-17. Two key workstreams are also planned which will incorporate OPdigital (UHS are a national pilot site) and medical pathway review.

OPdigital includes developments in My medical record, a patient online service developed and operated by UHS. The service has been designed to support patients whilst they are away from the hospital and, as such, is seen as an ideal tool in the management and support of long-term condition patients. The patient can access their record and information anywhere, anytime, but the real power of the service is its ability to support the transformation of the way we provide clinical services.

A case study of prostate cancer patients has seen 90% of patients now being managed in this way, with significant time savings for nurses, who can see 20 patients remotely in the same time it takes to see six face-to-face.

In the three years the service has been running over 2500 patients have been registered across five hospital sites and around 15,000 traditional outpatient follow-up appointments have been prevented. Further efficiencies lie in the speed with which cancer nurse specialists can review patients online versus traditional outpatients, freeing up time for more complex cases.

Wider rollout of My medical record for other pathways already include paediatric nephrology, paediatric cardiology, cystic fibrosis, multiple sclerosis, sleep teams (adult and paediatric) and rheumatology.

In 2017/18 we have successfully started the transfer from traditional paper record keeping to an electronic programme known as Electronic Patient Record (EPR). This is a rolling programme with areas going live in a planned manner.

We have also introduced a patient acuity monitoring system which is currently live in 40 ward areas across the Trust. The electronic patient acuity monitoring system (ePAMS) enables nursing and medical staff to record patient observations and some assessments without the need for paper charts. In addition to providing nurses and doctors with accurate and real-time information to review a patient's progress, the system automatically calculates early warning scores to alert staff to patients who may require urgent intervention to prevent their conditions worsening.

Its introduction reduces the need for nursing staff to transcribe patient data onto paper charts and, as a result, lowers the risk of errors occurring. It helps to change the previous practice from one where staff react to a change in a patient's condition, to one where they can identify changes much sooner and therefore pro-actively prevent problems from developing.

GDE projects which have continued to be successfully developed include the introduction of electronic whiteboards. This touch screen technology displays information taken directly from a patient's electronic record, including clinical alerts, such as existing medical conditions, length of admission and estimated date of discharge. It also acts as a tracking system to identify what is preventing discharge when patients are medically fit to leave hospital.

Previously this information was handwritten on boards when patients were admitted or moved. This required staff to take time out to interpret and re-write a patient's notes, and increased the risk of inaccuracies during translation.

Adrian Byrne, the Trust's director of informatics and chair of the Health CIO Network, said:

> **"This is another important step forward in our drive to enhance the use of digital technology across clinical services. Replacing handwritten notes on whiteboards may not seem revolutionary, but saving the time taken to write up notes repeatedly when patients move and minimising the risk of inaccuracies is a significant development."**

It is hoped the electronic whiteboards will be rolled out across all wards by the end of this year.
Further examples of technology-led projects to improve how we deliver services are:

- Telephone and patient screening perioperative anaemia clinic
- Alternative minimally invasive surgery (open/laparoscopic to endoscopic) for oesophageal cancer reducing follow-up appointments.
- 24hr nurse-led advice and guidance for patients post laparoscopic surgery
- Acute surgical consultant hotline
- Virtual outpatient reviews in ophthalmology
- Remote monitoring for NIV patients avoiding outpatient appointments and home visits

Our commitment to the Care Quality Commission (CQC)

The CQC carried out a follow-up inspection of the Southampton General Hospital site between 25-27 January, 2017 with an unannounced inspection on 7 February, 2017. This inspection was to follow-up the comprehensive inspection in 2015 which had identified some services that required improvement.

They inspected all key questions in four of the eight core services of surgery, critical care, end of life care and outpatient and diagnostic imaging and noted the Trust had a stable leadership team in place since their last inspection.

The previous inspection in 2015 had found safety of medicine and maternity services, along with responsiveness of urgent and emergency care and children's services 'required improvement'. At the 2017 inspection the following observation was made:

> **At this inspection we saw significant improvement across the areas we inspected. There were improvements in surgery, critical care, end of life care and outpatients. Critical care is rated overall as 'Outstanding', with surgery, end of life care, and outpatients and diagnostic imaging as 'Good' overall. These services had been rated requires improvement in 2015. The improvements were in line with the Trust's improvement plan and had been assisted by the Trust Board and executive leadership team".**

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall rating for this trust	Are services at this trust safe?	Are services at this trust effective?	Are services at this trust caring?	Are services at this trust responsive?	Are services at this trust well-led?
					
Good	Requires improvement	Good	Outstanding	Requires improvement	Outstanding

The CQC saw areas of outstanding practice including:

- The integrated medical examiners group (IMEG) reviewed all deaths twice each day and approved the death certificate before it was signed, including contact with the coroner if needed. This had proven benefit to an improved accuracy of mortality data, opportunity to reflect upon practice, an improved understanding of correct death certification, consistency amongst reviewing staff, and an overall improvement to patient safety after learning.

- The chief executive officer (CEO) held patient lunches, which both staff and patients consider unique and valuable. The relevant teams then received feedback on any issues raised at the lunches.

- There were focus groups within specific cancers for patient involvement, although no patients have taken part in the governance groups as yet. The Trust used representatives from the local Healthwatch when planning major redevelopments.

- There is a culture of innovation and research, and staff are encouraged to participate. There are examples of research that were nationally and internationally recognised. Staff were supported to lead innovation projects in their work environment.

- The Trust had implemented a new tool called the favorable event reporting form (FERF). Anyone who sees an incident or an event which had gone particularly well was invited to document this. Everyone mentioned in a FERF received a personal letter, thanking them for their contribution, and the positive practice was cascaded throughout the Trust.

- The Trust has established engagement links with young people and children within the community, and many diverse activities took place on and off site for these groups. Recent 'Life labs' at Open Days gave local children the opportunity to try experiments and learn about personal health. Opportunities such as this encourage children of every socio-economic background to view healthcare as a potential career option.

- Hospital teams, supported by hospital volunteers and emergency services, ran 'family road safety days' in central Southampton. Local children and their parents learned about road signs and had opportunities to practice resuscitation techniques.

The recommendations and findings from the CQC report have been developed into an implementation action plan. These included the areas where the CQC rated us as requiring improvement (where the service is not currently performing as well as it could). Progress against these actions is monitored on a quarterly basis by the head of clinical quality assurance with oversight from the director for nursing and organisational development, and shared with quality committees and commissioning groups.

Review of quality performance

All NHS trusts are required to report their performance against statutory quality indicators in a set format as part of their quality reports to enable the public to compare performance across organisations.

The tables in appendix two 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 did not have a payment by results (PbR) audit during 2017/18.

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.

Clinical research

Research lies at the heart of our mission to deliver quality care and health and, as a major national site for clinical research, we are proud to provide our patients with some of the best access to new treatments in the UK. The number of patients receiving relevant health services provided or sub-contacted by UHS in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 18,056.

In 2017/18 we further expanded our research activities across our clinical services, including the development of a nasal drop to help prevent meningitis, pioneering therapies for cancer patients, further results from the Southampton Women's Survey, and the development of a new, more effective and longer-lasting treatment for knee arthritis.

In outright performance measures we have also delivered strongly. Over 2017/18 we were again in the top 10 of NHS Foundation Trusts in England for trial recruitment, with around 20,000 patients gaining access to clinical trials, and we secured over £20 million of external funding to further support our research.

With particular strengths in nutrition, respiratory and cancer research, the past year saw advances across all of these areas.

In 2017 our nutrition experts provided evidence showing access to a wider variety of food outlets is linked to healthier diets in children, strengthening the argument for local authorities to better support healthier childhood nutrition by supporting the establishment of more healthy food outlets in their areas. Alongside that work, a £2.2 million award is looking at encouraging better health, diet and life choices amongst teenagers.

In respiratory medicine Southampton researchers received £2.3 million as part of a European-wide study to develop a new whooping cough vaccine, whilst a study looking at how tuberculosis (TB) bacteria interacts with the body's immune system has shown great potential in developing a life saving TB vaccine.

Beyond the hospital walls, the already successful 'pre-habilitation' programme (pre-surgery exercise sessions for cancer patients) has been awarded £2.3 million to pilot exercise sessions, as well as psychological wellbeing support, at gyms and cancer support centers across the region – widening access to this service, the first of its kind in the UK.

Southampton patients have been part of a pioneering urine test that is set to revolutionise the diagnosis of bladder cancer, whilst women across the region took part in the highest recruiting cancer study in England last year, incorporating alcohol awareness into breast cancer and screening appointments.

Innovative cancer research like this received a boost through Cancer Research UK's recent £3.5 million investment into the Southampton Clinical Trials Unit. This support, combined with the UK's first dedicated centre for cancer immunology research, based at University Hospital Southampton secures our role as a leading cancer research site.

These successes underscore the commitment and quality of our research teams and clinical researchers in driving better quality health and care to date. The '2017 – 2022 UHS Research Strategy' is our blue-print for securing and expanding this progress from here. The result of extensive consultation, 'Research for all' aims to ensure UHS remains a leading research site, working towards access to trials for all.

Review of services

During 2017/18 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 on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by University Hospital Southampton NHS Foundation Trust for 2017/18.

CQUIN 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 2017/18 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.

The conditional income in 2017/18 upon achieving quality improvements and innovation goals was £13,821,000. This compares to the 2016/17 figure of £13,366,000.

We have used the CQUIN framework to actively engage in and agree quality improvements with our commissioners, to improve patient experiences across our local and wider health economy.
Our CQUIN priorities for 2017/18 can be found in appendix three.

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.

UHS submitted records between April 2017 - March 2018 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2017 (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 care
- 99.7% for outpatient care
- 99.9% for accident and emergency care

UHS 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. UHS 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 three accreditation against the NHS Litigation Authority risk management standards for acute trusts which contains two standards specific to records management and record keeping.

UHS will be tasking the following actions to improve data quality:

- Data quality for transformation (DQfT) is a cost improvement and transformation project involving a group of diverse multidisciplinary team members.

- This team of process specialists have been looking at ways of improving data capture, data quality and the use of data to support all aspects of decision making. This corporate team are working with doctors and managers, to understand and map processes of information recording and to create options for improvement where omissions or errors are found.

- The team have reviewed clinical areas, assessed the information flows which lead to billing, service improvement and cost improvement. The team recommend options for optimisation of income recovery, operational efficiency and cost reduction. They are also strongly focusing on data quality, which of course has many long-term benefits in addition to the financial impact, and are constantly contacting and communicating across many service areas in order to create these improvements.

- The team are currently leading on the analysis and impact of HRG4+, utilisation of the Lord Carter report alongside its Model Hospital, the national Getting it Right First Time programme headed by Professor Tim Briggs, as well as acting as project support on the Trust InfoQlik Dashboards.

Participation in national clinical audits and confidential enquiries

During 2017/18 57 national clinical audits and three national confidential enquiries covered NHS services that UHS provides.

During 2017/18 UHS participated in 96% (55) of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The NCEPOD studies that UHS participated in during 2017/18 were:

- Cancer in children, teens and young adult study (0-25 years)
- Acute heart failure
- Peri-operatives' Management of Surgical Patients with Diabetes' Study

The national clinical audits that UHS participated in, and for which data collection was completed during 2017/18, are listed in appendix three 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.

How we are implementing the priority clinical standards for seven day hospital services

Priority clinical standard 1: patients should not wait longer than 14 hours to initial consultant review
We have achieved this by embedding high level departmental reviews of waiting times across the Trust which hold managers accountable for their services. We monitor our performance via our in-house performance tool (CHARTS) in addition to participating in the biannual national audit. Appropriate investment has been made where service need requires, for example into the clinical workforce to enhance the out of hours teams across the Trust. Good practice and lessons learned are shared between departments at seven day services meetings, a regional 7 Day-Service forum and during an in-house nationally advertised and attended conference.

Priority clinical standard 2: patients should get access to diagnostic tests with a 24-hour turnaround time. For urgent requests, this drops to 12 hours and for critical patients, one hour
We are achieving this by directing significant investment in radiology clinical staff over the last decade, including consultants, nurses, radiographers and housekeepers which has allowed the department to restructure its on-call service into a full shift system and specialty advice being available on a seven day basis. Occasional gaps in specialist radiology have been bridged by working in partnership with other organisations.

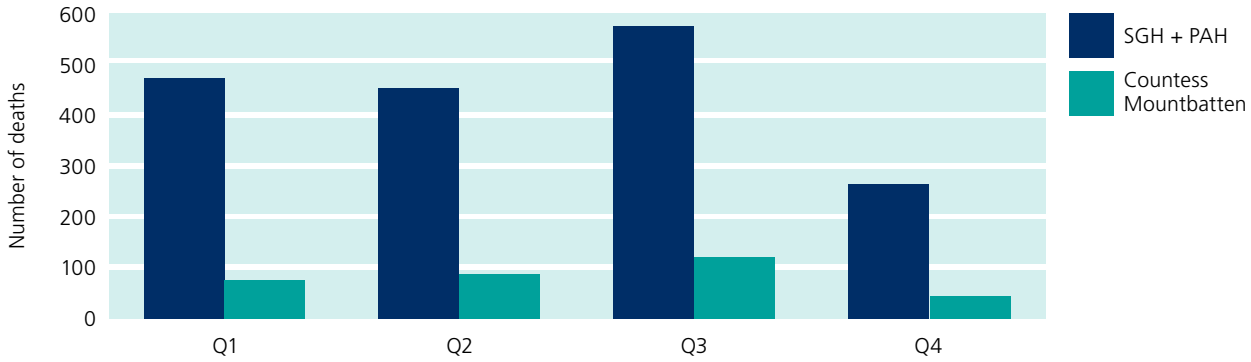
Priority clinical standard 3: patients should get access to specialist, consultant-directed interventions
In addition to our work in radiology, this is addressed via a number of initiatives: there has been an expansion of cardiology staff to deliver a seven day emergency angiography/plasty service as well as non-invasive cardiology treatments; emergency endoscopy is provided by a multidisciplinary team of gastroenterologists, hepatologists and surgeons, increasingly covering endoscopy on-call gaps in our neighbouring smaller hospitals.

Priority clinical standard 4: patients with high-dependency care needs should receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.
UHS has moved to daily consultant ward rounds in all clinical areas receiving emergency admission patients over the last few years in order to ensure appropriate and timely patient reviews. Patients in admission and high care areas may or may not require twice daily reviews as clinically indicated. If a twice daily review is not required, this will be clearly documented. We assess our performance against the national data set, acknowledging that patients are often seen more frequently than twice a day but that this not captured in the national data set.

Learning from deaths

For many people death under the care of the NHS is an inevitable outcome although they experience excellent care from the NHS in the months or years leading up to their death. National guidance indicates that it would be inappropriate to draw comparisons or use any published data for benchmarking between organisations. This is because organisations have determined their approach to mortality review locally, including the scope of deaths to be included in mortality review and reporting processes. There are also likely to be inter-reviewer variations. As such, the data is not comparable across organisations. It is therefore the Trust's intention to focus on using mortality data internally to monitor quality of services and, in accordance with the overarching aim of the national guidance, to derive learning from the review of deaths that will ultimately enable the Trust to improve the quality of the services it provides.

During 2017/18, 2,147 of UHS patients have died. 1,802 of these patients have died at Southampton General Hospital and Princess Anne Hospital, while 345 of our patients died at Countess Mountbatten House.



The internal medical examiners group provides a forum whereby a rapid review can be made of every death within UHS to give advice on death certification and identify concerns related to the deceased's care or cause of death. This process facilitates communication with the bereaved, the process of death certification, referral to HM Coroner, management of complaints, review at morbidity and mortality meetings, discussion at trust mortality review group (TMRG) and investigation of adverse events.

Between the 1 April, 2017 and the 11 February, 2018, 2,110 cases were reviewed by our Internal Medical Examiners Group (IMEG). The remaining 37 cases not reviewed were from the emergency department during Q1 as we only started to review these deaths from Q2, on the 7 July, 2017.

Following the IMEG reviews 173 more detailed reviews were carried out:

- 72 cases went on to have a detailed case note review at the Trust Mortality Review Group (TMRG)
- 47 cases were sent for an investigation with the patient safety team
- 37 cases were reviewed at the Child Death and Deterioration group (CDAD) and
- 17 cases reviewed at the Learning Disabilities Mortality Review group (LeDeR).

To date, 25 cases representing 1.2% of patient deaths during the reporting period of 2017/18 were judged more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of:

Quarter	Amount	Percentage Per Quarter
Q1	12	2.12%
Q2	8	1.44%
Q3	5	0.72%
Q4	N/A	N/A

** Please note that there are still some review data outstanding for Q3

These numbers have been established using the structured judgement and Root Cause Analysis (RCA) methodologies. For the RCA, an initial multidisciplinary meeting will take place to examine the details of the case, give the incident a classification and set out the terms of reference, including:

- key questions that need to be looked at for further investigation
- who needs to be interviewed or provide a statement
- the appropriate support that needs to be offered to the patients, relatives and staff
- That duty of candour has been observed.

Information is then gathered from people, documentation, equipment and the site of the incident for the investigation. This is documented in chronological order, and problems identified. All issues that are identified are then analysed to see which had the most significant impact, the root causes are the most significant and fundamental of these issues, but there may be many significant contributory factors. From the root causes, solutions will need to be found and actions/preventative measures will need to be put in place to stop or mitigate the risk of recurrence of a similar incident.

Main areas of failing identified in RCA	
Recognition	4
Escalation	13
Action	4
Communication	5
Timeliness	2
System	1
Process	6
Human Factors	11

The learning from our RCA's clearly indicate that human factors were a key issue. This is being addressed at education half days where the patient safety team are replacing the sessions on duty of candour (which is also covered by a VLE package) with a session on human factors. This will be initiated from the new financial year. The Trust has also appointed Dr Gillian Ansell as the new Trust lead for human factors education.

We are aware that human factor issues are a recurrent theme but we now need to introduce a system where we can outline the learning, demonstrate the actions we have taken in response, embed these throughout all relevant areas and communicate these across the Trust. We are currently introducing such a system, which will enable us to more easily track actions across the divisions, thereby giving reassurance that they have been completed.

Failure to escalate concern about deteriorating patients in an effective way is also a recurring theme, often compounded by problems with recognition or communication, and is a problem being addressed by the ROAR (recognise, observe, assess, rescue) working group. It also links in with our plans for implementation of the NEWS 2 early warning score ongoing rollout of the electronic patient acuity monitoring system (to be completed in June/July 2018) and further development of our escalation trigger tools.

The broad themes for actions (from the RCA's reporting during 2017/18) are:
- Individual learning and reflection
- Human factors discussion and educational meetings
- RCA's shared at the sub-specialty morbidity and mortality (M&M) meetings
- RCA to be given/shared with the Divisional Governance team and named clinician
- Trust-wide learning
- Development of new pathways, processes, safety checks and guidelines
- Introduction or improvement of escalation trigger tools
- Communication training
- Introduction of audits to ensure quality improvement has occurred

Trust-wide learning includes all learning points that are published in:

- Safety Matters – a tool for disseminating information provided by RCAs – this comes in the form of an anonymized case study and links in with themes from complaints and litigation
- Organisational Wide Learning (OWLs) – a practical theme based article, addressing recurring safety issues, for example missed doses of insulin
- Patient safety alerts – actions that come from a serious adverse event case review or RCA which immediately need implementing across the Trust and require notification of all clinical staff or relevant non-clinical staff.

For the next reporting period we will continue as above. We also aim to improve the way we share the results from all mortality reviewing panels with all relevant clinicians and relevant morbidity and mortality leads so that it can all be fed back to as many colleagues as possible with better triangulation between these processes. We have started to put a system in place for this.

Many of these actions are difficult to objectively assess in terms of their impact as they may relate to rare occurrences, which are difficult to meaningfully audit, or to improvements in individual's knowledge or the wider safety culture.

The intention is to improve individual awareness for those involved in incidents, raise awareness in teams and put additional safety checks or immediate actions in place to mitigate risk and reduce recurrence with organisational awareness of key safety themes.

The impact is assessed by audits when appropriate, with oversight from divisional governance and clinical effectiveness (COSG). Ongoing themes are considered and reviewed by the patient safety team and the Trust mortality Review Group (TMRG). Quarterly reports are submitted to Quality Governance Steering Group (QGSG) and the Trust Board about the continued strive for improvement.

An additional 17 case record reviews were completed after 1 April, 2017 which relate to deaths that took place before the start of the reporting period.

However, due to the prospective review of deaths through IMEG almost all cases with safety concerns are now identified within 72 hours of death, thereby largely eliminating late investigation of deaths with concerns, although investigations can take up to 60 working days to complete. They are provisionally graded according to avoidability within 72 hours of death, although subsequent information may adjust this grading during the investigation, the majority are correctly attributed through IMEG and the initial serious incident case review 'scoping' meeting.

Of the 17 deaths which occurred during the previous reporting period, but which were reviewed in the current reporting period, three (representing 0.14%) were judged more likely than not to have been due to problems in the care provided to the patient. This number has been established using the RCA method.

Figures for 2017/18 period:

Total number of deaths at UHS	**2444**	**-**
Total number reviewed (including IMEG)	2219	90.79%
Number that was sent to TMRG	68	3%
Number sent to a serious adverse event root cause analysis	60	2.5%

This number has not previously been reported through this process; however it has been identified internally, using the same methodology as that used for the current reporting period. The final established number of deaths identified through IMEG, TMRG and serious adverse event root cause analysis as being more than likely avoidable is 33, which represents 1.4% of deaths in the period of 2016/17.

Progress against 2017/18 priorities

This section outlines how we have performed against the delivery of our 2017/18 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 1 IMPROVING PATIENTS' EXPERIENCE OF AND THE SAFETY OF DISCHARGE FROM HOSPITAL

Our aims were:

1. Standard information to be generated to set expectations on admission.
2. Standard information to be provided 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 integrated discharge bureau.
4. Clear timelines between each stage of the process to be established.
5. We aimed 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.

Our achievements for 2017/18 were

In 2017/18 the Managing Complex Discharge Policy was reviewed against the NHS England template and updated accordingly. This policy includes standard information to be given to patients on admission regarding discharge planning, explaining who is available to support them with each process and how to access this. The policy also explains the escalation process for staff to follow where discharge planning becomes a conflict between the patients and the organisation. Clear timelines between escalations are outlined. Training slides have been agreed between partners and UHS and system training is being planned for the coming months, into the new financial year.

PRIORITY 1

Each clinical ward area now has access to a discharge officer, senior discharge officer, continuing healthcare coordinators and team leaders, all in post within the integrated discharge bureau (IDB) to support the wards with discharge planning. 2017/18 has seen the substantive appointment of two senior managers within the UHS IDB to embed the service improvements projects already underway, to support wards with training and development around complex discharge and to ensure relationships between primary care, hospital services, social services, voluntary services and the private sector continue to grow and thrive. Joint training is now planned between Acute and community Trusts.

In 2017/18 the IDB staff underwent a 7 day working consultation to ensure that complex discharge support was available to wards over weekends. Agreement was gained that 7 day working has a place in complex discharge planning. The consultation was a collaborative and positive staff consultation experience and the service has expanded to be available on a Sunday, with phase 2 reviewing stepping up the service to cover Saturdays also.

PRIORITY 2 MEETING PATIENTS' NUTRITIONAL AND HYDRATION NEEDS

Our aims were:

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 chart to all adult inpatient areas.
4. Work collaboratively with our new service provider to increase the percentage of patient satisfaction with foo

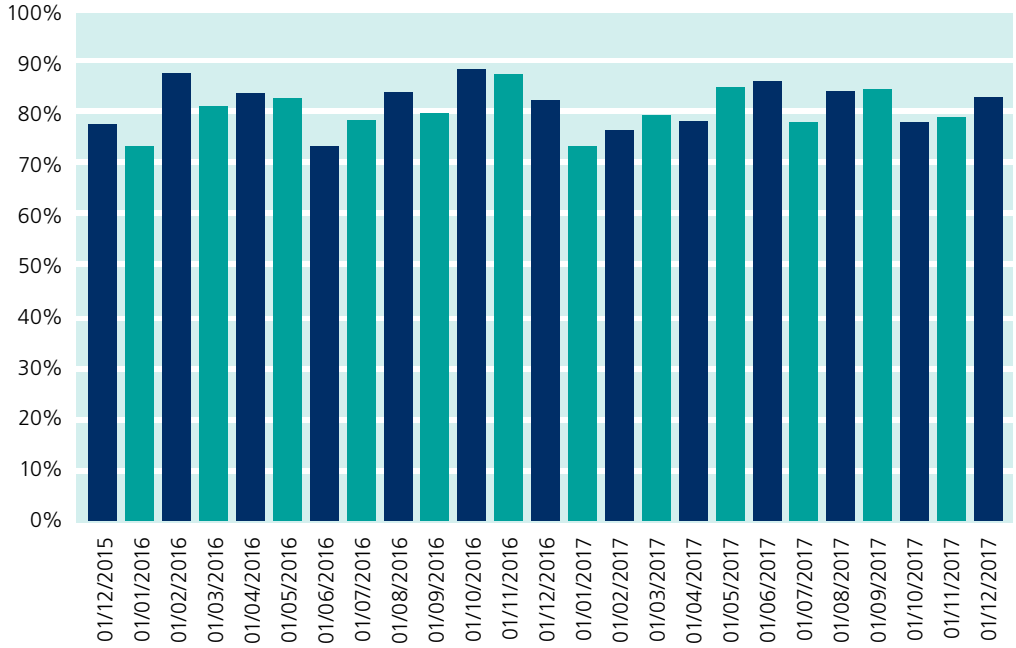
Our achievements for 2017/18 were

The use of the Malnutrition Universal Screening Tool (MUST) has been reviewed and a new simplified version developed to help with compliance. The new version of the tool is due to be printed in the next print run of the nursing assessment documentation and new care plans (red/orange/green denoting escalation of care needs) implemented for all patients. Education is currently in progress prior to the organisational launch of the tool.

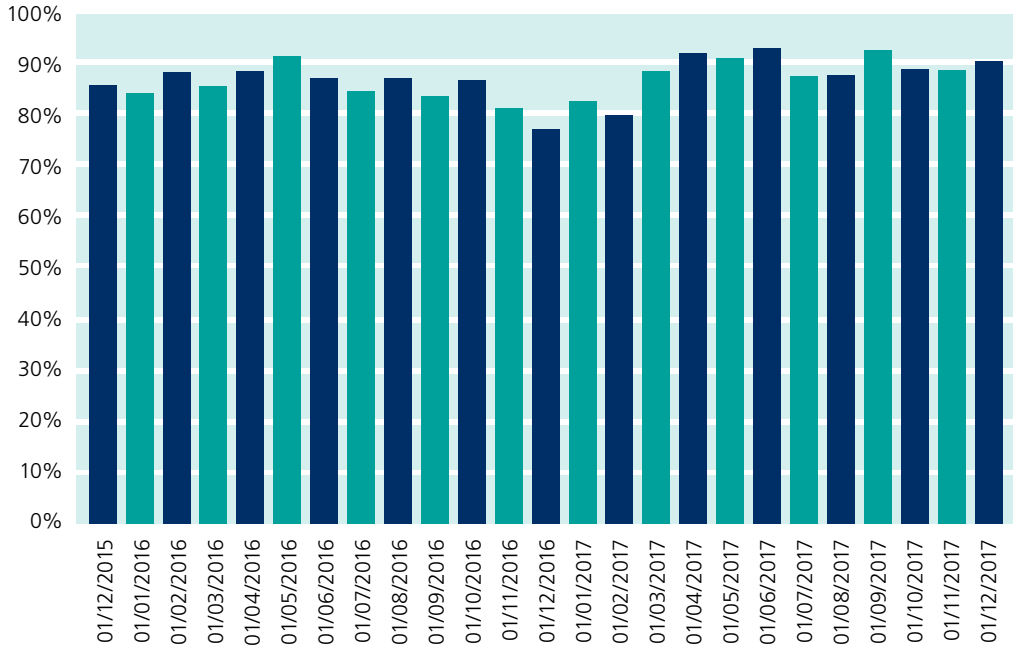
Changes to the audit process have also been made this year with the focus now on whether the tool has been completed in the last 7 days, and whether an appropriate care plan has been implemented. Data is collected monthly with all wards asked to submit data on all current inpatients. These results are shared monthly with ward leaders and matrons and have resulted in a slight increase in compliance.
However the implementation of the new tool and care plans is expected to improve compliance further.

There has been a focus on ensuring weights and heights of children are measured and recorded accurately on growth charts with implementation of a training programme on the VLE for measuring, recording and interpreting growth in children.

% of high risk patients with nutritional care plans in place



% of MUST score completed after 7 days



We have undertaken a review of compliance with Protected Meals guidelines, and generated a revised patient meal poster which has been issued to all wards. There is work underway to review mealtime co-ordinator roles and responsibilities in clinical areas to ensure collaborative working with catering providers at mealtimes and ensure patients are prepared for meals.

By September 2017 we had successfully introduced a hydration assessment and chart to all adult inpatient areas. All adult inpatient areas now complete regular self assessment of the completion of the hydration assessment and chart. Acute Kidney Injury (AKI) lead advanced nurse practitioners carry out spot audits on this data.

PRIORITY 2

Work is also being completed to add an electronic hydration assessment and chart to the safe track electronic observation system.

This year UHS started working with a new service provider, Serco. The new service went live on the 1 June, 2017, so is still in the early stage of implementation. Early indications show that the quality of the food, taste and availability have been positively acknowledged by staff and patients alike; however no formal audit data is yet available. The contractor is currently planning its first audit of patient satisfaction, which will be circulated on completion. The first patient-led assessment of care environment (PLACE) since change of provider took place, but results were not available at the time of publication.

Patient satisfaction scores from Serco for January 2018 are included below:

Overall, how would you rate the quality of the hospital food delivered to your bedside?		
	No.	**%**
Very good	93	54.07%
Fairly good	59	34.30%
Neither good nor poor	12	6.98%
Fairly poor	4	2.33%
Very poor	3	1.74%
Don't know	1	0.58%
Total	**172**	**100.00%**
No responses	5	

PRIORITY 3

IMPROVING CARE FOR VULNERABLE ADULTS

Our aims were:

1. To meet the rising demand of patients presenting in mental health crisis, grow the service, complete a gap analysis of current service delivery and develop a plan to address this.
2. Develop robust training programmes for our staff so they feel well-equipped with the clinical skills to support patients, to de-escalate challenging behaviour and refer to other specialist or professional teams.
3. To develop a UHS mental health board to address the challenges and impact for mental health patients and for staff looking after them.
4. To evaluate responsiveness and effectiveness of the enhanced care support team and potentially expand service.
5. Focus on the autism agenda.
6. Develop leadership and evaluate progress with a dementia strategy.
7. Consider a proposal for joining adults and children's safeguarding teams with associated joint governance and meeting structure.
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. Provide training and awareness on mental health capacity assessment and deprivation of liberty.

Our achievements for 2017/18 were

A Mental Health Board has been developed in order to scrutinise and improve the quality of the delivery of mental health care within UHS. Whilst the board is in its infancy, its role will include analysis of current service provision as well as a vision for the future provision. In addition, a recent internal mental health quality review was completed which will further inform the development of the mental health strategy. Early achievements include; terms of reference have been agreed and signed off, the board meet bimonthly, task and finish groups focus on key priorities and a mental health dashboard is being developed.

Furthermore, closer joint working across mental health teams and services is being facilitated by:

- The appointment of two mental health nurses with the overall aim of delivering the provision of specialist mental health nursing, practicing within the multidisciplinary team. They provide advice, education and support to patients, their carers and other health care professionals.
- UHS mental health nurses attend a weekly Older Person Mental Health (OPMH) and Acute Mental Health (AMH) allocation, and daily multidisciplinary team (MDT) meetings to facilitate joint working and working across boundaries.
- UHS admiral nurses (dementia) attend a weekly G7 MDT on G7 Enhanced Care ward and patients from OPMH, admiral nursing and UHS wards are discussed to decide which would most benefit for transfer to OPMH.
- A part-time liaison 8b psychologist has been appointed (February 2018) to better integrate psychology provision in the liaison psychiatry (Adult Mental Health and OPMH) services and enable liaison psychiatry to offer brief psychological interventions and supervision.
- Health psychology continues to offer psychology in a number of specific areas where business cases have been successful in integrating psychology into medical and surgical teams.
- Division of preventative medicine (DOPM) offer a weekly one hour education programme which all nurses working in mental health in UHS and DOPM are welcome to attend.
- Health psychology offers a psychological supervision/reflective practice group for DOPM nurses to support working effectively with mental health patients.

Education and training achievements include:

- DOPM ran a UHS Mental Health Day with a whole day of speakers in 2017. This was open to all staff at UHS and Southern Health NHS Foundation Trust locally and received excellent feedback. The intention is to repeat these annually in October on World Mental Health Day.
- DOPM (OPMH and AMH) staff offer bespoke training for clinical teams as requested on mental health topics as part of their commissioned service.
- UHS Dementia Working Group is currently liaising with the education team to monitor UHS staff compliance with mandatory dementia training on our virtual learning portal, and this is a standing item on the group for oversight purposes.
- The Mental Health Board commissioned a workshop in October 2017 to scope the knowledge and skills of frontline staff around three key areas; mental capacity, absconding and patients detained and admitted under the Mental Health Act.

Conflict resolution and breakaway training has been provided to emergency department (ED) staff and other high risk areas over nine days, in partnership with the UHS training and development team, with further days to be arranged. Further key actions undertaken by ED to support staff and de-escalate behaviours include:

- Introducing a ‘code green’ approach for managing acute behavioural disturbance which prompts the involvement of senior nursing and medical staff, alongside security officers, to promote senior decision making.

PRIORITY 3

- Working closely with commissioners and multi-agency partners to improve pre-hospital decision making and management of persons / patients detained under Section 136 of the Mental Health Act. UHS have been part of developing and agreeing S136 pathways for use across Hampshire and within ED at UHS.
- Secured funding for the build of two high risk assessment rooms in ED as a 'safe space' environment to de-escalate patients with acute behavioural disturbance.
- Introducing a new protocol for managing psychotic and manic episodes, with associated training.
- Introducing the role of Band 5 registered nurses (mental health) as part of the ED workforce to manage patients who present in mental health crisis. Once established in role, the team will provide training to ED healthcare assistants on providing enhanced support to patients in crisis.

There are a number of specialist teams across the Trust to support staff, patients and carers which include; learning disability liaison clinical nurse specialists; admiral nurses; mental health clinical nurse specialists ; vulnerable adults support team (VAST); enhanced care and support team (ECST); and the department of psychological medicine (Southern Health NHS Foundation Trust service).

Positive progress has been made with the autism agenda. Funding has been secured from West Hampshire CCG to expand the learning disabilities team and this investment was used to develop a focused autism and transition post. The post holder has been appointed and is working closely with the wider learning disabilities team to scope the Trust's requirement around this agenda. The learning disabilities /autism working group will be the forum for developing and driving the strategy and this has been re-launched as part of the new safeguarding governance structure.

A new medicine for older people dementia lead has been appointed who is working closely with the admiral nurses and OPMH liaison to deliver a dementia service. The dementia working group has been re-launched with refreshed membership, the Dementia Champions programme is being re-invigorated ensuring all clinical teams have champions in their area, and development of the 2018-2021 strategy is ongoing. The Mental Health Board will offer scrutiny and oversight of the overall service.

In October 2017 the children's and adult's safeguarding teams were merged in order to facilitate a more holistic, effective and efficient approach to safeguarding within UHS – 'think family'. Whilst the change is in its early stages, the benefits have already been noted and well received, with partner agencies showing interest in developing similar models across Hampshire. A joint governance structure has been developed with the joint safeguarding governance steering group already being well established. This facilitates the learning for complaints, incidents and statutory reviews being shared. A monitoring and evaluation task and finish group has been established with the focus of identifying key performance indicators for safeguarding, development of a 'live' safeguarding dashboard, development of a formal reporting schedule and a formal annual effectiveness programme.

The learning disability, mental health and admiral nurse specialists are working with patient experience to re-launch all support available to carers across the Trust. This includes carer's passports, John's campaign, a carers' café / forum and signposting and support. This area of work is included within both the LD and Dementia strategies.

The vulnerable adults champion role is being reviewed following a change in structure of both the ECST and the safeguarding team.

PRIORITY 3

Additionally, the adult safeguarding team have introduced a daily multi-agency safeguarding huddle with local authority partners to effectively and efficiently triage every referral and incident where a safeguarding concern has been identified.

A whole review of the current Mental Capacity Act and Deprivation of Liberty (DoLS) process has been undertaken following the appointment of a new named nurse for safeguarding adults. This review has highlighted the need for a number of changes to the current process, and we are therefore writing a new policy. Once this is completed and ratified, all training will be updated and modernised.

Patient safety

PRIORITY 4

RECOGNITION AND MANAGEMENT OF THE DETERIORATING PATIENT

Our aims were:

1. For the consultant body and acuity practice development matron to develop an annual action plan for acuity improvement which would inform training and education and feedback to clinical areas.

2. To further improve on the recognition and deterioration of patients, with focus on progressing deterioration escalation on electronic systems (ePAMS).

3. Organisational review of Acute Kidney Injury (AKI) and sepsis outcomes.

Our achievements for 2017/18 were

An annual action plan has been successfully developed during 2017/18.

Part of that plan includes supporting the ROAR group who worked with the Wessex Academic Health Sciences Network (WAHSN) to improve recognition and response to patient deterioration. The AWHSN's present a unique opportunity to align education, clinical research, informatics, innovation, training and education and healthcare delivery.

We worked collaboratively with WAHSN to speed up the adoption of innovation into practice to improve clinical outcomes and patient experience. During the year WAHSN have helped support the development and roll-out of an electronic monitoring system, successfully introducing the mobile electronic observation system MetaVision Safe Track™.

Using mobile devices, nurses of all grades capture observations for their patients directly onto MetaVision Safe Track™, which calculates the modified early warning system (MEWS) and advises the next appropriate steps regarding escalation and monitoring. Clinicians can review the observational data from any UHS PC, laptop, iPad or iPod, as well as any personal device connected to the hospital Wi-Fi. MetaVision Safe Track™ is currently live on the trauma and orthopaedic, surgery and gynaecology wards (a total of 320 beds) and will next be implemented across medicine as part of the hospital-wide roll-out. Running in parallel is the implementation of the MetaVision PDMS into the intensive care and high dependency units. The major benefit of having both the MetaVision PDMS and MetaVision Safe Track™ is a single patient observation record across all clinical areas, ensuring a complete continuum of care across the Trust.

PRIORITY 4

Other benefits include complete observations capture, accurate and safer MEWS score, ease of clinical handover of patients between MetaVision Safe Track™ wards, quick identification of deteriorating patients and those who are at risk, remote patient management for the out of hours teams, and viewable observations via the UHS Electronic Patient Portal (CHARTS).

Lorna Adams-Jones, Project Lead, said:

> **MetaVision Safe Track is easily configurable and has been customised to support our clinical workflow. Our staff have embraced the system with minimal training and have been tremendous. We are excited to roll it out to the remaining wards across our hospital."**

We have evaluated the introduction of the system in AMU and note 50% reduction in cardiac arrest and an increase in outreach calls evidences improved earlier recognition of deterioration. This outcome information has been shared with commissioners, WAHSN, and partnership hospitals and we continue to monitor early warning escalation across the Trust and feedback findings each month to clinical areas for learning.

Sepsis and AKI assessments and alerting tools have continued to be developed, with full fluid balance charting functionality on the Metavision Safe Track™ system nearing completion. We aim to implement this later in the year.

AKI and sepsis outcomes have improved (see priority six) and it is the recognition of deterioration in both conditions that is key.

Training and development has been supported with the delivery of the new Senior ALARM course which targets senior nursing staff across UHS and focuses on simulation training on leadership and patient clinical deterioration. In addition, there is a much more robust process for thematic interrogation of incident reports and sharing of learning via the Recognise, observe, assess and react (ROAR) group and through governance groups across the Trust.

PRIORITY 5 NATIONAL STANDARDS FOR SAFER INVASIVE PROCEDURE (NATSSIPS - NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES)

Our aims were:

1. To embed the NATSSips into our own local safety standards to support staff in providing the very best care and treatment for our patients.
2. To focus on reducing not only never events but all avoidable harm related to invasive procedures.

Our achievements for 2017/18 were

NatSSIPs have been developed and implemented in all theatres and areas carrying out invasive procedures under general anaesthetic or in catheter labs across the Trust over the last two years. They follow a standardised format, however, following the first round of implementation audits of specific areas (cardiac surgery, ophthalmology, obstetrics) it was found that major differences in practice consistently rendered parts of the standard NatSSIPs checklist irrelevant. Consequently staff have been permitted to modify the format to remove questions that are of no value and replace them with specific questions that enhance the safety of their practice.

PRIORITY 5

Audit

A rolling audit programme has been introduced and refined within the main theatre areas. This has deliberately set the bar at a high level with a multiple point review of each stage of the process carried out by a small number of trained observers. The levels of complete compliance within each stage of the 2017 audit are outlined below.

Speciality	Overall	Team brief	Sign in	Time out	Sign out
ENT/OMF	79%	83%	94%	73%	74%
Thoracic	73%	94%	91%	59%	70%
Urology	76%	80%	100%	66%	63%
Paediatrics	81%	91%	91%	83%	69%
Orthopaedics	71%	79%	91%	62%	69%
Paeds orthopaedics	66%	81%	87%	53%	64%
Neuro	75%	70%	98%	78%	63%
General/HPB/Upper G.I/ CEPOD	82%	85%	95%	71%	85%
Vascular	94%	96%	100%	93%	88%
Average Score 2017	77%	84%	94%	71%	72%

The questionnaire includes subjective assessments of engagement, behaviour and communication as well as objective assessment of compliance with attendance, completion of checklists and tasks. The overall scores shown above reflect that, whilst our theatres consistently have a very good safety record, there are still significant areas for improvement in order to achieve ideal practice in all areas. It would have been easy to design an audit tool that simply addressed whether or not we completed checklists and which would have shown near 100% compliance in all areas, however this would have missed the point of the introduction of the safety standards which should serve to improve communication, benefit team working and change culture within the theatre environment.

In the first round of audit this observational tool did not involve early feedback to the teams, this has been addressed in the revised observational tool, which has increased engagement with the theatre team, allowing the observer to challenge practice and feedback where appropriate following each stage of the process. This then helps to facilitate discussion and learning. The revised audit tool being used in 2018 also identifies notable areas of positive practice for feedback, encouragement and wider dissemination.

Ongoing areas for development identified by our 2017 audit:

- Use of paper documentation during checks
- Clinician engagement in some areas
- Surgeon starting the operation without looking at the consent form during time out
- Surgical handover if the consultant leaves before the sign out phase.
- 'Timing' of 'Sign Out'
- Handover processes

The audit data has been fed back to each theatre and sub-specialty and presented during the educational half day programme.

Development of the debrief at the end of the theatre list has been the last major step in the introduction of NatSSIPs within the Trust. Whilst this has been established practice in some theatres, this has been a minority and the NatSSIPs steps are being formally revised in order to make this mandatory within all theatres from 1 April, 2018.

PRIORITY 5

The second round of theatre audits has started and will also involve cascade training of additional observers to facilitate further audits as this evolves into an observational feedback tool that can be used outside of the formal annual audit process.

Cardiac theatres, eye theatres and Princess Anne theatres will all be included in the 2018 theatre audit, with minor alterations to the observational tool.

Interventional radiology, neurosciences and cardiac catheter labs all perform procedures under general anaesthetic in a catheter lab environment where NatSSIPs apply; these areas have developed a further modification to our NatSSIPs standard which is relevant to their way of working. An audit tool based upon the main theatres observational audit tool is being piloted by the cardiology team and will be used in other catheter lab areas.

LocSSIPs – local safety standards for invasive procedures

LocSSIPs are the more abbreviated set of stop points and checks prior to invasive procedures that are performed either by a solo practitioner or outside of a theatre environment.

A core three-step framework has been established for LocSSIPs:

- Sign in (team brief)
- Time out (knife to skin/procedure start)
- Sign out (completion of procedure)

with a series of prompting questions to ensure:

- completion of consent/agreement to proceed
- confirmation of procedure and patient identity
- review of appropriateness of procedure, supervision and competencies
- preoperative, intraoperative and post-operative checks
- availability of equipment and monitoring
- escalation and recovery pathways
- post-procedure requirements

This three-step framework is backed up by procedure specific questions. The core questions and procedure specific questions are widely available as laminated cards (and on MetaVision) in all areas carrying out invasive procedures.

There has been a phased adoption and introduction of these across the hospital, with early uptake from endoscopy, surgery, intensive care, radiology, dermatology and the emergency department. They have also been developed and are in the process of being implemented in cancer care, neurosciences, AMU, medicine for people, specialist medicine, paediatrics, obstetrics and gynaecology.

There are some minor invasive procedures (such as venous cannulation, adult bladder catheterisation) where it has been agreed that LocSSIPs do not apply. Each division has provided a list of those procedures where this is not required which has subsequently been assessed and agreed by the working group. Completion of LocSSips requires documentation in the notes.

Audit of LocSSIPs will predominantly be a notes based retrospective audit of documentation as to whether LocSSIPs were followed. This is because in many areas procedures are only being performed infrequently and therefore it is not practical for the use of an observational tool.

Areas performing high numbers of procedures (such as radiology and endoscopy) will be assessed by an observer completing an observational audit tool.

Audits commenced in April 2018 in critical care, emergency department, endoscopy, neuroradiology and cardiac catheter labs.

PRIORITY 6

RECOGNISING AND TREATING SEPSIS

Our aims were:

Our aim throughout 2017/18 was to improve our recognition of patients at risk of sepsis and, as a consequence, allow the early management of septic patients recognising that if patients with sepsis are treated quickly, mortality is reduced. We used the national sepsis CQUIN as a framework to drive improvement and worked towards a Trust-wide, systematic approach for the identification and appropriate treatment of life-threatening infections. At the same time we worked to reduce the chance of the development of strains of bacteria that are resistant to antibiotics. These priorities were discussed in depth with the UHS Quality Committee.

Through this we aimed to reduce death and morbidity related to sepsis in all areas of the hospital, reducing patient length of stay, critical care length of stay and thus improve patient experience and outcome.

Our achievements for 2017/18 were

The national sepsis CQUIN started in 2015 and continues until 2019. Over this time the CQUIN requirement has changed and enabled UHS to drive awareness amongst staff and service users as to the importance of recognising sepsis.

This year we have refined and embedded our sepsis screening tool. The roll out of the paper tool was phased over the year to ensure all areas received full education and support prior to its implementation. To support this the Trust ensured a clinical lead (consultant intensivist) oversaw the projects and created secondment roles for one band 7 sepsis nurse, one band 6 sepsis nurse and a band 4 data analyst. Alongside this the medical division recruited a substantive band 6 sepsis nurse within their education team and the pharmacy department recruited an antimicrobial resistance nurse.

A sepsis working group was previously established which had excellent engagement from ward based nurses, medical consultants (ICU, AMU, surgery, paediatrics, ED and neurosciences), consultant pharmacist, consultant microbiologists, consultant infectious diseases, antimicrobial resistance nurse, critical care outreach team, and specialist nurses. This year the group has amalgamated into the Trust acuity group – ROAR (Recognise, Observe, Assess and React) as the work stream of sepsis cannot work in isolation but needs to be aligned with the deteriorating patient work stream.

All paper screening tools have gone through a number of PDSA cycles and the adult tool is now included in the escalation of clinical deterioration form with the aim to improve escalation and recognition of a deteriorating patient. The tool is now also included in the Trust's electronic Doctors Work List.

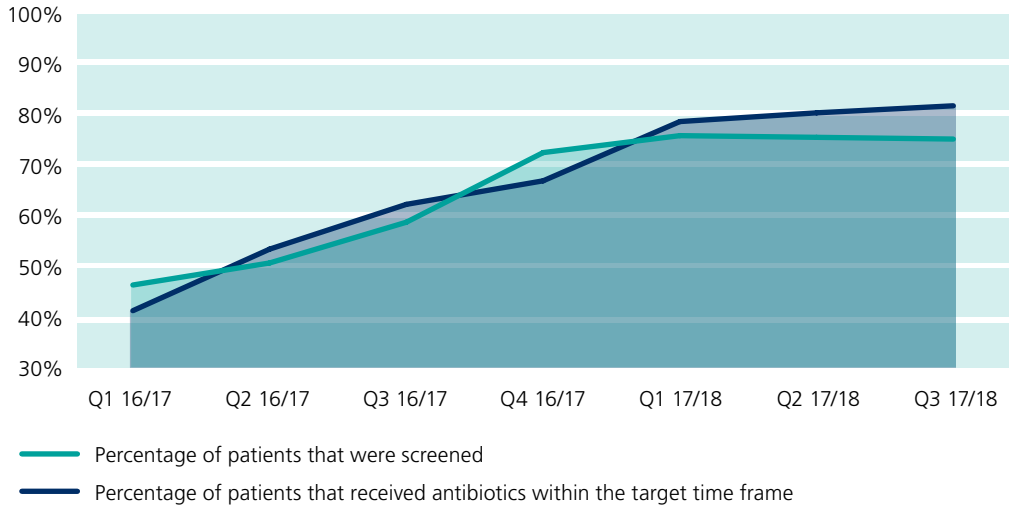
The Trust had previously developed sepsis electronic learning packages for both adult and child health patients in 2015. These are now well established. Antimicrobial resistance cards for staff have also now been developed. Sepsis boxes were trialled the acute admission areas – ED, AMU, ASU, and PAU and maternity, however the uptake in use of these boxes has not seen a significant increase in the management of sepsis and so has not been rolled out to the rest of the Trust.

The CQUIN time scale for delivery of antibiotics was reduced from 90 minutes to 60 minutes in April 2017, which for the Trust has since shown a slower increase in achievement for timely administration of antibiotics.

PRIORITY 6

The graph below shows the overall Trust percentage for achievements for both sepsis screening and timely antibiotic delivery from April 2016.

April 2016 – December 2017
Trust-wide percentage success



CQUIN percentage achievements Q2 2015 – Q3 2017

	Emergency screening	Emergency antibiotics	Inpatient screening	Inpatient antibiotics
Q2 2015/16	24%	46%	-	-
Q3 2015/16	51%	61%	-	-
Q4 2015/16	90%	70%	-	-
Q1 2016/17	85%	36%	8%	47%
Q2 2016/17	90%	45%	12%	66%
Q3 2016/17	93%	56%	25%	73%
Q4 2016/17	94%	61%	51%	80%
Q1 2017/18	91%	78%	61%	79%
Q2 2017/18	93%	85%	58%	76%
Q3 2017/18	92%	76%	59%	89%

Text code – Green is full CQUIN target achieved, amber partial CQUIN target achieved.

PRIORITY 6

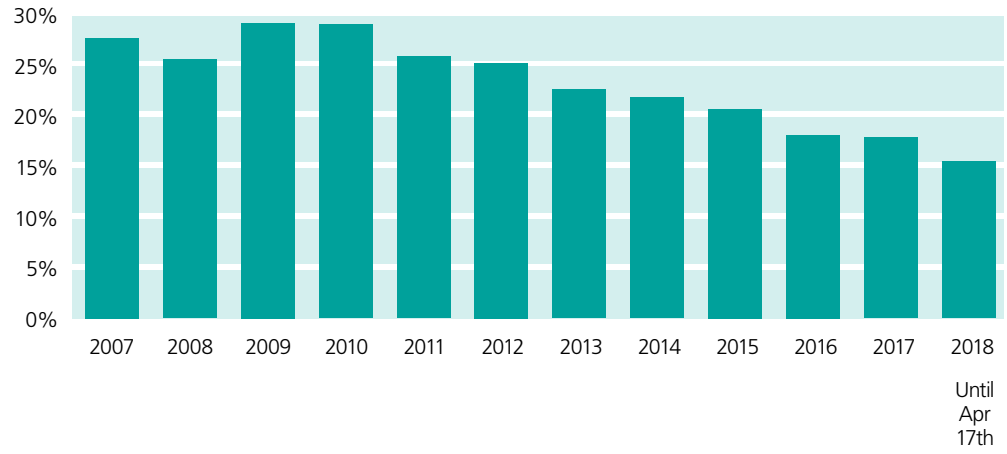
2007 – 2018 Sepsis Coded Patients

(patients whose deaths were attributed to sepsis)

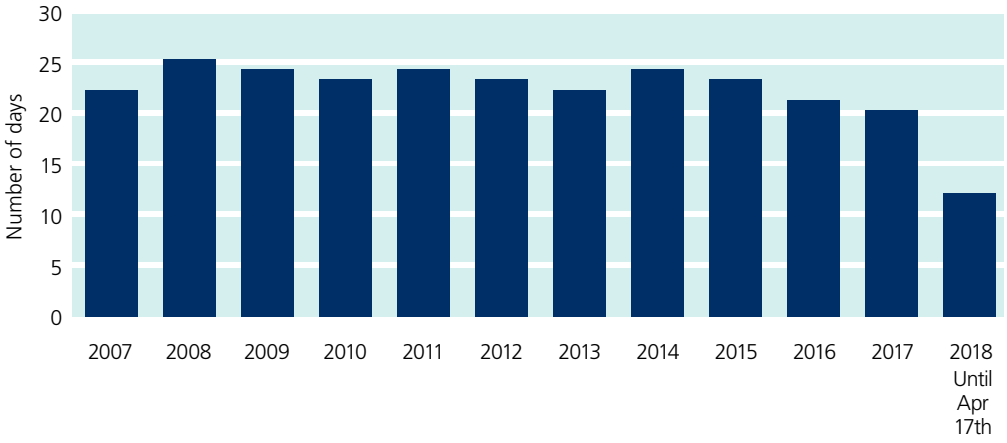
Year	Average Length of Stay (Days)	Total Number of Patients Coded A40/A41	Number of Deaths on Discharge	% of Deaths on Discharge	Total Number of Deaths within 30 days of Discharge	% Deaths within 30 days of Discharge
2007	22	646	180	27.86%	29	4.49%
2008	25	665	171	25.71%	35	5.26%
2009	24	668	196	29.34%	49	7.34%
2010	23	843	246	29.18%	48	5.69%
2011	24	1068	278	26.03%	49	4.59%
2012	23	1033	262	25.36%	72	6.97%
2013	22	998	227	22.75%	38	3.81%
2014	24	1030	226	21.94%	43	4.17%
2015	23	1183	246	20.79%	51	4.31%
2016	21	1279	233	18.22%	53	4.14%
2017	20	2077	373	17.96%	67	3.23%
2018 until April 17th	12	495	77	15.56%	16	3.23%

Percentage of deaths on discharge

(the % of patients who die within 30 days of discharge)



Average length of stay



PRIORITY 6

The CQUIN data will continue to show areas of achievement and areas for improvement. UHS has been recognised by NHS England's medical director for clinical effectiveness as being one of the trusts which has seen the greatest improvements in sepsis recognition and treatment.

The data collected for CQUIN is only a small part of the data we collect for each patient where we look at time of observations, time of sepsis tool completion, time of review by medical team, sepsis biomarkers, outreach review, sepsis six care bundle delivery, antibiotics started, three day antibiotic review, etc. This data enables a wider data set that is shared internally to divisions and care groups to identify where recognition and management of patients can be improved. This information is also shared with the Trust acuity group (ROAR), Patient Safety Steering Group, Quality Governance Steering Group and Trust Board to enable escalation of concerns and support for required developments.

Sepsis has been added as a separate cause code onto the electronic adverse event reporting system which enables sepsis incidents to be easily identified and reviewed. All patients who have sepsis as a cause of death that have been through the IMEG process (Internal Medical Examiners Group) are reviewed by the sepsis clinical nurses and investigated as required.

Favourable Event Reporting Forms (FERF) is written for staff, teams or wards that have provided excellent recognition, care and management to a patient.

The Trust is in the process of rolling out an electronic observation system to all wards. The sepsis screening tool will be included on this system thus providing a mandatory screening tool which should improve compliance similar to that seen within the ED.

We can demonstrate that mortality and length of stay has decreased.

Clinical effectiveness

PRIORITY 7

PRIORITY SEVEN: REPORT OUTCOME MEASURES IN EVERY SPECIALITY ACROSS THE HOSPITAL

Our aims were:

To continue developing the work streams across all clinical specialities and to establish an outcomes group to provide a greater level of scrutiny and assurance.

That every speciality would identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes.

Each care group would be able to present their outcomes to a newly established outcomes scrutiny group on an annual basis, demonstrating progress against the identified outcomes.

Our achievements for 2017/18 were

An outcomes group was established with a rolling programme which ensures that all care groups attend on an annual basis to present their outcomes. This group reports into the quality committee.

More specialities are identifying outcomes each quarter. This remains work in progress.

PRIORITY 7

All care groups have presented their outcomes to the scrutiny group during 2017/18 and the programme for 2018/19 ensures that this will continue. This will allow care groups to update their progress against identified outcomes since being presented in 2017/18.

PRIORITY 8 IMPROVE CARE FOR PATIENTS AT THE END OF LIFE

Our aims were:

Eight priorities were set in the 2016/17 UHS Quality Account for End of Life Care.

1. Deliver 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 of 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.

Our achievements for 2017/18 were

There has been progress in all domains. The Trust Board have acknowledged that end of life care is a field which requires continuous quality improvement.

We have started delivering our new five year UHS End of Life Care Strategy which includes:

- Role specific mandatory training has been agreed for all staff groups from April 2018.
- We are providing increased education on end of life care including: all FY1 and FY2 doctors, weeklong situational and more formal teaching on a ward by ward basis.
- In November 2017 we held our fifth annual End of Life Care conference for UHS staff which was both well attended and positively evaluated.

PRIORITY 8

- The Hospital Palliative Care Team clinical activity continues to rise year on year providing even more opportunities for the team to teach situationally and influence the care of far more people than they see.
- An enhanced proactive palliative care team service for the UHS cystic fibrosis service commenced in January 2018.

We have progressed our intention to discuss with the patient (if well enough and appropriate) with family, carers or other advocates that they are approaching the end of life:

- Our most recent comparison of UHS Dying in Hospital Audits of the care of patients who died in June 2015 and in September 2016 (repeating previous National Audit) shows improvement from 81% to 91% (national target is 83%).
- The percentage of notes in which there was documented evidence of a discussion with the patient about the probability that they would die in the coming hours or days was 29% in both audits against the national target of 20%. A large percentage of patients were deemed too ill to have such a discussion.
- The percentage when this was discussed with a nominated person important to the patient increased from 80% in 2015 to 87% in 2016 against a national target of 79%.

We have enhanced our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met. In 2018, the Spiritual Care Team diversified its service; employing Christian chaplains of varying denominations, the team now also employs those of other faiths and none – specifically, Muslim and Hindu assistant chaplains have been appointed as well as a Humanist Pastoral Carer. Whilst all chaplaincy includes generic care, Muslim, Hindu and the non-religious now have dedicated spiritual care staff available should they require this.

Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying has been an area of focus in 2017/18. Whilst we believe there are more discussions initiated about individuals' preferences at the end of life, there is no single system to record these preferences and, in any case, those discussions are usually best placed to occur in the community. Of those patients from UHS 2016 Dying in Hospital Audit, only one out of 77 patients was admitted from the community with an advance care plan (ACP).

We are concerned about the number of patients who are unable to be discharged home when approaching the very end of their life due to social care constraints and are interrogating the data to identify the root causes of this. The number of adult patients dying in the Trust is increasing. In 2015/16 there were 2,111 adult deaths of whom 364 died in Countess Mountbatten House (CMH), in 2016/17 2,341 with 415 deaths at CMH. The proportion of patients referred to and followed up by the Hospital Palliative Care Team (HPCT) who die in hospital has increased; 541 (25.8%) and 634 (28.4%) of HPCT referrals died in SGH in 2015/16 and 2016/17 respectively. The number and percentage have continued to rise 590 deaths (30.6 %) of HPCT referrals in the first 10 months of 2017/18.

The HPCT was directly involved in the care of 86 of the 215 (40%) adult patients who died in SGH/PAH as inpatients in December 2017.

In order to improve our working relationships with relatives and carers we conducted a survey of bereaved relatives. 160 questionnaires were handed out during February 2017, with a response rate of over 50%. Over 90% of respondents rated their relative's care as good or very good for the majority of the questions. Feedback about specific ward areas was sent to relevant clinical leaders so they could learn from both the accolades and any negative comments. In addition we ensured the feedback was shared across all the clinical areas to improve practice.

PRIORITY 8

In July 2017 we also held the second of the UHS CEO patient lunches for bereaved relatives, which is held on a three yearly cycle. Relatives were given the opportunity to discuss directly with the CEO their experience of the care for both the dying person and themselves. Where necessary the CEO asked for some of those who were involved to communicate with families and to harness their ideas about improvement. One family is now working with us to improve the 'Coping with Dying' information for relatives.

In 2017/18 we committed to 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). We have actively been part of the local, regional and national work streams for TEP throughout the year.

During 2017/18 we replicated the National Care of the Dying Audit locally ahead of the anticipated next national audit round. We carried out this audit using data from the notes of 77 adult patients who had died in September 2016. On the whole the results showed an improvement compared to the audit of those who died in June 2015, and in some domains we exceeded the national targets. Where the results suggested a need for improvement this has been incorporated into our End of Life Care Action Plan.

In order to assess the use of the individualised end of life care plan we have carried out a baseline audit of staff knowledge and experience of the UHS End of Life Care Plan to establish standards for practice. We have developed an education programme which we are implementing and will then re-audit and use the results to inform continuing improvement in the care of the dying.

PRIORITY 9 REDUCE THE IMPACT OF DECONDITIONING AND IMMOBILISATION ON THE FRAIL ELDERLY

Our aims were:

1. Increasing ambulatory care at the front door.
2. Increasing the identification and better understanding of frailty.
3. Initiatives to positively encourage mobilisation on the wards including Implementation of the 'Eat, Drink, Move' and 'End Pyjama Paralysis' initiative in AMU and medicine for older people 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.

Our achievements for 2017/18 were

During 2017/18 we re-launched our present ambulatory pathways aimed at increasing ambulatory care (AEC) at the front door. We rolled out AEC clinics seven days a week and reviewed the headache pathway with ED colleagues and looked at diabetes and superficial thrombophlebitis.

Our biggest success in 2017/18 is the introduction of the Eat, Drink, Move initiative. This is part of a national initiative linked to #endpjparalysis and #last1000days looking at how we can value every moment of our patient's time while they are in hospital. The initiative is headed up nationwide by Professor Brian Dolan and has taken on great momentum over recent months. It is important because 65% of patients admitted to hospital are 65 or older, and a person over 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This could be the difference between going home and going to a home. UHS has taken on this concept and following permission from the Heart

PRIORITY 9

of England NHS Trust have used their 'Eat, Drink, Move' campaign focussing on the importance of eating and drinking well while in hospital. We are working closely with the dieticians and Serco to ensure this is happening.

The initiative also links to the Red to Green days and SAFER ward rounds, ensuring that a patient's hospital journey is moving forward at all times. SAFER is a bundle of interventions to ensure better discharge, including all patients having a daily senior review in the morning; all patients being given an expected discharge date and clinical criteria for discharge; efficient patient flow ensuring patients are in the right place at the right time; patients are sent home when it is safe and timely to do so; and any patients in for extended lengths of stay are reviewed by a senior multidisciplinary team to work to get them home.

Link in to this, in 2017 the Trust became one of five pilot sites for the Helpforce initiative. This is a national company which is developing the invaluable role volunteer's play in hospitals to enhance patient experience. At UHS we already have an established, extensive volunteer service that undertakes a huge variety of roles. In 2016/17 we participated in the SOMOVE study, looking at the feasibility of training volunteers to encourage patients to mobilise and prompt them to complete bed and chair exercise programmes. This study was highly successful and demonstrated a significant increase in the activity levels of those patients involved.

Priorities for improvement 2018/19

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 year's Quality Improvement Framework (appendix one) to ensure that our quality priorities are aligned with feedback from patient surveys and complaints, as well as incidents. We have used our progress against last year's priorities to help decide which priorities need continuing focus in 2018/19. 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.

- **Priority one**: Improving the experience of discharge (continues the work we started in 2016/17 prompted by the benchmarking of UHS against other trusts described in the Inpatient survey 2017 www.picker.org).

- **Priority two**: Improving end of life care (also continues the work undertaken in 2016/17 and is selected in response to the results of the National Audit of Care at End of Life www.nice.org.uk)

- **Priority three**: Shared decision making. This has been selected in response to recommendations from NICE (Coulter, A. and Collins, A. 2011. Making shared decision-making a reality: no decision about me, without me). This indicator has not previously been prioritised in the UHS quality account, and benchmarking has not been completed. However it is recognised as an area which could have a significant impact on quality of care.

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.

- **Priority four**: Recognition and management of the deteriorating patient continues to focus on improvements started in 2016/17. We have seen a great deal of progress, but recognise we need to maintain momentum for this key area in response to data from patient safety incident reporting, serious incident investigations and complaints. We also recognise we currently sit as an outlier across the region for not adopting the Royal College of Physicians National Early Warning System (NEWS) tool.

- **Priority five**: Keeping patients eating, drinking and moving - this priority is adapted from the Eat, Drink, Move campaign developed by Heart of England NHS Foundation Trust and is a new initiative not currently benchmarked, but with encouraging early evidence of adding significant value in delivering quality care.

- **Priority six**: Delivery of the national safety strategy for maternity care is underpinned by the Department of Health Maternity Safety Strategy and NHS Resolutions 10 criteria. We know that trusts that are able to demonstrate compliance with these recommendations are likely to deliver safer maternity services and may be expected to have fewer cases of brain injuries or other harm.

Clinical effectiveness: providing high quality care, with world-class outcomes, whilst being efficient and cost effective.

- **Priority seven**: Antimicrobial resistance (AMR) was highlighted as a priority by Kings Fund in 'What if antibiotics were to stop working? 14 November 2017'. International work on antimicrobial resistance is led and coordinated by the World Health Organisation. A Global action plan on AMR was published in 2015, and the WHO also provides guidance for countries on the development of national action plans, and conduct international surveillance on AMR. Despite international commitment to address AMR, concerns have been expressed recently that action has been slow. We are committed to improving this area and including it as a priority in our QIF and quality account.

- **Priority eight**: Every outpatient encounter adds value. There is a growing need for our Trust to respond to advances in technology to help improve our effectiveness and the patient experience. We know from patient feedback that many patients would value contact via technological options rather than face to face meetings, and have chosen this as a priority in order to ensure we are moving forward in this field.

- **Priority nine**: Best use of resources. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS which would improve quality of care for patients, and we are committed to engaging with this work stream to continue to work towards improved quality of care.

Patient experience

PRIORITY 1 IMPROVING THE EXPERIENCE OF DISCHARGE

Why we have chosen this priority

Getting discharge right is a challenge facing most acute providers. The multi-agency and multi-faceted nature of the discharge process combines to cause delayed transfers of care, avoidable hold ups, and other process issues that keep patients from going home, keep beds filled when there is no longer a clinical need for the patient to be in them, and ultimately impacts on a patient's overall experience of care.

Many of the problems are outside our control, with the lack of availability of ongoing community and residential care the biggest factor in delayed transfers of care at UHS. But there are things within the Trust that we know we can continue to improve.

We know from our patients that our discharge experience requires improvement. In the latest National Inpatient Survey results, published in 2017, the Trust underperformed when compared to other trusts. In particular, patients reported concerns about:

- Discharges being delayed due to a wait for medicines and / or patient transport
- Information given to patients about their medication and side effects to watch out for
- Patients reporting that they knew what to expect regarding their care after leaving hospital
- Family members or carers being given the appropriate amount of information about a patient's condition and ongoing care needs

We also know that sometimes we do not work as effectively with our care and nursing home colleagues as we could. This has an impact on the quality of discharge when sending residents back to their care home. This is evidenced by the increasing number of concerns raised to us by care and nursing homes about poor discharge.

Finally, we recognise that our systems and processes do not always work towards an effective and timely discharge. Delays in review, dispensing medications, and arranging transport all create avoidable hold-ups in getting patients home. Because of these factors, we will continue our focus on discharge in 2018/19 to ensure we deliver the best possible discharge experience for our patients.

What are we trying to achieve

Improving patients' experience of discharge is an important part of our work to improve the efficiency, safety, and timeliness of the discharge process itself. We want our patients, and their relatives and carers, to be fully informed and involved in their discharge from hospital. There are many varied but related factors that impact upon the experience of discharge, and our work ranges across a number of different areas outlined below.

PRIORITY 1

Great discharge starts at admission, and UHS is working on embedding the SAFER patient flow initiative to improve the safety and effectiveness of our discharge process.

A core element of SAFER is ensuring that patients know what is wrong with them, what is going to be done, what they need to go home, and when they can expect to go home.

To actively encourage patients to be involved with their discharge planning, we will provide patients with a checklist to start thinking about what they will need to ensure a timely discharge. The checklist will be included in a new inpatient welcome booklet that will provide patients with information about their stay. The booklet will encourage patients to start thinking about, and planning for their discharge home from the day they are admitted. By thinking ahead we can work to remove avoidable delays. This could range from ensuring that transport is arranged, asking friends or relatives to ensure there is food in the fridge and the heating is on at home, to being clear on medications and their side effects.

We know some patients do not have family support, so we will be developing a discharge volunteer role. These volunteers will support patients in preparing and planning for discharge by ensuring that all of the patient's questions have been answered and all arrangements have been made to enable a safe and positive discharge.

We will also be looking to improve our collaborative working with local care and nursing homes, to ensure a coordinated and joined up approach to discharge to homes. This will include a number of engagement activities, including a care home survey to help triangulate key barriers and obstacles to smooth and safe discharge back to care, nursing, and residential homes.

We will also improve our nursing discharge checklist to ensure patients receive the right information about their medication. This will enable patients to leave the hospital knowing what medication they have been given, how to take it, and what side effects to look out for.

Continue to work with the wards to ensure Complex Discharge Policy is being followed appropriately.

Continue to develop the discharge officer, senior discharge officer and CHC team to be able to further support patients with timely and relevant information regarding their discharge plans.

Finally, we know that patients want to get home quickly on the day of their discharge, and we are working to ensure that for patients for whom it is safe to do so, we discharge home before lunch. This will require more efficient working and collaboration between clinical teams, ward staff, and pharmacy, but will not only improve patient experience but increase our flow and capacity.

What will success look like

Our aim is for every patient to leave hospital in a timely and safe manner, knowing what has been done, what to look out for, and who to contact if they have any questions. We want our patients to leave having been fully informed and prepared for their discharge, and for the discharge process itself to enhance and not detract from their overall experience of care.

How we will monitor and measure progress

We will continue to monitor patient feedback through the annual National Inpatient Survey, as well as locally through our own inpatient survey. We will focus questions on how prepared patients feel about their discharge and how informed they have been kept about the process. Oversight of performance will be through our quality governance steering group, Trust executive committee, and ultimately Trust Board.

As we continue to embed SAFER, we will track how well we are meeting the estimated day of discharge and how successfully we have removed avoidable obstacles to sending patients home.

We will thematically review calls to our medicines helpline to ensure that patients are being given the right information about their medications when they are discharged.

We will continue to work with local care homes and our commissioners to ensure that our work is collaborative, effective, and joined up, and that discharges to homes are safe. We will also monitor the number of concerns being raised to us.

PRIORITY 2 IMPROVING END OF LIFE CARE

Why we have chosen this priority

We outlined recent achievements in end of life care in 2017/18 priorities – priority seven on page xx, however there are some significant areas where we acknowledge we still need to improve.

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. We also aim to improve the regular and effective communication between staff and the dying person and those close to them.

We know from patient feedback that we usually get it right:

> All the staff from resus/majors and especially AMU1 were so caring and patient. They took time to listen to our Dad's wishes and listened to the family".

> The doctor on duty the morning my mother died had such a lovely caring attitude over the phone when he informed me her passing was near. Thank you for all everyone did in the short time Mum was with you".

> The care received was exceptional. We could not have asked for more and the person concerned died in peace, with dignity and in the most tranquil way possible".

But there are still some areas where our feedback prompts us to improve:

Communication:

> We all knew what the outcome was going to be but when we asked to see the doctor we were left waiting a very long time if they came at all. I told them I lived in Exeter but every time I phoned I was told the same thing, that he had a quiet night which was not always the case. I feel very strongly that they could have given us more time and information".

PRIORITY 2

Education:

> "I feel that the staff had a serious shortfall and needed a lot of training to be able to deal satisfactorily with end of life. It is necessary for staff to understand all aspects about their patient and try to understand the emotional distress that families are suffering. It is important the relatives have confidence that staff are in control of the situation and have the knowledge to deal with it".

Meeting the needs of others:

> "When it was apparent that Dad was near the end, it would have been nice for him to have been in a separate room so we could have talked without the noise of the other patients".

We believe these are priorities which must be embraced as part of a continuous learning cycle within the organisation.

What are we trying to achieve

Building on the work started in 2017/18 we aim to continue to improve our care of dying patients and their families and the way this is communicated and documented. We will work towards better formal and informal mechanisms to engage with and hear the voice of patients and families, including families who have been bereaved. This will be achieved through:

- A complete revision of the UHS Individualised End of Life Care Plan including the development of a workable electronic version which can be shared with patients (if well enough) and their families, ideally with a section which can be completed by the families.
- Working with bereaved relatives to learn from their experiences.
- The development of both role specific mandated end of life care education and of communication skills training which focuses on talking to very ill patients and families about uncertainty and dying.
- Auditing the use of the UHS Individualised End of Life Care Plan and using the results to drive continuous improvement in the care of the dying.
- Participation in the National Audit of Care at the End of Life 2018/19 which will audit in-patient hospital deaths in April 2018.
- Utilising the PICKER methodology and system to establish a rolling survey for bereaved families to feedback about their experience.
- Continuing the CEO Listening Lunches for bereaved families.
- Harnessing the feedback from complainants, where their perception is that aspects of end of life care could have been better, and where possible working with them to improve.

We recognise we need improved compliance with the NICE Quality Standard 144, 'Care of dying adults in the last days of life' (QS 144 Statement 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." March 2017). This will be achieved through embedding a 'board to ward' focus on recognising the possibility that a patient may be dying.

In response to the audit of case notes of adult patients who died in September 2016 (UHS Dying in Hospital Audit) we will set up a system through which adults in the last days of life will have their hydration status assessed and documented daily and will have a discussion about the risks and benefits of hydration options.

PRIORITY 2

We aim to facilitate more timely and proactive discussions with patients about their end of life care preferences, including preferred place of care and death, and a cross-organisational infrastructure to record this. This will be achieved through:

- Encouraging patients to talk about their preferences and wishes as they approach the end of their lives.
- Up-skilling the UHS workforce through providing increased opportunities to work alongside the Hospital Palliative Care Team and through communication skills training focused on advance care planning and end of life care.
- Working in partnership with providers of community care, commissioners and the Wessex End of Life Care Network to develop a truly cross-organisational IT system.
- The further development of our 'proactive' palliative care approach for example our new ways of working with our emergency department and AMU, our heart failure team and our regional cystic fibrosis team. Early feedback in February 2018 from a patient with cystic fibrosis seen in outpatient clinic was:
  "it was fantastic and really helpful to see palliative care when I am sort of OK and not just when I have been admitted in a crisis."

At UHS we are setting ourselves the goal to ensure that end of life care remains a key priority for the Trust and that we are known as a 'dying friendly hospital'. This will be achieved through:

- The development of a better corporate structure for End of Life Care within UHS.
- Continuing to raise awareness locally, nationally and further afield, to promote the quality of palliative and end of life care in UHS.
- Collaborative working with our clinical academic colleagues and the Wessex CLARHC.

Last year we worked hard to grow our spiritual care team. We would like to develop the service further and be able to offer comprehensive out of hours service provision by the spiritual care team. By continuing to engage with local religious and faith leaders we will explore ways of meeting the out of hours demand for spiritual care, which mainly relates to the care of dying patients and their families.

What will success look like

1. Staff will be competent and compassionate in caring for patients and their families at the end of life.

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 settings
   - Current and anticipated preferences for symptom management and maintaining hydration
   - Needs for care after death

3. Whenever possible we will support our patient's wishes on their preferred place of care.

4. The needs of families and others identified as important to the dying person will be actively explored, respected and met as far as possible.

5. Each adult patient will have an agreed individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support.

6. Sensitive communication will take place between staff and the dying person, and those identified as important to them.

7. The National Care of the Dying Audit results will have improved from the previous National and UHS audits.

How we will monitor and measure progress

1. We will record the training delivered and attended as part of role specific mandatory end of life care education across divisions and staff groups to demonstrate we are meeting the Trust's target levels. Education Leads report to the End of life Care Board on their divisional compliance with role specific End of Life care education.

2. We will carry out spot audits of case notes of patients recognised as approaching the end of life monitoring:
   - The quality of documentation, including the UHS Individualised End of Life Care Plan.
   - Anticipatory prescribing
   - Communication between the health care team and patients and their families
   - Discussions about care preferences including preferred place of death
   - Assessment of hydration and nutrition requirements and each patient's ability to eat and drink.

3. We will participate in the National Care of the Dying Audit and benchmark our performance against the national picture and our previous results.

4. An annual End of Life Care Action Plan will drive our continued quality improvement and be shared quarterly with senior divisional management and executive teams. Reports of progress will be presented through the Trust's End of Life Care Groups to the Trust's executive committee and the Board of Governors. Reports and action plans will be cascaded through divisional and care group mechanisms to ward level.

PRIORITY 3 SHARED DECISION MAKING

Why we have chosen this priority

Shared decision making (SDM) has been defined by the National Shared Decision Making Collaborative as:

> **"a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences."** (NICE 2015)

The shared decision making process is a conversation which takes place in the "black box" of consultation. The conversation draws on each of the participants' skills and expertise. The clinician brings knowledge and insight of diagnosis, pathology, treatment options available, and evidence-based information about risks and outcome probabilities, and the patient brings knowledge and insight of their personal values, outcome preferences, and experience of illness, social circumstances, and attitude to risks. (Coulter and Collins 2011).

There are a number of policy drivers supporting the business case to ensure high quality shared decision making is delivered to patients. These include:

- Benefits in improved allocative efficiency and effective value. These improvements are delivered by mitigating the risk of market failure in the "black box" of consultation from asymmetrical information. (Blomgvist 1991; Gafni, Charles and Whelan 1998; Lee 1995; and Mulley, Trimble, and Elwyn 2012).
- Statutory duties of CCGs and NHS England to promote patient choice and the duty to promote involvement of patients and carers in decisions about prevention and diagnosis of their illness, and in their treatment and care. (Health and Social Care Act 2012 s23(1)(13H) and s25(1)(14U)).

PRIORITY 3

- Statutory duties of providers to deliver person-centred care to patients, including: delivering care and treatment which reflects their preferences; collaboratively assessing needs and preferences for care and treatment with the patient; and supporting patients to make decisions about their care to the maximum extent possible. (The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2936 reg 9).
- The contractual requirement for providers to deliver against regulation 9, outlined in the NHS Standard Contract (Full Version) Service Conditions SC10.
- The common law duty to obtain informed consent which, following the judicial ruling of the UK Supreme Court, includes the need to present options and risks up-front to patients. There is also a vicarious liability for those who make provision for those services. (Montgomery v Lanarkshire Health Board 2015).

A shared decision making approach to making decisions in healthcare is a departure from traditional, paternalistic, models of healthcare services. Effective delivery of high quality shared decision making needs culture change across whole pathways and services.

Shared decision making may already be happening in the NHS in England, but the quality is not routinely monitored, and there is no national reporting for shared decision making. Contractual levers such as CQUIN present an opportunity for us to promote shared decision making, lead quality improvement and meet our statutory duties.

What are we trying to achieve

NHS England (NHSE) have asked us to carry out the Shared Decision Making (SDM) CQUIN for two years, with year one focusing on transcatheter aortic valve implantation (cardiology) and neuro-oncology teams.

Our approach to achieving this will begin with planning. A working group has been established to agree which parts of the pathway (decision nodes) present different treatment options and review tools. An implementation plan will be written and submitted to commissioners which will include a team building and training plan for staff, and agreement of a plan for the mechanisms for gathering, and analysing information about decisions made to ensure evaluation.

We will then undertake a pilot to test and evaluate the use of our SDM tool and further develop it to meet shared patient and service needs.

What will success look like

This is a difficult one to answer. NHSE themselves are unsure of how to measure the success of this CQUIN as effectively it is a culture change. We are expected to survey patients before and after, beginning to use SDM in consultations. However, we will not be penalised if the post-SDM questionnaires show no improvement. The same applies to the staff questionnaires that were administered before and after SDM training, no penalty applies for failing to show an improvement post-SDM training.

We have been advised to try and apply the principles of SDM within consultations with the help of a Decision/Option Grid which states simply benefit/risks of each option. Clinicians in both departments have developed these Option Grids and use them as an aide memoire in consultations. Our aim is to ensure that the patient is fully informed and is a 50/50 partner in decisions involving their healthcare.

How we will monitor and measure progress

We produce quarterly reports for NHSE which accomplish that purpose. These reports go to the clinicians involved and to NHSE via contracting. We will also report to our commissioners on progress against our implementation plan including any new patient cohorts.

Patient safety

PRIORITY 4

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. 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 deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

Managing the risks associated with the deteriorating patient has been identified as a recurring theme through incident reporting, serious incident investigations and complaints during 2016/17 and 2017/18.

We are committed to building on the significant progress made as described in priority four (2017/18). This progress has meant that we are now in a position to identify our most useful tool to focus on in identifying and preventing deterioration, which is (MEWS). However, although we have used this tool within the Trust since 2000, there are least six different modified MEWS algorithms used across UHS and we currently sit as an outlier across the region for not adopting the Royal College of Physicians National Early Warning System (NEWS) tool.

We recognise now that the identification of deterioration starts in the community, and that systems need to work together with a single scoring system from community through to acute hospitals. To deliver the best quality for our patients we need a standardised assessment method which is streamlined, speaks the same language across primary and secondary care, helps streamline handing over care and which can utilise healthcare resources more effectively. The NEWS tool offers this refinement.

What are we trying to achieve

- Ability to track deterioration more precisely.
- Whole systems approach to deterioration, escalation and response.
- Better outcomes for patients – reduction in higher scoring acuity levels.
- Standardisation of NEWS 2 across Trust.
- Ability to facilitate early detection, diagnosis and escalation.
- Reduction in safety errors.
- Share key patient information.

What will success look like

- One tool across Trust for adult patients (excluding paediatrics and obstetrics).
- Seamless language from community to acute hospitals and back out.
- Ability to track patient's deterioration.
- Research and audit associated with whole systems deterioration.
- Collaborative pan pathway system.
- Evidence based prioritisation of resources.
- Seamless transitions of care.
- Align hospitals within UHS and region.
- Close working with Wessex Academic Health Sciences Network to develop this community of practice.

How we will monitor and measure progress

- Reduction in patient safety matters associated with deterioration.
- Monitoring of where we have rolled out across UHS.
- Gain feedback from partners.
- Monitoring number of outreach calls and expect an increase.
- Monitor cardiac arrests and expect a reduction

PRIORITY 5 KEEPING PATIENTS EATING , DRINKING AND MOVING

Why we have chosen this priority

Our success with this priority in 2017/18 has established an excellent baseline for continued improvement. In 2018/19 we are looking at developing the role of patient support volunteers who will be multi-trained, enabling them to undertake the roles of mobility volunteers, meal time assistants and time for you involvement. This volunteer role will be enhancing the work undertaken through the Eat Drink Move initiative.

What are we trying to achieve

Through these projects we hope to continue to promote physical activity of patients in hospital to reduce the risk of deconditioning and the consequences of this.

What will success look like

- Enhanced patient safety
- Improved reports of patient satisfaction
- More timely discharges
- Reduced length of stay
- More timely admissions for other patients
- Reduced laundry costs where hospital gowns/pyjamas are used

In addition, it would lead to enhanced mental wellbeing of people as they are encouraged to take greater responsibility for their own health and become active participants in their personal health journey. Many more of their red days would be green days and in the last 1,000 days, each and every day counts.

We will be monitoring length of stay across the areas taking up this initiative, as well as looking at patient experience, the percentage of patients up and dressed in their own clothes, pressure ulcer and falls rates, and rates of discharge to own residence. In addition to changes in these outcomes, we will be looking for a change in culture, where patients being dressed in their own clothes and moving around the ward is the norm.

The initiative will be rolled out area by area with medicine for older people (MOP) and acute medical unit (AMU) already on board, and surgery, orthopaedics and stroke anticipated to follow April 2018. Training sessions will be offered to all ward staff to encourage them to embrace the change.

Success will be a change in culture so that all patients who are well enough are up, dressed and moving around the ward safely. All patients will be offered snacks and drinks at intervals throughout the day and there will be a variety that will meet the patients' dietary needs. It is hoped there will be an improvement in the outcome measures mentioned above, which will enhance the improvements made with the roll out of the SAFER board rounds and red to green days.

How we will monitor and measure progress

Data has been collected on MOP prior to intervention to gather a baseline. This was monitored monthly for five months and is now reviewed every quarter. The intention is to gather data pre implementation in all areas so we can track the improvement. This will be reported to the Eat Drink Move working party and the clinical area. By November 2018 we will produce a report that will summarise the improvements made across the different areas with the roll out of this initiative. It is important to remember that Eat Drink Move is not all about outcome measures but rather an improved experience for the patient which will become part of the embedded culture at UHS.

PRIORITY 6 DELIVERY OF THE NATIONAL SAFETY STRATEGY FOR MATERNITY CARE

Why we have chosen this priority

Maternity is different from other clinical specialities as most pregnant women are generally healthy and pregnancy is a natural physiological process that usually culminates in the birth of a healthy baby.

We receive excellent feedback for our maternity services via our Friends and Family feedback:

> Very happy with all the midwives. There is a strong team of staff. They should all be very proud of themselves. Very attentive and extremely helpful and informative with everything. Midwives deserve a pat on the back. The team made me feel confident and helped me massively with the right techniques".

> Cannot thank all the staff enough for being amazing, helping me deliver the baby and providing extra support with breast feeding. Thank you all so much".

> Great care from labour ward HDU and Lyndhurst, including all staff I was in contact with. Very supportive and understanding".

> All staff absolutely fantastic. You would not have known the ward was full. Took the time to call us all by name at all times. We had an exceptional, caring experience from start to finish".

> The entire team for my c-section was professional, supportive and absolutely wonderful. The post care was exceptionally good. Many thanks".

However we remain aware of the potential for safety issues for this patient cohort. The vast majority of deaths and injuries in maternity care are unexpected outcomes, but where a death or injury could have been avoided the consequence for both families and the professionals involved can be devastating. Trusts that are able to demonstrate compliance with recommendations made with the Maternity Safety Strategy and NHS Resolutions 10 criteria, are likely to deliver safer maternity services and may be expected to have fewer cases of brain injuries or other harm which can lead to negligence claims.

Maternity safety has always been a fundamental driver within maternity at UHS. Since 2015 we have signed up to the Department of Health's (DoH) ambition to halve the number of stillbirths, neonatal deaths and brain injuries that occur during or soon after birth, as well as maternal deaths, by 2030. This forms part of our sign up to safety initiative. We have attended all of the quality improvement workshops with NHS Improvements and we have an agreed Quality Improvement plan in place.

What are we trying to achieve

Safety incidents within maternity services have lasting impacts on women their families and staff. Therefore the service recognises that in the coming year there needs to be a greater focus on leadership, culture in learning, reviewing data and good review processes alongside openness, honesty and good communication. We are committed to providing a focus on patient safety, professional and public accountability, whilst acting responsibly when things go wrong. The maternity service understands that it is important that the response to all incidents is one of openness and learning with a drive to reduce future risk for patients, support for patients, staff and anyone who may suffer as a consequence.

In addition we plan to continue to drive quality improvement by becoming part of the Wessex Maternity Community of Practice to provide a regional forum to profile QI and patient safety in support of Local Maternity Systems in Wessex.

What will success look like

All women, babies and families across maternity care settings will have a safe, reliable and quality healthcare experience. We will have created the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system, including SHIP collaborative. We will also be contributing to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

How we will monitor and measure progress

The maternity service is developing an action plan to ensure monitoring and to deliver all of the separate elements highlighted within the November 2017 Safer Maternity Care National Maternity Safety Strategy Progress and Next Steps Report, including the 10 criteria for the CNST discount. The action plan will be monitored and scrutinised. We plan to deliver this action plan by end of May 2018. Monitoring will be lead nationally by the Maternity Transformation Programme and locally monitored through the UHS Women and Newborn Governance Group with oversight from the divisional management team (DMT) and QGSG as requested.

Compliance with the criteria will be assessed through a verification process that will be completed by the end of June 2018.

Clinical effectiveness

PRIORITY 7 ANTIMICROBIAL RESISTANCE (AMR)

Why we have chosen this priority

In Europe 25,000 people die each year as a result of hospital acquired infections from five key resistant bacteria. Globally a failure to address the problem of bacteria resistance could cost 10 million deaths by 2015, at a financial cost of 366 trillion.

Total antibiotic consumption in hospitals based in England has been increasing steadily and these increases in prescribing ultra broad-spectrum agents have coincided with increased antibiotic resistance in the UK. Antimicrobial resistance (AMR) is the ability of micro-organisms to withstand antimicrobial treatments such as antibiotics. This resistance occurs as bacteria, for example, adapt and find ways to survive the effects of an antibiotic, meaning the drug no longer works to fight the infection it was previously used to treat. The more an antibiotic is used, the more bacteria become resistant to it.

PRIORITY 6

The consequences of AMR include increasing treatment failure for the most commonplace infections, such as urinary tract infections and decreasing the treatment options available where antibiotics are vital, such as during cancer treatment when patients are prone to infection. Without effective antibiotics, even minor surgery and routine operations could become high risk procedures if serious infections cannot be treated

The world's largest healthcare incentive scheme to prevent the growing problem of antibiotic resistance was launched last year. The programme offers hospitals incentive funding worth up to £150 million to support expert pharmacists and clinicians review and reduce inappropriate prescribing. Providers will also receive payments for gathering and sharing evidence of antibiotic consumption, and review within 72 hours of the beginning of treatment.

Given the measurable impact to our patients and the additional financial resource available to support us delivering we have chosen this as a priority this year to ensure our practice is exemplary.

What are we trying to achieve

Our ultimate aim is driven by the 2020 UK AMR 'goal' to cut inappropriate prescribing of antibiotics by 50%. Our approach to achieving this is via:

- Face-to-face teaching targeting junior medical staff.
- Regular presentations at consultant meetings for education purposes.
- Ongoing antibiotic stewardship ward rounds.
- Revision of Trust sepsis guidelines to bring them in line with the most current evidence.

First line empirical (best guess) treatment of red flag sepsis and septic shock in adult inpatients

All inpatients require a review of any antibiotic therapy, for any indication, documented in the medical notes or electronically (e.g. on doctor's worklist), within 72 hours of antibiotic treatment being started (i.e. by the end of day three).
The review may document decision to de-escalate or switch IV to PO therapy (e.g. in response to microbiology results or improved clinical status), or give a reason for continuation of current antibiotic therapy, noting next antibiotic review or stop date.

	No penicillin allergy	Non-severe penicillin allergy	Severe or life-threatening penicillin allergy
Red flag sepsis of known source e.g. Respiratory tract Urinary tract Skin/cellulitis Bone/patient CNS Intra-abdominal Endocarditis/intravascular Invasive line Graft/prosthesis	If clear source if infection follow organ-specific guideline for severe infection in MicroGuide app© (e.g. body systems > respiratory > pneumonia community-acquired severe) NOT the recommendations below for UNKNOWN source of sepsis.	If clear source if infection follow organ-specific guideline for severe infection for non-severe penicillin allergy in MicroGuide app© (e.g. body systems > respiratory > pneumonia community-acquired severe) NOT the recommendations below for UNKNOWN source of sepsis.	If clear source if infection follow organ-specific guideline for severe infection for severe penicillin allergy in MicroGuide app© (e.g. body systems > respiratory > pneumonia community-acquired severe) NOT the recommendations below for UNKNOWN source of sepsis.
Red flag sepsis of unknown source	Co-amoxiclav 1.2g IV 8 hourly (bolus over 3-5 mins then flush with 10ml 0.9% sodium chloride) PLUS Gentamicin 3mg/kg¶ IV bolus single dose (bolus over 3-5 mins then flush with 10ml 0.9% sodium chloride) (#check MRSA status)	Cefuroxime 1.5g IV 8 hourly PLUS Gentamicin 3mg/kg¶ IV bolus single dose PLUS (if suspected intra-abdominal infection) Metronidazole 500mg IV 8 hourly (#check MRSA status)	Telcoplanin 10mg/kg (up to 800mg) IV 12 hourly for 3 doses then once daily PLUS Gentamicin 3mg/kg¶ IV bolus single dose PLUS (if suspected intra-abdominal infection) Metronidazole 500mg IV 8 hourly
Septic shock	Piperacillin-tazobactam* 4.5g IV 6 hourly PLUS Gentamicin 3mg/kg¶ IV bolus single dose (#check MRSA status) *use Meropenem monotherapy if colonisation or infection with an ESBL-producing organism within the last year (check for 'Coliform' alert on doctor's worklist)	Meropenem 500mg IV 6 hourly ¶ For BMI >30 patients, dose Gentamicin on ideal body weight + 40% of excess weight. For other patients use actual body weight.	Meropenem 500mg IV 6 hourly (if known Meropenem allergy contact microbiology or ID doctor # Add Teicoplanin 10mg/kg (up to 800mg) IV if suspected MRSA (check for MRSA alert on DWL)

PRIORITY 7

- e-prescribing course lengths (e.g. "trimethoprim for 3 days") to be embedded in the e-prescribing system to guide prescribers. Using e-prescribing to support appropriate durations with new default options for oral antibiotics to encourage shorter course lengths and prompt patient review.
- Pre-72 hour antibiotic review prompt on Doctors' Work list.

ABx	Patient has started antibiotics, review will be required in the next 48 hours.
ABx	48 hours have elapsed since prescription and review must be completed.
ABx	Review has been completed and patient is still on antibiotics.
ABx	Review has been completed and patient is no longer on antibiotics.

- Pharmacist-led audits of pre-72 hour antibiotic reviews.
- A business case to be submitted to senior Trust leaders for additional nursing/ pharmacy/data analyst support.
- Appoint a Band 6 nurse to a new antimicrobial stewardship specialist role to lead on nursing engagement with AMS.
- Appoint a part time data analyst to support pharmacists in data surveillance and antibiotic consumption data submission to Public Health England.
- Micro Guide app to be updated to reflect revised UHS sepsis guideline.
- Revised maternity services sepsis guidelines to be generated.

What will success look like

The percentage of UHS patients who receive a dose of antibiotics on any given day will have decreased further and the prescription of ultra-broad spectrum antibacterial agents without appropriate indication will have stopped. The 'just in case' antibiotic prescribing culture will no longer be seen. 90% of UHS patients will have had a documented antibiotic review within 72 hours and the percentage of UHS patients who receive a dose of an antibiotic on any given day will have dropped to 40%.

Standardised mortality for pneumonia, urinary tract infections and septicaemia will all continue to fall.

How we will monitor and measure progress

We will be compliant with the 2018/19 CQUIN for AMR.

PRIORITY 8

EVERY OUTPATIENT ENCOUNTER ADDS VALUE

Why we have chosen this priority

UHS sees in excess of 500,000 outpatient (OP) appointments per year and as clinical practice develops more and more patients need to be followed up, such as ophthalmology.

There is evidence already in existence that shows that OP services can transform to ensure every OP encounter adds value, is more responsive, produces less inappropriate visits to hospital and ensures patients are signposted to the right clinician at the right time and right place.

Transforming the patient experience will rely on closer integration, planning and co-ordination of services across a spectrum of clinical settings at national, regional and local level.

Better access to clinical decision making support and specialist advice will significantly impact patients getting the right treatment and removing unnecessary steps from their journey. Maximising the roles of the wider multidisciplinary team to help achieve this will be crucial to ensuring the patient has access to the right clinician first time, and in removing unnecessary delays in their outpatient journey. Whilst some new roles have been adopted or extended this has not been at scale. Extending the range of training and development to opportunities will be essential in delivering a modern workforce, which ensures the extended multidisciplinary teams have the skills, confidence and capacity to work to the full range of their competencies.

Our sustainability and transformation partnerships (STPs) have signed up to reduce outpatient appointments by 20% but increasing the value of every encounter.

What are we trying to achieve

By following up patients based on clinical need rather than set periods of time we hope to provide better access to care and to avoid outpatient appointments which add no value.

Technology allows us to monitor patient's progress remotely rather than relying on a routine follow-up, which we hope will help reduce the stress and expense of patient travel when this isn't necessary.

What will success look like

- Patients managing their own care and connecting with the hospital via new technology.
- 'Priority patients' getting quicker access to limited resources.
- Pathways redesigned based on patient feedback (patient reported outcomes).
- Every outpatient encounter adding value.

How we will monitor and measure progress

- Attendance data will be tracked to measure changes in pathways (and reported to the Transformation PMO)
- Patient reported outcomes will be monitored at a service level to understand the impact of new pathways.
- RTT access times will be monitored at a service level.
- Progress will be reported to both our internal and system level Outpatient Transformation Boards.
- Patient surveys will reflect improvement in their experience.

PRIORITY 9

BEST USE OF RESOURCES

Why we have chosen this priority

As public-sector organisations NHS Trusts and NHS foundation trusts are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal constraint. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.

In August 2017 NHS Improvement published their Use of Resources assessments document which aims to help patients, providers and regulators understand how effectively Trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of operational productivity.

They will do this by assessing how financially sustainable trusts are, how well they are meeting financial controls, and how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients. Initially, their approach will focus on acute non-specialist services due to the availability and quality of data in this area.

What are we trying to achieve

- An improved focus on better quality, sustainable care and outcomes for patients.
- For UHS to be proportionate, minimising regulatory burden, and draw on existing data collections where possible.
- To be clear what 'good' looks like – using data from the Model Hospital and Insight Dashboard to help guide improvement in the use of resources and focusing on quality.
- To promote good practice to aid continuous innovation and improvement.

What will success look like

The Use of Resource domain of our next CQC inspection will achieve a rating which is reflective of the organisations' achievements.

How we will monitor and measure progress

A robust process to analyse data from the Model Hospital and Insight Dashboard will be in place, and this will be clearly linked to timely investigation and improved outcomes.

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-today 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 2017/18 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 2018/19.

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 (UHSFT) Quality Account for 2017/18. 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.

We are pleased to note that the Quality Account continues to reflect the Trust's values of "always improving, patient first and working together" to provide patient centred care through a continued focus on quality improvement.

The CCGs would like to congratulate the Trust on the very positive results from the national staff survey, Friends and Family Test and 'Outstanding' rating by the Care Quality Commission in the well led domain. It is clear that progress has been made against the 2017/18 priorities, although the Quality Account could be clearer in terms of whether the priorities have or have not been fully achieved. It would have been helpful to see a summary of measurable milestones of achievement clearly outlined for each priority.

Key areas of note include:

- Work to improve patient's experiences of and the safety of discharge from hospital with the Trust providing wards with access to additional staff roles to support the discharge process. The CCGs agree with the continued work in 2018/19 to provide robust and improved processes
- Developments in joint working and the trust's engagement with the Mental Health Board and other areas of work to improve the care for vulnerable adults
- The work in the recognition and management of the deteriorating patient, with improved outcomes for patients with acute kidney injury and sepsis
- The work from the 2016/17 priorities to further embed the National Safety Standards for Invasive Procedures (NatSSIPs) into the Trust's local safety standards to support staff in providing high quality care and treatment

The CCGs are pleased to note the Trust's achievement of elements within the 2017/18 priorities and where further progress is required that these are carried over into 2018/19.

The Quality Account has met the new regulations with the inclusion of learning from deaths information with most cases in 2017/18 reviewed via the Internal Medical Examiners Group. The CCGs recognise this work is significant and has made a clear impact on improving the Trusts mortality ratios. The account provides details and transparency of the reviews undertaken, learning and areas to be improved with actions. It is good to note that it includes the required detailed progress to work towards a seven day hospital service.

The CCGs note that the Trust undertook a number of other quality improvement activities during the year, which are to be commended, resulting in:

- The implementation of a Clinical Accreditation Scheme to ensure quality standards are embedded at ward level using key performance indicators, patient feedback and complaints and compliments
- Development of the 'Being Open Policy'- a Duty to be Candid
- Development of the Speak Up Policy and the appointment of a Freedom to Speak Up guardian
- The development of a Single Sex Accommodation Policy and its implementation leading to the reporting of mixed sex accommodation breaches

It is noted that for 2018/19 the Trust has changed its approach to focus on fewer priorities captured within the Quality Improvement Framework clearly setting out the overarching ambitions for the coming year.

Commissioners look forward to the Trust continuing to work with system partners to demonstrate further progress in 2018/19 to continue improving the quality and timely discharge of all patients, the achievement of constitutional targets such as Cancer treatment times and Emergency Department four hour waits and the management of patients presenting in mental health crisis.

Overall the Quality Account reflects the challenges experienced by UHSFT over the last 12 months and highlights some of the work undertaken through UHSFT's continued ambition to improve the quality of services. The CCGs opinion is that it meets the minimum national expected reporting requirements, but as suggested in previous years, the CCGs would like to see the inclusion of patient stories. These provide a different perspective and an opportunity to understand personal experiences to inform improvements.

Southampton City and West Hampshire CCGs are satisfied with the Quality Account for 2017/18 and fully support the new and continued quality priorities. The CCGs 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

It must be remembered that, the public perception of a hospital, can be very different from the reality of what goes on, day by day, in delivering a complicated and integrated health service.

The role of governors is sometimes to help bridge that gap and observe, inform and where required, assist in making, both the public and the Trust, aware of issues of concern or appreciation.

On behalf of the Governors let me first express our appreciation for the way that the Trust board, NEDs, The Chair, chief executive and all the senior management team have ensured that the financial position is sound (in light of the disjointed National position) and have given clear direction as to the ethos expected within UHS.

We recognise the significant dilemma that the Trust and the management team have in reacting to every day issues and planning for expansion and the health care needs of the future, and the report has demonstrated their ability to balance these competing factors well.

The report demonstrates that the 10,500 staff are not only motivated to perform, but are generally content in the continued circumstances where financial pressure can have an effect, on the distribution of mental resources, when balancing health care and affordability.

The Trust has managed to maintain the quality of service delivery, in a caring manner, whilst ensuring that staff morale is focussed on and, where personal help is required, attention has been given. The policy of "Being Open "has enabled staff to feel they are included and supported. This is clear from the staff survey and the willingness for them to recommend the hospital as a good employer.

The Governors were pleased to note the content of the CQC inspection, particularly where the inspection identified areas of "Outstanding" performance and an overall "Good" report. Doing the simple things well and consistently, whilst including people in seeking improvements, will lead to a better caring/sharing culture which will benefit all.

The Governors were pleased with the willingness to "link and learn "from groups such as the "Patient experience group" the Membership and engagement group" and "Strategy group". These are areas where interaction of ideas and thoughts can lead to improvements in service delivery and engagement with new ideas.

It has been agreed that future meeting with all governors will take place to ensure that roles and areas of responsibility are clear, and that Governors and the Trust can feel that we are all making the best use of our time with a common clearly understood objective.

The recruitment of two young people onto the governing body, has increased our diversity and the whole governing body is undertaking Equality and Diversity training to enable us to further assist the Trust, by widening and engaging more with the membership, in an area which has a high youth population as well as a substantial elderly group, with increasing health needs.

We believe that this Quality Report has not only identified Best and Good practices, but has clearly indicated the priorities that the Trust have determined, to ensure the best use of resources and clear measures for monitoring progress.

The Board of Governors is more than content to commend the report and to endorse the objectives identified.

Bob Purkiss MBE
Lead Governor May 2018

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. The account is well laid out, easy to read, and as far as we can judge is complete and accurate with no serious omissions.

Healthwatch Southampton has continued to be involved and consulted by the Trust on many issues. We were consulted on the change to produce a quality improvement framework and with priorities set against outcomes, safety, and experience. We support the concept and believe it will be easier for all staff to understand and implement the key directions and priorities of the Trust. Healthwatch Southampton is also heavily involved in the clinical accreditation scheme (CAS) in which patient representatives, together with expert staff, undertake unannounced visits to wards and departments. We are also involved in the clinical quality reviews. Our involvement is a good illustration of the Trust's open policy and we can attest to the importance that the Trust places on duty of candour.

The staff survey findings are a testament to the leadership of the Trust and show clearly how well the staff are supported and consequently how this reflects on their belief in the care provided. The increased use of technology is most welcome and in particular the e-whiteboards are a great improvement. Emphasis on clinical research is proving invaluable to many patients and we hope that the Trust will continue to encourage research.

The section dealing with the progress against the 2017/18 priorities is comprehensive and informative. In general, it is written in language that the lay person can understand. Furthermore, it is good to read that good progress was made on most of the objectives. Patient discharge is clearly important, and some progress has been made; Healthwatch Southampton will continue to monitor this to ensure discharge is suitable for the patient as well as for the Trust and we are pleased that this has been carried forward as an objective.

The new catering provider, Serco, has made a promising start and our observations from speaking to patients is that the service has improved. We will continue to work with the Trust to ensure that other aspects of the food service enhance the patient experience. The work done to improve the care for vulnerable adults has made good progress by providing a better environment for dementia patients and in coping with challenging behaviour; securing funding for high risk rooms in ED is especially welcomed. End of life care is important, and we are pleased that the Trust continues to monitor progress and has carried this forward as a priority for next year. The eat drink, move initiative is beginning to have an impact and being expanded to other ward areas; it is good that it has been included in next year' priorities and we will follow this as part of the CAS process.

The future year's priorities are again 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? introduced last year have been supplemented by 'How will we monitor and measure progress' which is an important addition. The four headings applying to each of the priorities make it easy to understand and importantly easy to monitor progress. We were particularly pleased that this year the Trust again took the opportunity to discuss the Quality Improvement Framework with us prior to its adoption. We support the QIF and the associated priorities for 2017/18. The decision to include shared decision making is welcomed and although many patients still adopt the principle that the doctor knows best, some patients will welcome the opportunity to be better involved.

Although not specifically mentioned, the PLACE process is important in ensuring that patients have a say on the environmental factors that affect the patient experience. Healthwatch Southampton has again played a major part in the PLACE process and it is gratifying that the Trust now places importance on

environmental issues. We are especially pleased that there will now be a reporting structure to ensure that items highlighted by PLACE are followed up. As a result of last year's assessments several improvements are planned. For future reports we would like to see some mention made of this and Part 3 of the account would be an appropriate place in which to list some of the action points that are planned.

Healthwatch Southampton will continue to work with the Trust to ensure that the best interests of the patients are maintained.

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 2017/18.

The Panel were pleased to see positive progress reported against a number of priorities set for 2017/18, including the establishment of a Mental Health Board to improve the quality of the delivery of mental health care within UHS, and improvement in sepsis recognition and treatment.

The Panel were encouraged by the findings from the Friends and Family Test and the 2017 NHS Staff Attitude Survey. The staff survey placed UHS 3rd nationally for Teaching hospitals and 6th overall. This reflects well on the Trust's engagement with, and commitment to, employees. This commitment was reciprocated by UHS staff in their tremendous response to the heavy snow that disrupted services in Southampton in December 2017.

The report recognises the key challenges facing UHS, including the requirement to meet ED performance targets; improving hospital discharge; and addressing workforce concerns in key areas. The Panel welcomed, as a solution to the identified workforce pressures, the commitment by the Trust to support existing talent and the developing apprenticeship programme.

The HOSP understand that progress has been made with regards to hospital discharge in 2017/18 but that more needs to be done, in conjunction with partners, to ensure that outcomes for delayed transfer of care improve and are sustainable. It is therefore welcome that improving the experience of discharge remains a priority for University Hospital Southampton in 2018/19.

The Southampton HOSP looks forward to working closely with University Hospital Southampton NHS Foundation Trust over the coming year to ensure that the quality of services for the people of Southampton continues to improve.

Yours sincerely

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 thabove 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 2017/18and 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 2017 to May 2018
  2. papers relating to quality reported to the board over the period April 2017 to March 2018
  3. feedback from commissioners dated 8th May 2018
  4. feedback from governors dated 3rd April 2018
  5. feedback from local Healthwatch organisations dated 1st May 2018
  6. feedback from Overview and Scrutiny Committee dated 27th April 2018
  7. the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 9th May 2018
  8. the national patient survey June 2018
  9. the national staff survey March 2018
  10. the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2018
  11. CQC inspection report dated June 2017

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered. We have identified a reporting issue at our satellite outpatient clinics in Salisbury and are investigating the impact on referral to treatment reporting.
- 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

24 May 2018

Chair

24 May 2018

Interim chief executive officer

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of University Hospital Southampton NHS Foundation Trust (the Trust) to perform an independent assurance engagement in respect of the Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (the 18 week RTT indicator) ; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge (the 4 hour A&E indicator);

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 2017/18* ('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 2017/18* (the Guidance).

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 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 8 May 2018;
- feedback from governors, dated 3 April 2018;
- feedback from local Healthwatch organisations, dated 1 May 2018;
- feedback from Overview and Scrutiny Committee, dated 27 April 2018;
- 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 June 2017;

- the latest national staff survey, dated March 2018;
- Care Quality Commission Inspection, dated 16 June 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2018; 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 2018, 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 on the 18 week RTT indicator

In testing a sample of 25 records included within the 18 week RTT indicator we identified four cases where administrative errors resulted in dates being incorrectly recorded and two pathway exclusions which should have been applied.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the 18 week RTT indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 indicators in the Quality Report subject to limited assurance have 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

KPMG LLP
Chartered Accountants
15 Canada Square
Canary Wharf
London E14 5GL

25 May 2018

APPENDIX

APPENDIX 1

Our Quality Improvement Framework 2018/19

The QIF is a tool to engage and communicate with staff and patients about transformation projects to improve care planned for 2018/19. 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 QIF 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.
- Looking after people is at the centre of everything we do and because of this, and the busy, challenging environment we work in, we recognise that supporting, caring for and developing our staff is crucial to delivery of the QIF.

Well-led	• **Embedding our values** • **Best use of resources**
Safe	• **Recognition and management of the deteriorating patient** • **Deliver the national safer maternity strategy**
Responsive	• **Embedding SAFER bundle and improving experience of discharge** • **Keeping patients eating, drinking and moving**
Effective	• **Every outpatient encounter adds value** • **Antimicrobial resistance**
Caring	• **Shared decision making** • **Improving end of life care**

APPENDIX 2

Quality performance data

Two of the agreed metrics previously used to measure performance are no longer used.

- Patient Safety Indicator - Falls Assessment tool
- Nutrition % of patients with nutritional screening in 24hrs (as average of monthly %)
- Patient outcome indicators-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 the low numbers being performed meant it was not statistically significant. This was confirmed by checking the registries via NHS Digital for hernia and varicose vein surgery for 2016/17. There were only small numbers for hernia repair and no data available for varicose veins. Varicose veins are treated at UHS, they are dealt with at the independent treatment centre.

For the latter we have replaced it with: Nutrition- % Patients with a care plan in place.

All the Core Indicators are updated with the most recent publications from NHS digital/NHS England/NHS Improvement/Gov.uk with the exception of emergency readmissions which has still not been updated by NHS digital – their data portal says "this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review".

Patient safety indicators

	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
Serious Incidents Requiring Investigation (SIRI)	35	54	63	25	25 for whole year
Never Events	2	7	3	1	0
Healthcare Associated Infection MRSA bacteraemia reduction	5	3	1	1	0
Healthcare Associated Infection Census" (as average of monthly %)	357%	363%	361%	322%	100%
Healthcare Associated Infection Clostridium difficile reduction	37	35	38	27	43 for whole year
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	26	36	11	12	30 for whole year
Falls - Avoidable Falls	9	3	0	5	1 a month. 12 for whole year
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.35%	95.18%	94.87%	93.77%	>=95%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	99.46%	97.75%	95.19%	93.55%	>=95%

	Apr - Sep 2015	Oct 2015 - Mar 2016	Apr - Sep 2016	Oct 2016 - Mar 2017
UHS				
Rate Incidents per 1000 admissions	31.50	41.40	44.50	43.90
Number Incidents	5911	7930	8519	8594
Number Severe Harm	54	74	54	47
% Severe harm or death	0.91%	0.93%	0.63%	0.55%
Highest scores (non-specialist trusts)				
Rate Incidents per 1000 admissions	74.70	75.90	71.80	69.00
Number Incidents	12080	11998	13485	14506
Number Severe Harm	89	94	98	92
% Severe harm or death	2.92%	2.04%	1.73%	2.13%
Lowest scores (non-specialist trusts)				
Rate Incidents per 1000 admissions	18.10	14.80	21.10	23.10
Number Incidents	1559	1499	1485	1301
Number Severe Harm	2	0	1	1
% Severe harm or death	0.07%	0.00%	0.02%	0.03%
National average (non-specialist trusts)				
Rate Incidents per 1000 admissions	39.30	39.60	40.77	41.10
Number Incidents	4647.43	4817.60	4954.89	5122.38
Number Severe Harm	19.98	19.43	18.50	19.29
% Severe harm or death	0.47%	0.43%	0.40%	0.40%

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. 2017/18 data was not available at the time of publication.

Cdiff per 100,000 bed days

Table 8b: Financial year counts and rates of C. difficile infection (patients aged 2 years and over) by acute trust – Trust apportioned cases only.

	2013/14	2014/15	2015/16	2016/17
UHS	9	11.8	9.7	9.8
National Average	14.7	15	14.9	13.2
Highest Trust Score	37.1	62.6	67.2	82.7
Lowest Trust Score	0	0	0	0
Lowest Trust Score (non-zero)	0.9	2.8	0.8	1.2

UHS considers that this data is as described for the following reasons: robust reporting and monthly scrutiny at multidisciplinary quality committees. UHS has taken the following actions to improve this indicator, and so the quality of its services; by focusing on improving hand hygiene; by adopting national and local campaigns including visual prompts and hand hygiene stations prominently positioned at entrances to the hospital and ward areas; raising the profile of infection prevention throughout the Trust and at Board level; training staff on infection prevention and hand hygiene; focusing on high standards of cleanliness, screening of emergency and elective patients.

2017/18 data was not available at the time of publication.

MRSA screening

2016/17	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17
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%

2017/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18
Eligible patients	16173	15967	15505	4554	52199
Screened for MRSA	56735	37888	54167	19330	168120
% achieved	350.80%	237.29%	349.35%	424.46%	322.08%

Patient experience indicators

Patient experience indicators					
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark
National Friends & Family Test Response Rate					
Emergency department	37.94%	10.76%	6.21%	6.67%	>10%
Inpatients	25.15%	21.74%	20.28%	18.36%	>20%
Maternity		23.38%	29.07%	32.01%	>20%
Percentage of patients recommending UHS to their friends & family					
Emergency department		92.26%	95.42%	97.06%	>90%
Inpatients		96.16%	96.68%	97.10%	>90%
Maternity		95.81%	97.66%	97.50%	>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 %)	13.47%	13%	11.34%	15.56%	<=15%
Same Sex Accommodation (Non clinically justified breaches)	10	5	3	99	20 a month
Nutrition: % Patients with a care plan in place	88%	82%	80%	82%	

Staff FFT

Staff Recommends Care %	2016/17 Q1	2016/17 Q2	2016/17 Q4	2017/18 Q1	2017/18 Q2
UHS	91%	92%	92%	93%	93%
Highest Score	100%	100%	98%	100%	100%
Lowest Score	50%	44%	44%	55%	43%

Inpatient survey

	2015-16	2016-17
UHS	71.70	67.40
Average (All Providers)	69.64	68.14
Lowest Score (All Providers)	58.90	60.00
Highest Score (All Providers)	86.20	85.20

2017/18 data not available at the time of publication.

RHM	Response rate														
Emergency department															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	19.60%	14.30%	8.94%	4.81%	5.23%	9.52%	6.02%	4.39%	1.88%	15.50%	3.43%		11.96%	6.21%	6.70%
National Average	21.15%	14.55%	13.05%	12.72%	12.99%	13.19%	12.18%	12.45%	12.66%	12.94%	12.41%		14.90%	10.62%	10.48%
Highest Trust	100.00%	45.12%	44.57%	47.22%	44.43%	45.31%	45.03%	45.46%	44.85%	47.15%	58.73%		100.00%	100.00%	100.00%
Lowest Trust	0.03%	0.18%	0.02%	0.19%	0.07%	0.00%	0.23%	0.46%	0.00%	0.30%	0.00%		0.00%	0.00%	0.00%
Inpatient and day case															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	22.66%	20.64%	21.22%	22.54%	20.79%	19.11%	19.87%	17.30%	20.76%	18.23%	16.23%		21.74%	19.73%	18.40%
National Average	20.51%	26.08%	24.43%	24.43%	25.77%	25.12%	24.26%	24.32%	26.08%	25.97%	24.27%		23.87%	17.29%	17.37%
Highest Trust	100.00%	100.00%	125.00%	100.00%	100.00%	100.00%	96.67%	100.00%	472.73%	124.49%	100.00%		100.00%	100.00%	100.00%
Lowest Trust	0.06%	4.16%	4.66%	4.56%	4.75%	3.27%	1.70%	3.83%	3.10%	3.10%	2.61%		0.00%	0.00%	0.00%

RHM	Positive														
Emergency department															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	94.53%	92.27%	94.04%	93.73%	93.79%	96.34%	94.82%	96.17%	96.61%	97.14%	96.94%		93.74%	95.42%	97.06%
National Average	90.82%	88.14%	87.07%	84.91%	85.95%	86.01%	86.04%	87.02%	87.29%	86.74%	86.35%		87.74%	73.09%	72.56%
Highest Trust	100.00%	100.00%	100.00%	100.00%	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%	45.75%	46.25%	56.76%		33.33%	42.75%	45.75%
Inpatient and day case															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	95.81%	83.04%	96.10%	96.48%	96.35%	96.23%	97.19%	96.83%	96.84%	97.13%	97.30%		92.92%	96.68%	97.07%
National Average	92.61%	95.71%	95.61%	95.70%	95.79%	95.60%	95.54%	95.75%	96.08%	95.85%	95.74%		95.11%	65.71%	64.93%
Highest Trust	100.00%	100.00%	100.00%	100.00%	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%	75.89%	71.97%	64.29%		61.40%	66.86%	64.29%

RHM	Negative														
Emergency department															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	2.10%	2.72%	3.12%	2.95%	3.03%	1.89%	2.49%	1.59%	1.81%	1.31%	1.65%		2.54%	2.24%	1.42%
National Average	4.15%	6.09%	6.89%	8.37%	7.62%	7.61%	7.63%	7.01%	6.99%	7.22%	7.60%		6.37%	5.31%	5.27%
Highest Trust	29.13%	26.11%	34.78%	37.23%	37.69%	33.31%	41.03%	32.28%	32.97%	31.03%	31.82%		37.23%	41.03%	32.97%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%
Inpatient and day case															
	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	Q1 201718	Q2 201718	Q3 201718	Q4 201718	201516	201617	201718
UHS	1.33%	0.88%	1.41%	1.07%	1.08%	1.23%	0.75%	0.79%	0.72%	0.77%	1.14%		1.18%	1.00%	0.86%
National Average	3.30%	1.43%	1.48%	1.47%	1.44%	1.56%	1.53%	1.51%	1.37%	1.52%	1.58%		1.80%	1.24%	1.23%
Highest Trust	21.05%	9.34%	10.00%	11.11%	10.55%	13.01%	8.59%	9.54%	17.78%	12.50%	26.19%		21.05%	13.01%	26.19%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%

Patient outcome indicators

	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark	
Emergency readmissions, within 28 days (as average of monthly %)	10.40%	10.10%	10.59%	10.83%	<=10%	Past annual figures benchmarked against their own FY Benchmark. Ongoing annual year benchmarked against latest month.
Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	105.19	102.5	95.4	95.57	100	
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	97.64	93.63	88.3	89.91	<100	
Hospital Mortality Rate (%)	1.76	1.63	1.7	1.7	1.61	
Patient Reported outcome measures. PROMS hip replacement data contributed	74.10%	86.70%	74.00%	63.00%	>=50%	
Knee replacement data contributed	105.90%	103.90%	104.40%	70.00%	>=50%	

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

	January 16 - December 16		April 16 - March 17		July 16 - June 17	
	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	0.96	2	0.95	2	0.94	2
National Ave	1.00	2	1.00	2	1.00	2
Highest Trust Score	1.19	1	1.21	1	1.23	1
Lowest Trust Score	0.69	3	0.71	3	0.73	3

UHS considers that this data is as described for the following reasons: robust reporting and monthly scrutiny at multi disciplinary quality committees. UHS has taken the following actions to improve this indicator and so the quality of its services; by introducing and embedding the IMEG process described on page 154-156 of the quality account. 2017/18 data not available at the time of publication.

VTE

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18
UHS	95.04%	95.12%	94.61%	95.09%	94.48%	93.47%
National Ave (Acute Providers)	95.64%	95.45%	95.57%	95.54%	95.09%	95.19%
Highest Trust Score (Acute Providers)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust Score (Acute Providers)	80.61%	72.14%	76.48%	63.02%	51.38%	71.88%

UHS considers that this data is as described for the following reasons; introducing and embedding a process of assess, document, prescribe; reassess; and patient education. UHS has taken the following actions to improve this indicator and so the quality of its services; by investing in patient education and introducing a more comprehensive e-learning education package for staff.

PROMS

	2015/16	2016/17 provisional
UHS	20.77	20.92
National Ave (All Providers)	20.88	21.32
Highest Trust Score (All Providers)	24.75	25.07
Lowest Trust Score (All Providers)	9.36	10.26

	2016/17	2017/18 provisional
UHS	15.06	16.42
National Ave (All Providers)	16.20	16.38
Highest Trust Score (All Providers)	19.97	19.88
Lowest Trust Score (All Providers)	8.33	8.62

UHS considers that this data is as described for the following reasons; robust data collection. UHS has taken the following actions to improve this indicator and so the quality of its services; by continuing monitoring at morbidity and mortality meetings. 2017/18 data unavailable at the time of publication.

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	January 16 - December 16	April 16 - March 17	July 16 - June 17
UHS	44.3	42.6	42.2	43.2	45.6	50.1	48.1
National Ave	27.6	28.5	29.2	29.8	30.3	30.9	31.2
Highest Trust Score	54.8	54.6	54.8	56.3	55.9	56.9	58.6
Lowest Trust Score	0.2	0.6	0.6	0.4	7.3	11.1	11.2

UHS considers that this data is as described for the following reasons; investment into the recruitment and training of a clinical coding team which works across all divisions to improve information flows and reimbursement through our internal audit programme. UHS has taken the following actions to improve this indicator and so the quality of its services; by utilising this team to deliver clinical staff induction and training programmes. 2017/18 data not available at the time of publication.

		2016/17	2017/18 YTD
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		92.0%	89.7%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		89.6%	89.1%
All cancers- 62 day wait for first treatment from:	Urgent GP referral for suspected cancer	83.0%	86.3%
	NHS Cancer Screening Service referral	96.1%	93.8%
C.difficile variance from plan		-11.6%	-19.4%
Maximum 6-week wait for diagnostic procedure		99.3%	98.5%

APPENDIX 3

CQUIN data

Clinical	CQUIN Scheme	CQUIN Target	National or local scheme	Financial reward for achieving scheme
CCGs	Sepsis 2a	Screening all patients for sepsis is appropriate who arrive through the emergency department and inpatients	National	£174,000
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	£174,000
CCGs	Staff health and wellbeing - staffing	To achieve an improvement in two of the three NHSE annual staff survey questions using baseline survey responses from the 2016 staff survey. Need to improve by 5% points in two of the following questions. 9a = Does your organisation take positive action on health and wellbeing 9b – In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	National	£233,000
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	£233,000
CCGs	Staff health and wellbeing – flu vaccine	Achieve a 70% uptake on the flu vaccine for frontline clinical staff	National	£233,000
CCGs	Antimicrobial Stewardship 4a	Reduction in antibiotic consumption per 1,000 admissions	National	£175,000
CCGs	Antimicrobial Stewardship 4b	Empiric review of antibiotic prescription	National	£175,000
CCG's	E-Referral	Deliver directly-bookable services to all patients referred from GP and community services	National	£688,000
CCG's	Advice & Guidance	To set up and operate A&G services for non urgent GP referrals, allowing GP's to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. A&G in the context of this CQUIN refers to structured, non urgent, electronic A&G provided via telephone, email or an online system	National	£688,000
CCG's	Improving services for people with mental health needs who present to ED	Having identified the top 0.25% of people who attend emergency department (ED) most frequently, review and identify the cohort for whom mental health interventions would have the greatest impact. Review and develop a joint care plan for each person within this cohort including a focus on preventing avoidable ED attendances. Strengthen existing/ develop new services to support this cohort. Reduce the number of attendances to ED frequent attendees by 20% ensuring this reduction is sustainable. Also improving the quality of ED diagnostic coding	National	£698,000

Clinical	CQUIN Scheme	CQUIN Target	National or local scheme	Financial reward for achieving scheme
CCG's	Improving proactive and safe discharge	Map and streamline existing discharge pathway, roll out protocols in partnership across local systems (acute, community, NHS care home providers). Establish a process for collection of baseline for responsiveness of community services to provide discharge to assess services. Undertake clinical audit of discharge to ensure appropriate referrals. We need to agree trajectories which reflect impact of implementation of local initiatives for: Achieving 70% national target for discharge to usual place of residence (without increasing admissions)	Local	£698,000
CCG's	Sustainability & Transformation Plans	Reinforcing the critical role providers have in developing and implementing local STP's. Encouraging providers and commissioners to work together to achieve financial balance and to complement the introduction of system control at STP Level	Local	£2,792,000
NHSE	Medicines Optimisation	Transitioning to new arrangements for the use and management of medicines commissioned by specialised services. Adoption of best value generic/biologic products of 90% new patients and 80% of existing patients	Local	£722,000
WHCCG	Shared Decision Making	To develop a condition specific resource to ensure that all treatment options are discussed with patients. TAVI and neuro to be used for the purpose of this years' CQUIN. Training staff in how to work with patients to ensure they are aware of the treatment options. Developing a method of recording the data and assessing success.	Local	£580,000
WHCCG	Chemotherapy Decision making	Using a specific group of patients, decisions regarding the start and continuation of further treatment to be made in direct consultation with peers and then as a shared decision with the patient. These discussions to be documented. To review our existing chemotherapy practice in relation to the decisions for these groups of patients and put in place procedures to allow for effective and documented peer discussion where not currently in place.	Local	£190,000
NHSE	Spinal Surgery	To set up a regional documented Spinal MDT with the set-up of a regional policy to manage spinal emergencies including transfer and emergency imaging. All specialised and non specialised spinal surgery to be entered onto the British Spine Registry or Spine Tango and that all elective specialised spinal surgery within the network should have the agreement of the regional MDT either by individual or mandatory audit.	National	£175,000
NHSE	Enhanced Supportive Care	Identify a cohort of patients newly diagnosed with a terminal illness and record how many are referred to the ESC service at the point of diagnosis. To involve the ESC team from an early stage and use cutting edge evidence based practice in supportive care and technology to improve communication. 80% of the eligible cohort to be referred to the ESC team	Local	£356,000
NHSE	CF Adherence	Extension of randomized trial providing services for cystic fibrosis patients	Local	£271,000
NHSE	HCV	Extension of 2016/17 CQUIN to manage the Infrastructure governance and partnership working across the healthcare providers	Local	£3,914,000
NHSE	SACT	Dose banding principles using local and national dose banding tables	Local	£309,000

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	£162,000
NHSE	Dental	100% attendance at Oral Surgery Network meetings	Local	£25,000
NHSE	Dental	Reviewing and improving as required the standard and appropriateness of dental referrals into secondary care. The work will be fed through the MCN and recommendations/ improvements rolled out across the network group as appropriate. It is also a requirement that this should include an undertaking of an audit of referrals, including the quality of these referrals, received to identify whether levels of treatment complexity are appropriate for secondary care services	Local	£25,000
NHSE	Public Health	Reducing inequalities and increasing overall coverage of screening programs. The CQUIN is relevant to three screening programs Breast, AA and Bowel	Local	£580,000
			Total	£13,821,000

APPENDIX 4

Clinical audit and confidential enquiries data

	Total number of NCAs UHS were eligible to participate in (n=57)	Eligible (57)	Participated (55 = 96%)	% actual cases submitted / expected submissions
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	Continuous 100%
2	BAUS Cystectomy	✓	✓	Continuous
3	BAUS Nephrectomy Audit	✓	✓	Continuous
4	BAUS Percutaneous Nephrolithotomy	✓	✓	Continuous
5	BAUS Prostatectomy Audit	✓	✓	Continuous
6	BAUS Female Stress Urinary Incontinence Audit	✓	✓	Continuous
7	BAUS Urethroplasty	✓	✓	Continuous
8	Bowel cancer (NBOCAP)	✓	✓	100%
9	Cardiac Rhythm Management (CRM)	✓	✓	Continuous
10	Case Mix Programme (CMP)	✓	✓	Continuous
11	College of Emergency Medicine (CEM)- Fractured neck of femur	✓	✓	In progress
12	College of Emergency Medicine (CEM)- Pain in children	✓	✓	In progress
13	College of Emergency Medicine (CEM)- Procedural sedation in adults	✓	✓	In progress
14	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	In progress
15	Coronary Angioplasty (NICOR)	✓	✓	100%
16	Diabetes Foot-care	✓	✘	Incompatible data systems
17	Diabetes in pregnancy (NPID)	✓	✓	100%
18	Diabetes Transition	✓	✓	100%
19	Diabetes Inpatient Audit (NADIA)	✓	✓	100% one day snapshot
20	Diabetes (Paediatric) RCPCH NPDA	✓	✓	In progress
21	Elective surgery (National PROMs Programme) hips and knees	✓	✓	85% continuous
22	Endocrine and Thyroid National audit	✓	✓	Continuous
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	✓	✓	Continuous
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)	✓	✓	In progress

	Total number of NCAs UHS were eligible to participate in (n=57)	Eligible (57)	Participated (55 = 96%)	% actual cases submitted / expected submissions
29	Lung cancer (NLCA) (LUCADA)	✓	✓	Continuous
30	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	An average of 1400 cases per year
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 – cancer in children and young adults (0-25 years)	✓	✓	100%
34	Medical and Surgical Clinical Outcome review programme NCEPOD – Peri-operative diabetes	✓	✓	ongoing
35	National Adult Cardiac Surgery Audit	✓	✓	In progress
36	National Audit of Dementia	✓	✓	Continuous
37	National Cardiac Arrest Audit (NCAA)	✓	✓	100%
38	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Workstream	✓	✓	continuous
39	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation Audit	✓	✓	continuous
40	National Comparative Audit of blood Transfusion 2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT)	✓	✓	100%
	National Comparative Audit of blood Transfusion 2016 Audit of Red Cell and Platelet Transfusion in Haematology	✓	✓	100%
41	National Clinical Audit of Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	✓	✓	Continuous
42	National Emergency Laparotomy Audit (NELA)	✓	✓	Continuous
43	National Heart Failure Audit	✓	✓	Continuous
44	National Joint Registry (NJR)	✓	✓	Continuous
45	National Maternity and Perinatal Audit	✓	✓	Continuous
46	National Ophthalmology Audit	✓	✓	Continuous
47	National Prostate Cancer Audit (NPCA) (2nd year)	✓	✓	Continuous
48	National Vascular Registry (NVR)	✓	✓	Continuous
49	Neonatal Intensive and Special Care (NNAP)	✓	✓	Continuous
50	Neurosurgical National Audit programme	✓	✓	Continuous
51	Oesophago-gastric cancer (NAOGC) (NOGGA)	✓	✓	Continuous
52	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	Continuous
53	Renal replacement therapy (Renal Registry)	✓	✓	Continuous
54	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit	✓	✓	Continuous
55	Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	✓	✓	90%
56	Serious Hazards of Transfusion (SHOT) UK National haemovigilance scheme (this is not an audit but an incident reporting database)	✓	✓	All incidents
57	UK Parkinson's	✓	✘	Data not submitted

APPENDIX 5

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
- Lymington New Forest Hospital - Surgical patient pathway and outpatients Wellworthy Road Lymington Hampshire SO41 8QD

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 2014-2018.

FR APPENDIX 6 STAND

BODY

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 2018.