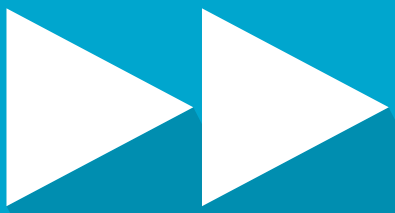
NHS
University Hospital Southampton
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2018/19



incorporating the quality account 2018/19
Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a) of the National Health Service Act 2006

University Hospital Southampton NHS Foundation Trust

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OVERVIEW AND PERFORMANCE REPORT

Welcome from our chair

2018/19 was a year of change in the leadership of UHS. Following the departure of Fiona Dalton in March 2018 to run a hospital group in Canada, David French took on the role of interim chief executive officer. On behalf of the Trust Board I would like to thank David for agreeing to do so and also for doing such an outstanding job. During the year we welcomed three new non-executive directors to the Trust; Jane Bailey, Professor Cyrus Cooper and Catherine Mason. Catherine's talents were also recognised by Solent NHS Trust and she has since left to help lead their organisation as chair.

We were delighted to welcome Paula Head as chief executive in September after a rigorous and robust recruitment process. Paula's experience as chief executive of Royal Surrey County Hospital NHS Trust and, prior to that of Sussex Community NHS Foundation Trust, shone through and we were confident that under her leadership UHS would continue to develop, grow and improve.

Demand for our services continues to rise rapidly as the result of a changing demographic and other factors, and at a rate far greater than our income. Despite this our staff continue to deliver exceptional care. I was delighted that this was recognised by the Care Quality Commission in their recent inspection when they again rated us as Good.

The revised NHS Long Term Plan will inevitably require us to adapt to the changing pattern of healthcare, but we do so with enthusiasm. This year has shown just how adept we are as an organisation at responding positively to change, not only rising to the challenges it presents, but thriving with it. This is evident in the significant investments we have made in the Trust's estate this year. Phase one of our new children's emergency department is complete thanks to the continued support of the Murray Parish Trust. We also approved one of the largest capital investments in our history with the updating and expansion of our general intensive care unit. We recognised that it was as crucial to invest, not just in the physical environment within which we provide healthcare, but within the digital environment too, acknowledging that UHS is an NHS digital exemplar. We have invested significantly in information technology to enhance accessibility and improve both patient and staff experience.

We look forward with confidence to helping lead the NHS into a new phase of delivering health and care for the United Kingdom into 2019/20.

Peter Hollins
Chair

A word from the chief executive

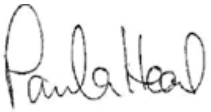
Since arriving at UHS to take up my position as chief executive officer, I have heard and witnessed some incredible achievements by staff at the Trust.

Dr Joanne Horne was named biomedical scientist of the year at the Advancing Healthcare Awards for her work in histopathology; Dr Beth McCausland, quality improvement fellow in dementia care, was named foundation doctor of the year by Royal College of Psychiatrists; Sarah Charters, consultant nurse and mental health lead for the emergency department was awarded an MBE for services to vulnerable adults and her vulnerable adult support team were also winners of a Nursing Times Award in the emergency and critical care category. The medicine for older people therapy team led by Hannah Wood was named most inspiring team at the national #EndPJParalysis awards while Marie Nelson, matron in research and development, and senior research sisters Jane Forbes and Kirsty Gladas won the silver award for clinical research site of the year at the PharmaTimes International Clinical Researcher of the Year Awards. Jean Piernicki, senior nurse manager in occupational health, was awarded the title of Queen's Nurse in recognition of her high level of commitment to patient care and nursing practice. Fiona Chaâbane, a senior clinical nurse in neurosciences was named winner of the nursing and midwifery award at the BBC's The One Show Patients Awards. The medicines advice service, led by Dr Simon Wills, picked up the HSJ Value Award for training and development for its medicines learning portal and Matthew Watts, head of news, was named operational services support worker of the year for the south of England at the Our Health Heroes Awards 2018. We were also delighted that the energy and sustainability team collected the clinical NHS Sustainability Award for its green wards project. These are just a few of the individual and team successes achieved this year.

Our entire organisation can also be incredibly pleased and encouraged by the outcome of the recent Care Quality Commission (CQC) inspection, which rated UHS 'good' overall, with many individual areas being recognised as outstanding by the CQC. You can find full details of the inspection on page 98 of the quality account. Such positive inspection results link to equally positive staff survey results which saw UHS ranked as the second highest acute trust for staff satisfaction and fifth highest for staff recommending the Trust as a place to work and receive treatment.

It's made me incredibly proud to be able to say that I am part of such a driven team and it's clear that the UHS team share my drive and determination to improve things for patients and staff every day. This is evident in both the successes I have already mentioned, but also in the pioneering work that is taking place across every department. Informatics has been pioneering new digital initiatives which they recently shared with Hadley Beeman, chief technology adviser to the secretary of state and social care. Surgeons Bhaskar Somani and Stephen Griffin have created a 'twin surgeon' model that has revolutionised the treatment of kidney stones in children. Dr John Paisey, consultant cardiologist, and his team were among the first in the world to implant and programme a pacemaker using Bluetooth technology. They performed four of the first five procedures in the world. While Professor Mike Grocott and his team created 'surgery school' which is transforming the fitness of patients prior to their operations and thereby reducing length of stay.

These are by no means the entirety of our achievements this year and I would like to take the opportunity to thank every single member of staff at the Trust who continues to make UHS one of the leading trust's in the UK.



Paula Head
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 11,900 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 2018/19 was more than £878m.

History of UHS

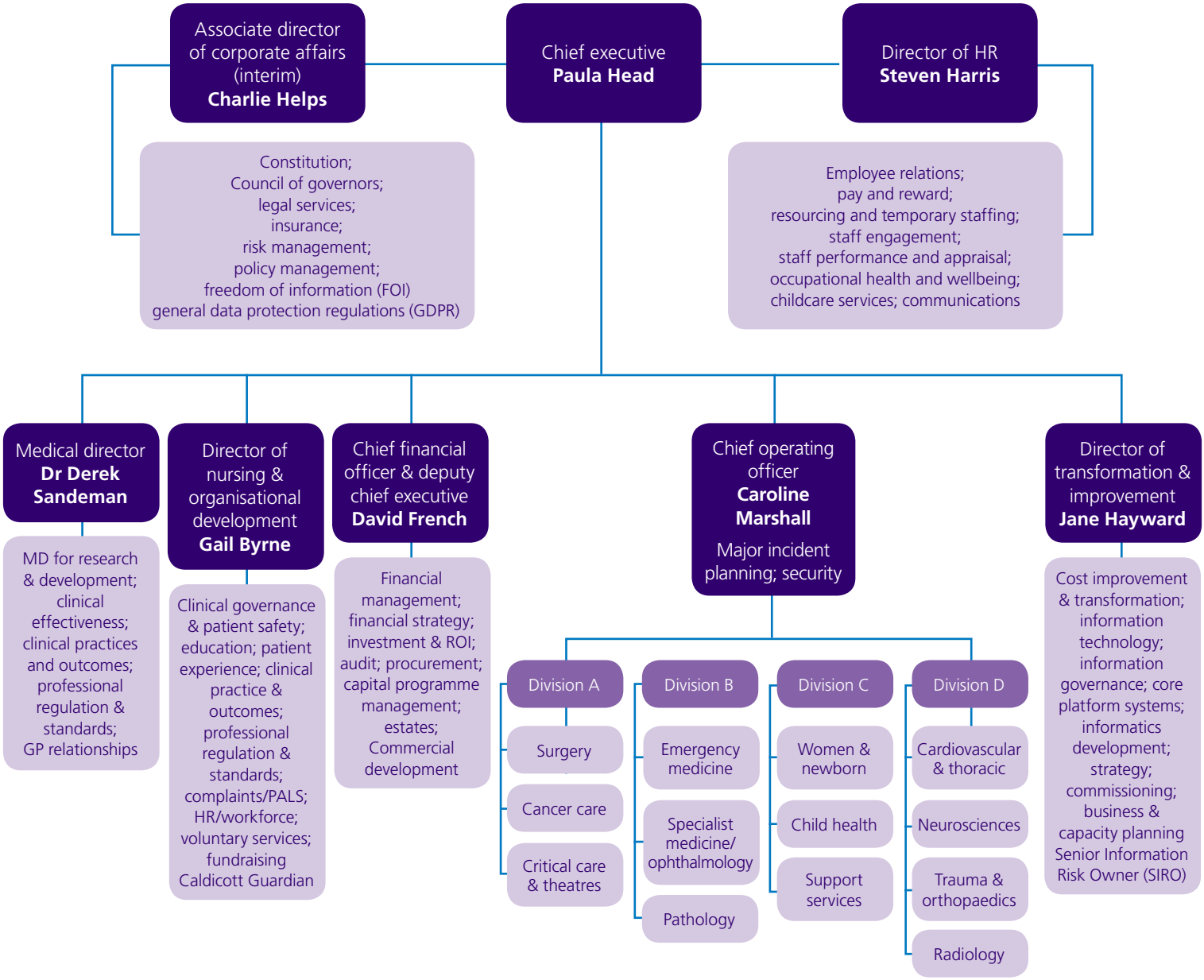
The Trust has its origins in the 1900s when the Shirley Warren Poor Law Infirmary was built on the site of what is now Southampton General Hospital.

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)).

Our executive team structure

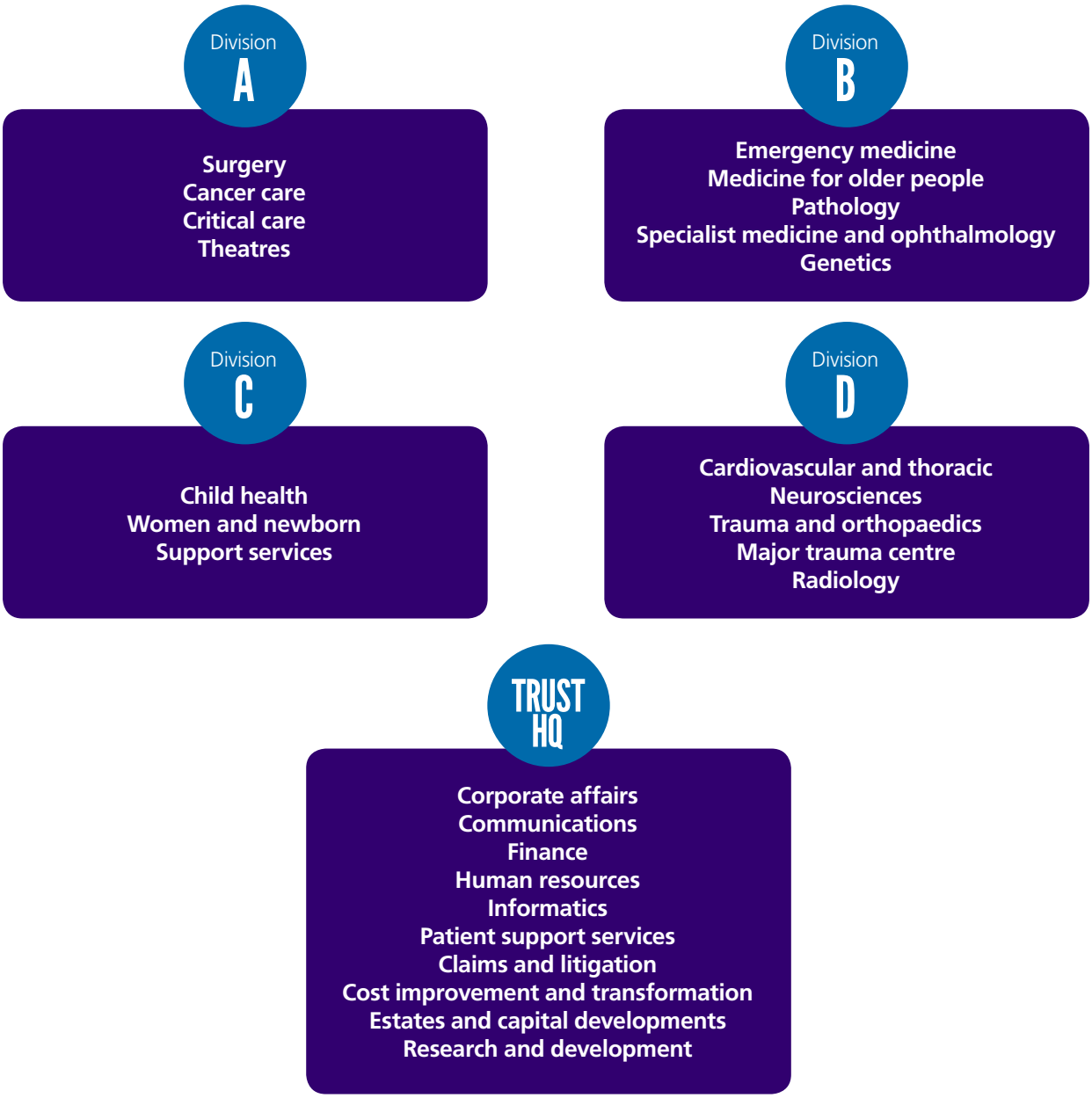


Structure of our services

Our organisation is split into five areas, with our clinical services grouped into four divisions. 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 2019/20.

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 our website which provides both the Board and the public with an overview of our performance. This report is constantly evolving as new areas of monitoring are developed and new areas of national focus become apparent. For 2018/19 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:

- Overview – Aggregation of commentary supporting all sections of the report
- Safe
- Effective
- Caring
- Activity
- Emergency access
- Referral to treatment and diagnostics
- Cancer waiting times
- Flow
- Staffing
- Research and development
- Estates
- Digital

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

The Emergency Access, 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 2018/19 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 is engaging with the model hospital team and has a member of staff on the 'model hospital ambassador program', as well as reviewing areas highlighted as having potential opportunities alongside finance and operational teams.

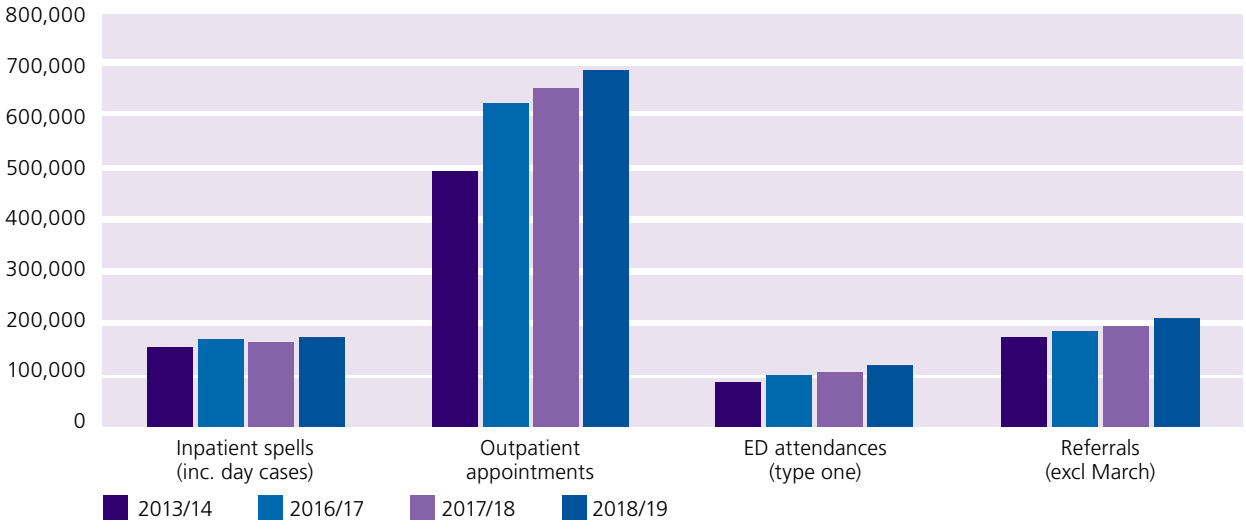
Detailed analysis and explanation of the development and performance of UHS

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 – 2016/17 to 2018/19



	2016/17	2017/18	2018/19	Increase 2016/17 to 2018/19
Inpatient spells (inc. day cases	160,000	157,993	168,791	5.5%
Outpatient appointments	630,045	658,147	695,343	10.4%
ED attendances (type one)	99,273	104,616	110,771	11.6%
Referrals (excl March)	189,194	197,522	207,209	9.5%

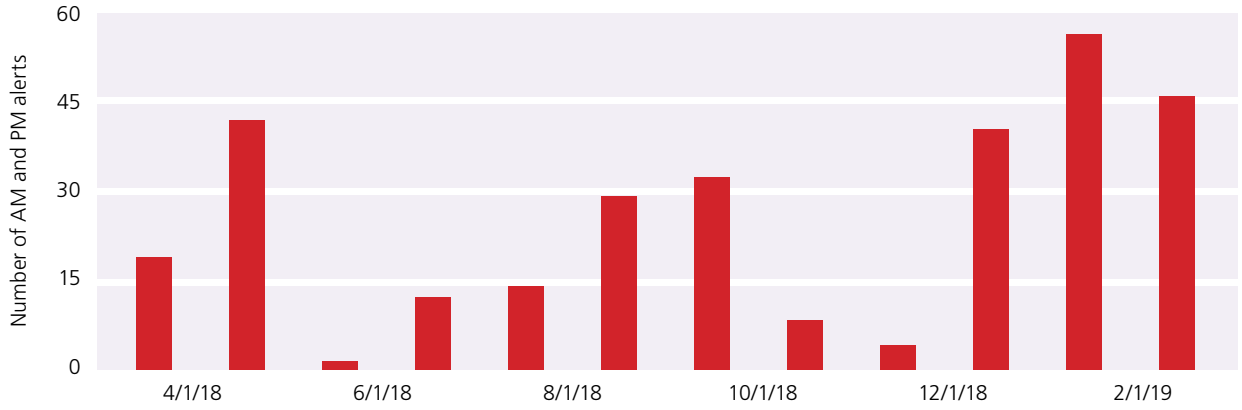
Hospital alert status

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, in 2017/18 this increased to twenty, however in 2018/19 there were no black alerts. The chart below shows red alerts logged during 2018/19.

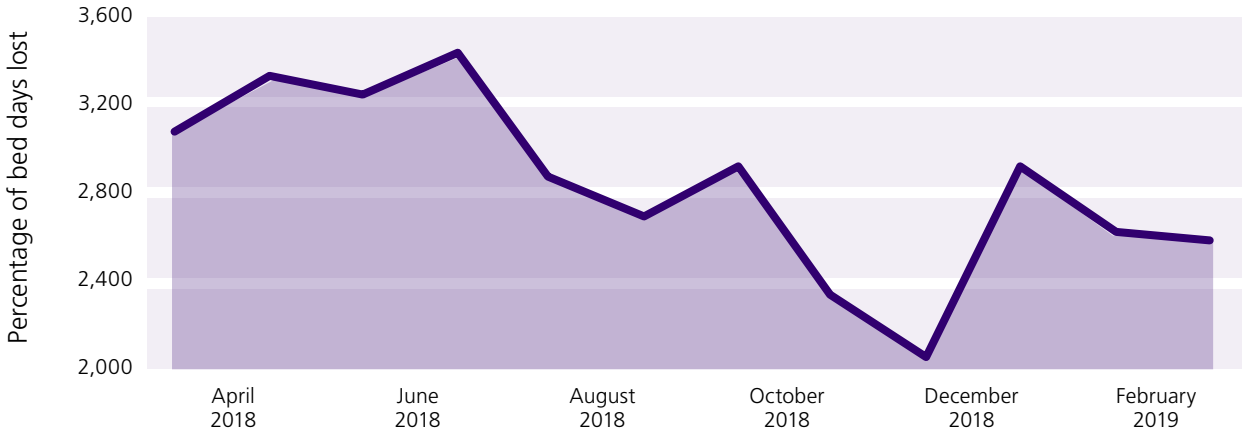
Red alerts 2018/19



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

UHS delayed transfers of care 2018/19

The chart below shows the total bed days attributable to delayed transfers of care at UHS in 2018/19.



Referral to treatment (18 weeks) performance

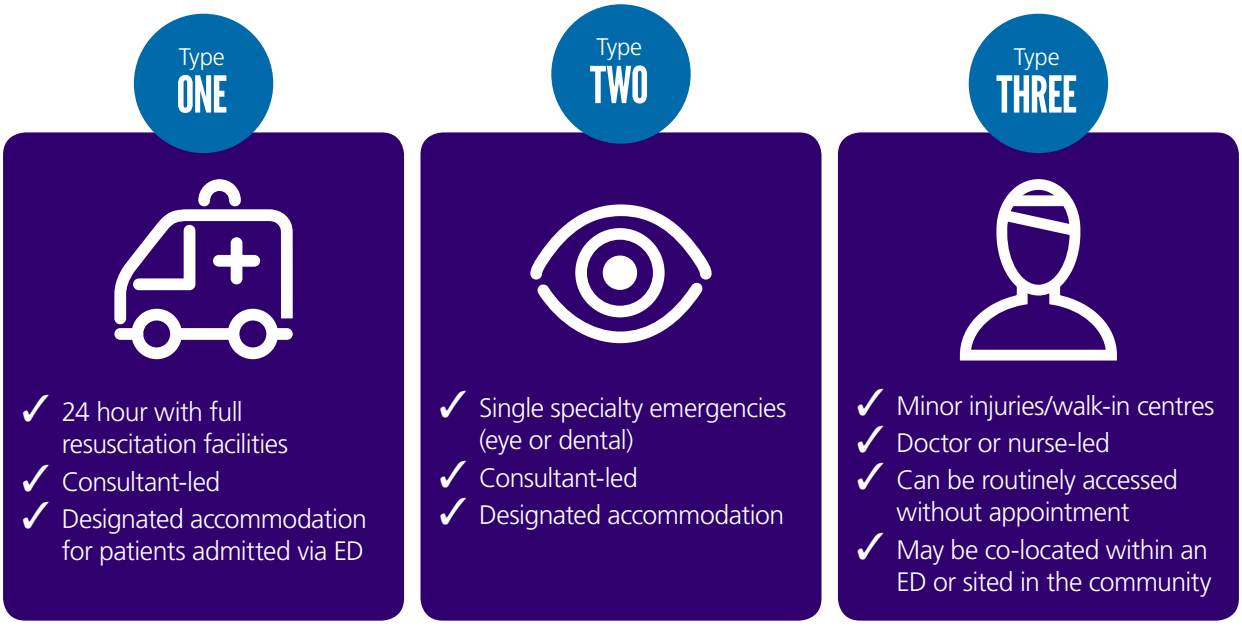
National target: 92% of all patients on 18 week pathway and not yet treated should have waited 18 weeks or less at the end of the month (incomplete pathways target).

How did we do?

UHS did not meet the target this year. Achievement of this target in 2018/19 should be set against a rise in patient referrals, which highlights the increased demands being placed on the Trust. The Trust has finished the financial year with no patients waiting greater than 52 weeks, and a total referral to treatment waiting list lower than in March 2018.

Emergency department (ED) performance

There are three types of emergency departments:



We run all three types of departments and all three types are subject to the national target and are therefore reflected in our figures.

National target: The constitutional standard states that 95% of patients should be treated and either admitted or discharged within fours of arrival into ED. However, NHS Improvement set local targets for all NHS organisations with an ambition that the NHS would return to meet the 95% target by March 2019. The local targets set by quarter (to allow for seasonal variations) for UHS were:

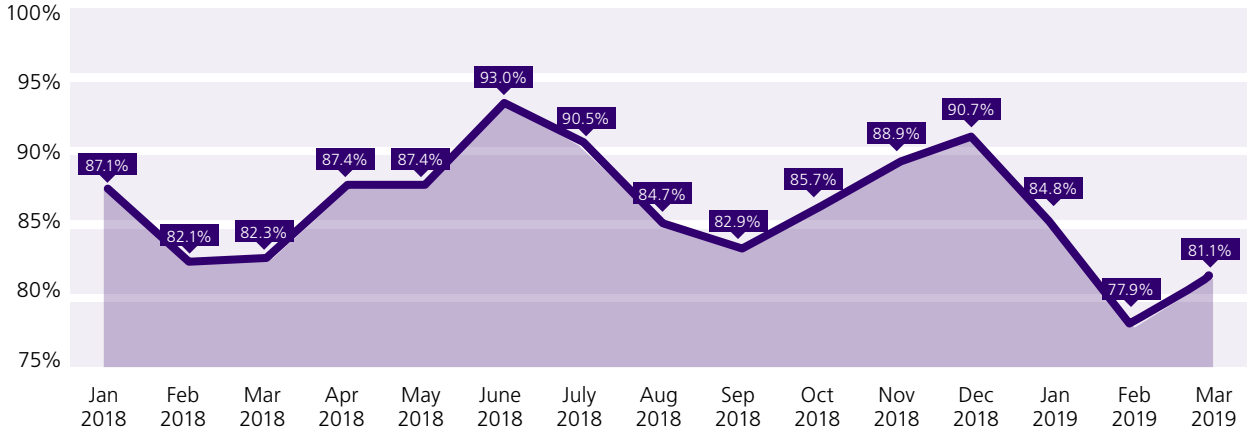
Quarter 1 - 90%
Quarter 2 - 91.4%
Quarter 3 - 90%
Quarter 4 - 90-95%

How did we do?

2018/19 was another challenging year for emergency patients for the whole Hampshire and Isle of Wight area. Whilst we had a positive start to the year achieving quarter 1 and 2 targets, we did not meet quarter 3 or 4 targets. We did, however, meet out local delivery system targets.

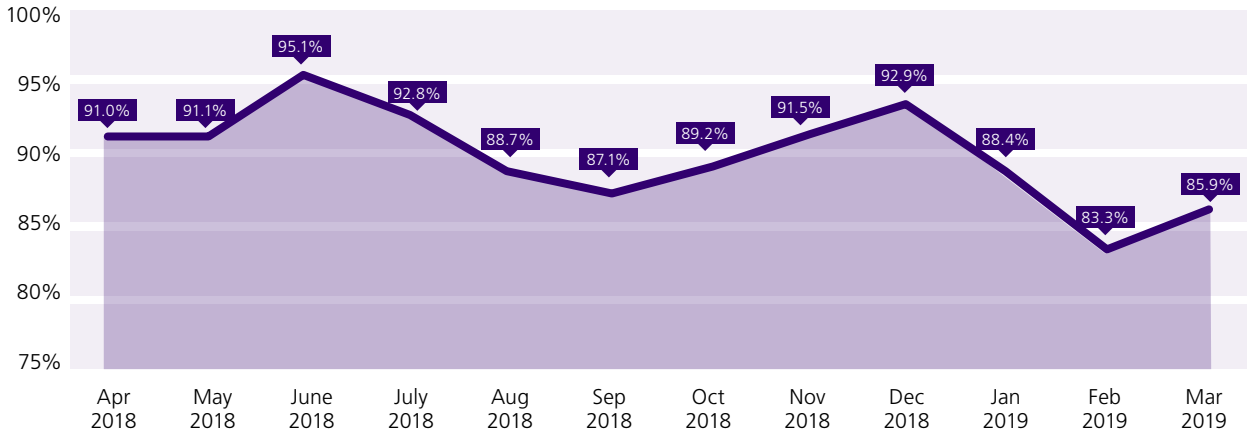
The graph below shows our performance against the four hour target over the last year (including all UHS types and Lymington).

National 4 hour access target – UHS performance



The graph below shows our local delivery system performance against the four hour target over the last year (including all SGH types, Lymington and Southampton Treatment Centre).

National 4 hour access target – Local delivery system



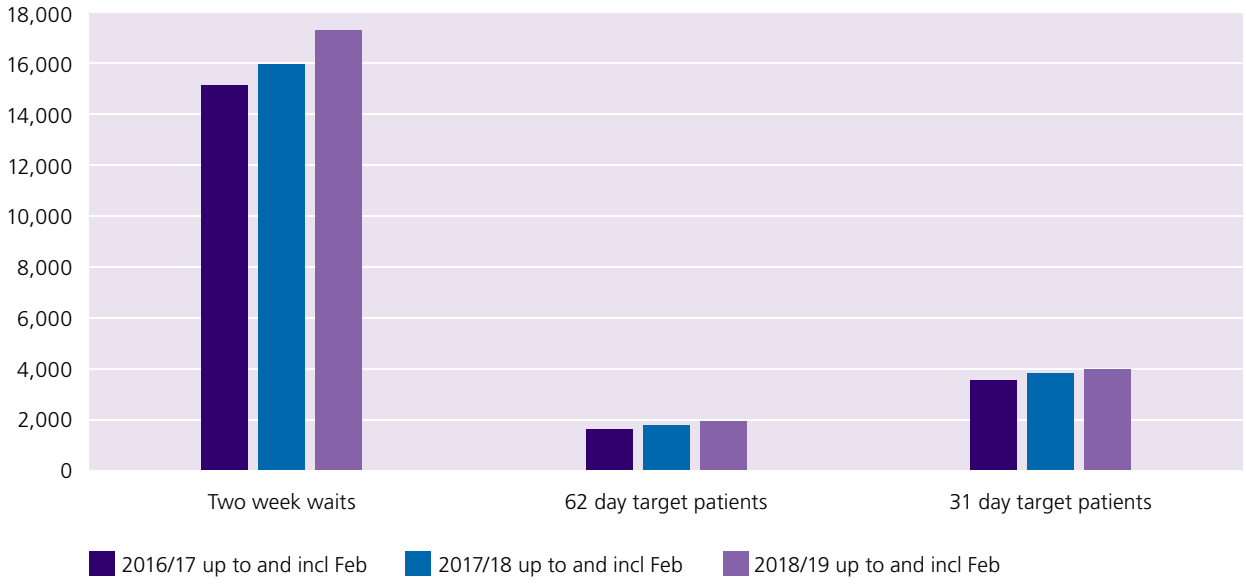
Cancer waiting times

There are nine separate cancer waiting times standards (below), each of which can then be split into tumour site specific performance groups.

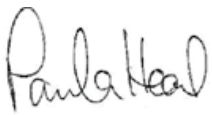
Measures	Target	18/19 YTD (up to and including Feb 19)	Achieved
Urgent GP referrals seen in two weeks	>93%	86%	✘
Breast symptoms referral seen in two weeks	>93%	50%	✘
Treatment started within 62 days of urgent GP referral	>85%	74%	✘
Treatment started within 62 days of referral (breast, cervical and bowel screening)	>90%	80%	✘
62 day consultant upgrades	>86%	86%	✓
Treatment started within 31 days of decision to treat	>96%	93%	✘
Second or subsequent treatment (surgery) started within 31 days of decision to treat	>94%	85%	✘
Second or subsequent treatment (anti-cancer drugs) started within 31 days of decision to treat	>98%	100%	✓
Second or subsequent treatment (radiotherapy) started within 31 days of decision to treat	>98%	100%	✓

The number of patients referred under the two week wait urgent suspected cancer protocol seen within two weeks of their referral, rose by 7.7% in 2018/19. The chart below shows the rise in demand for UHS cancer services over the past three years

UHS growth in cancer actvity – 2016/17 to 2018/19 (up to and including month 11)



For staffing performance, please refer to page 58. For financial performance please see page 177.



Paula Head, chief executive officer
28 May 2019

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 2018/19 the Trust was confirmed as being placed within segment '2'. This segmentation information is the Trust's position as at 31 March 2019. 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	1	1
	Liquidity	1	1	1	1
Financial sustainability	Income and expenditure margin	1	1	1	1
Financial sustainability	Distance from financial plan	1	2	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	Outstanding	Good	Requires improvement	Good

In December 2018, the CQC inspected four core services; urgent and emergency care, medicine, maternity and outpatients. It also looked at management and leadership, and effective and efficient use of resources.

The CQC report (published on the 17 April 2019) rated the Trust as 'good' overall and 'outstanding' for providing effective services.

> **"Our inspectors found a strong patient-centred culture with staff committed to keeping their people safe, and encouraging them to be independent. Patients' needs came first and staff worked hard to deliver the best possible care with compassion and respect. Inspectors saw many areas of outstanding practice, with care delivered by compassionate and knowledgeable staff. Several teams led by example with a continuous focus on quality improvement. The Trust did face some challenges especially with the ageing estates. Some patient environments were showing significant signs of wear and tear – but again staff were doing their utmost to deliver compassionate care".**

Dr Nigel Acheson
Deputy chief inspector of hospitals (South)

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 80 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

Members of the Trust Board

Board member			
Name	**Title**	**Biography**	**Declarations**
Paula Head	Chief executive officer	Paula joined the Trust as chief executive in September 2018, having been chief executive at the Royal Surrey County NHS Foundation Trust in Guildford and before that at Sussex Community NHS Foundation Trust. She began her career as a pharmacist working in the community, hospitals and at health authorities before moving into general management and her first board position at Kingston Hospital. Since then she has spent time on the boards of commissioners and providers, including director of transformation at Frimley Park Hospital NHS FT. Paula lives in Hampshire and has a daughter studying medicine at the University of Southampton.	Daughter is a medical student at University of Southampton; Member of Hampshire & Isle of Wight Sustainability and Transformation Partnership Executive Delivery Group
David French	Deputy chief executive officer and chief financial officer	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; Member of Hampshire & Isle of Wight Counter Fraud Board; Member of Hampshire & Isle of Wight Sustainability and Transformation Partnership Capital Planning Panel (from May 2018)
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; Daughter is a midwife at UHS (from March 2019)
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 and mother are UHSFT simulated patients (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; Member of Hampshire & Isle of Wight Sustainability and Transformation Partnership Clinical Executive Group
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 employed within the emergency department at UHS (from 1 August 2018)

Non-executive directors			
Name	**Title**	**Biography**	**Declarations**
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 and risk committee, Radian Group; Non-executive director and chair of finance 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

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); Member of Regulatory Committee of the English Cricket Board
Professor Cyrus Cooper	Non-executive director	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	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	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.	Non-executive member of the advisory board of the system operator for Network Rail (from July 2018); Governor of St Bede Primary School (from December 2018)

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 purpose and structure

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 54.

Development of the Board

The Board held monthly study sessions during 2018/19 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 53 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 2018/19

Board member	26 Apr	15 May Extra CS	24 May Extra CS	31 May	28 Jun	26 Jul	Aug No meeting held	27 Sep	1 Nov	29 Nov	20 Dec CS only	31 Jan	28 Feb	28 Mar
Peter Hollins Chair	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Simon Porter Non-executive director (Senior independent director and deputy chair)	✔	✔	✔ telecon	✔	✔	✗		✔	✗	✔	✗	✔	✔	✔
Mike Sadler Non-executive director	✔	✔	✔	✔	✔	✗		✔	✔	✔	✔	✔	✔	✔
Jenni Douglas-Todd Non-executive director	✗	✔	✔ telecon	✗	✗	✗		✗	✔	✔	✔	✔	✗	✗
Jane Bailey Non-executive director	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Cyrus Cooper Non-executive director	✔	✔	✗	✔ part CS	✗	✗		✔	✔	✔ CS only	✔	✔	✔	✔
Catherine Mason Non-executive director (from 1/1/18)	✔	✔	✔ telecon	✔	✔	✔		✔	✔	✗	✔	✔	✔	✔
Paula Head Chief executive (from 3/9/18)								✔	✗	✔	✔	✔	✔	✔
David French Deputy chief executive and chief financial officer (interim chief executive 1 April 2018 to 31 August 2018)	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Paul Goddard Interim chief financial officer (from 1 April 2018 to 17 June 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	✔	✔	✗	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔ part CS

Telecon = telephone conference
CS only = closed 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 Trust was inspected by the Care Quality Commission (CQC) in December 2018 to assess performance in respect of the Well-Led Framework which is the standard measure for leadership across NHS providers. The CQC rated the Trust's standards of leadership overall as 'good' with some areas of outstanding practice.

The CQC report, published in April 2019 found that:

- The Trust had a vision to deliver excellence and value in patient care, teaching and research within a culture of compassion and integrity.
- The Trust's strategy, vision and values underpinned a culture which was patient-centred. Local managers across the service promoted a positive culture that supported and valued staff.
- Managers in the Trust had the right skills and abilities to run a service providing high-quality sustainable care.
- The Trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.
- The services engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The services collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The services were committed to improving services promoting training, research and innovation.
- The priorities of different health professions were considered and discussed at governance meetings. Nursing and medical priorities were aligned and professional standards were upheld and promoted by the leadership team. Clinical effectiveness, safety, patient experience, quality, performance and financial sustainability were all considered equally.

Areas of outstanding practice across the Trust included:

- The staff survey results for 2017/18 which showed Trust staff engagement had remained consistently high (3.95) compared to the NHS average (3.79). The Trust was rated second in good communication between senior managers and staff (reviewed prior to publication of 2018/19 staff survey results).
- The Trust had established an integrated medical examiner group (IMEG) to review all deaths. There was a clear inclusive process for twice daily medical examiner reviews Monday to Fridays for which all deaths had to be presented no later than the day following the death.
- The Trust was recognised as one of 16 Global Digital exemplar acute trusts in England. An example of the benefit for staff and patients was through the medical patient records (My medical record) being accessible to patients and promoting supportive management of long term conditions. Also, the use of electronic white boards introduced to improve patient safety.
- People were also encouraged to become volunteers for the trust and there were at least 859 volunteers in October 2018, who worked at the hospitals and were involved with a wide range of activities including hospital radio, patient support and chaplaincy and spiritual care.

Further examples of outstanding practice were identified in urgent and emergency care, maternity services, and in medical care services.

However, the CQC did identify some areas that the Trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. These were accepted and action plans immediately drawn up to ensure full compliance.

Strategy and finance committee

The strategy and finance committee is a sub-committee of the Trust Board responsible for scrutinising the financial performance and strategy of the Trust. Major areas of discussion and focus during the year included:

- Financial performance. Given the financial target and challenging environment, a key focus for the committee has been undertaking an in-depth review of in-year financial performance each month. As a result corrective actions have been discussed to ensure the year-end financial target was achieved.
- The Cost Improvement Programme was reviewed each quarter to monitor how the Trust was delivering against its increasing revenue goals and cost reduction objectives.
- The capital expenditure programme was reviewed twice. The committee recommended Board approval of several specific capital projects including the purchase of a new surgical robot and a programme to replace all light bulbs with energy saving light bulbs, which will lead to cost saving, improved quality lighting and will have a positive environmental impact.
- With the increasing focus on the strategy and transformation partnership, the committee discussed the Hampshire and Isle of Wight plan several times through the year to understand the different roles UHS may have within the partnership.
- Scrutinised the inputs into operational planning for 2019/20, with a focus on the new methods of payments and the implication on the Trust's targets.

The committee updates its terms of reference and carries out a review of its own effectiveness on an annual basis.

Quality committee

The quality committee is a non-executive committee of the Trust Board. The committee's purpose is to explore, scrutinise and gain a deeper understanding of clinical quality in the Trust, and provide assurance to the Board on patient safety, patient experience, clinical effectiveness, and patient outcomes. Major topics considered by the committee in-year included:

- Patient experience quarterly reviews
- Emergency access performance
- Emergency readmissions
- Ambulatory emergency care, now called same day emergency care
- Delayed transfers of care
- Hospital standardised mortality
- Cancer waiting times
- Medication safety
- Clinical audit, outcomes and effectiveness
- National 'Getting It Right First-Time' reports
- Maternity services
- Rising caesarean section rates
- CQC reports
- Quality improvement framework
- Never events and serious incidents requiring investigation
- Staff recruitment and retention
- Complaints trends, policy and responses
- Development of key performance indicators for quality
- In depth review of specific service aspects arising from incidents or audits such as ophthalmology and pathology
- Mental health pathways
- Outpatient activity and the reduction of face to face follow-ups
- 7-day services
- Consultant job planning
- Clinical accreditation scheme
- Accessible information standards

Audit and risk committee

The audit and risk committee is a committee of the Trust Board responsible for oversight of financial reporting, including the financial statements included those provided in this annual report, and the systems of internal control and risk management operated by the Trust. It approves and oversees the programme of work carried out by our internal auditors PwC and reviews the findings of the external audit work carried out by KPMG.

Major topics considered by the committee during the year included:

- Regular reviews of the Trust's approach to risk management, including the board assurance framework (BAF) and operational risk registers. It conducted in-depth reviews of BAF topics including risks around the hospital estate, promoting better patient flow through the hospital and the challenge of balancing capacity with rising demand.
- The preparation for and implementation of a new framework for data protection legislation (known as GDPR) introduced in May 2018. Data protection is a standing item on the committee's agenda.
- An internal assessment of data quality in the many systems used to report operational performance to the Board, including against national standards such as treatment times for emergency care, elective waiting times and the delivery of diagnostics and cancer care.
- Business continuity management and major incident planning.
- The application of accounting policies (such as income recognition, finance leases and valuation of assets) and significant areas of estimation or judgement including valuation of land and buildings, and receivables.

The committee updates its terms of reference and reviews its effectiveness each year.

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 28.

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 2018 and March 2019 in relation to matters covered in this annual report.

Member	21 May 2018	23 July 2018	15 Oct 2018	14 Jan 2019	18 Mar 2019
Simon Porter Senior independent director and deputy chair Chair of audit and risk committee	✔	✔	✔	✔	✔
Mike Sadler Non-executive director	✔	✔	✔	✔	✔
Jane Bailey Non-executive director	✔				
Catherine Mason Non-executive director	✔	✔	✔	✔	✔

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. KPMG regularly report to and attend the audit and risk committee, enabling the committee to monitor their performance. The statutory audit fee for 2018/19 was £62,773 plus VAT and for UHS Pharmacy Ltd and UHS Estates Ltd was £7,900 plus VAT. The quality audit fee for 2018/19 was £9,075 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.

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 57 and in 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 31/03/2019 YTD Number	Actual 31/03/2019 YTD £'000
Non NHS			
Total bills paid in the year	+	98,858	375,872
Total bills paid within target	+	84,213	320,718
Percentage of bills paid within target	%	85.2%	85.3%
NHS			
Total bills paid in the year	+	3,995	57,162
Total bills paid within target	+	3,133	43,604
Percentage of bills paid within target	%	78.4%	76.3%
Total			
Total bills paid in the year	+	102,853	433,034
Total bills paid within target	+	87,346	364,322
Percentage of bills paid within target	%	84.9%	84.1%

Trust performance against the Better Payment Practice Code has deteriorated since Q3. This is following the implementation of a new finance and procurement system and enforcement of the No Purchase Order No Pay policy. We would anticipate this deterioration being temporary, with first-time touchless invoice matching improving performance in 2019/20.

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 2018/19 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.

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 88. 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.

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 88.

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.

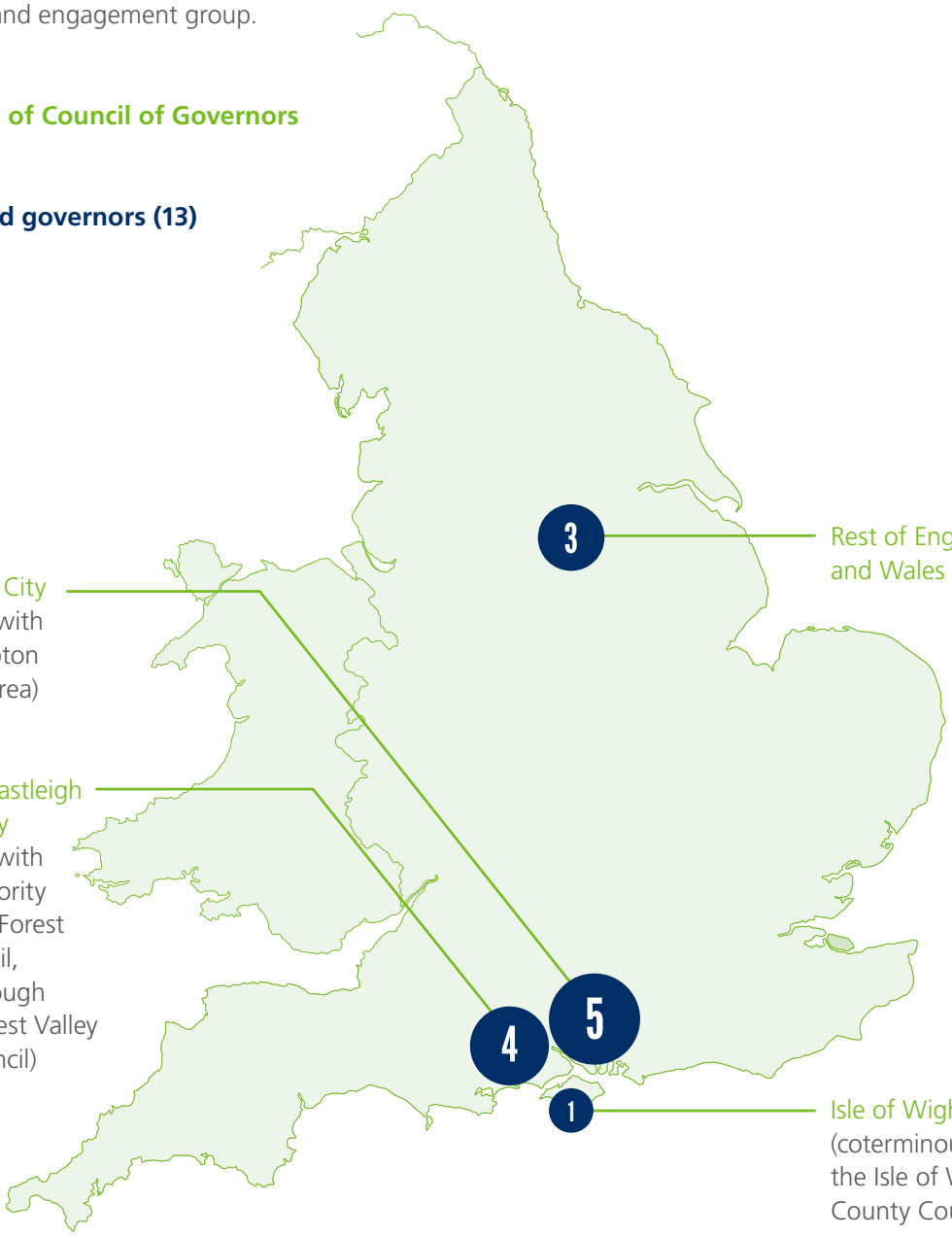
Council of Governors

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.

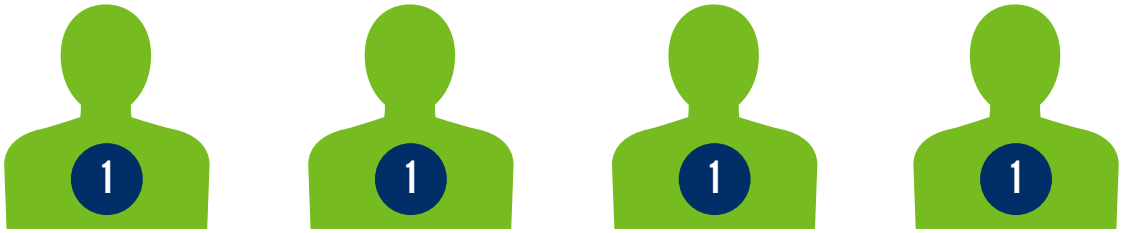
The Council of Governors is made up of 13 publicly elected governors, four elected staff governors, and six appointed governors. The governors serve a three year term of office. The Council has five working groups – governors' nominations committee, staff experience group, strategy group, patient experience 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 were appointed to the Council from University of Southampton and Richard Taunton Sixth Form College.

During 2018/19 there were a number of changes to the Council:

1. Two governors stepped down during 2018/19. These included one governor from New Forest, Eastleigh and Test Valley and one from staff nursing and midwifery. One governor sadly passed away in 2019 from the New Forest, Eastleigh and Test Valley area.
2. Two governors reached the end of their terms in 2018/19. Both were at the end of their first term and were from the Rest of England and Wales constituency. Of those reaching the end of their first term, one decided not to stand for re-election. The second governor was not re-elected on this occasion.
3. Elections for six seats took place in August 2018 with elected governors taking up their roles from October 2018. Of these, five were newly elected governors and one position was not filled. Unfortunately the staff nursing and midwifery governor did not take up their role and there was no further candidates available to take the position. This vacancy was therefore held until the 2019 elections.
4. Southampton City Clinical Commissioning nominated a replacement appointed governor who commenced during March 2019.

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:
Edward Osmond, Southampton City Centre: Member of the Conservative party

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

Diane Eldridge, Southampton City Centre: Nil

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

Anne Murphy, New Forest, Eastleigh and Test Valley (until 1/2/19): Town councillor in Ringwood; Caseworker for Soldiers, Sailors, Airmen and Families Association (SSAFA), the Armed Forces charity

Jade Young, New Forest, Eastleigh and Test Valley (until 1/2/2019): Nil

Reuben Pengelly, New Forest, Eastleigh and Test Valley: 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 (until 1/10/2018): Nil

Colin Bulpett, Rest of England & Wales (from 1/10/2018): Nil

Ian Ward, Rest of England & Wales (from 1/10/2018): Nil

Bob Purkiss, Rest of England & Wales: Nil

Elected staff members:
Max Jonas, Medical and dental: Nil

Amanda Turner, Non-clinical and support: Nil

Emil Bica, Other clinical: Nil

Appointed under 21 representatives:
Aimen Maksoud, Nil

Lorner Cotter, Nil

Appointed stakeholder members:
Mark Kelsey, Southampton City Clinical Commissioning Group (CCG) (until 1/03/19): Clinical chair, Southampton CCG

Helen Eggleton, Southampton City Clinical Commissioning Group (CCG) (from 1/03/19): Employed as quality manager, Southampton CCG

Ellen McNicholas, West Hampshire Clinical Commissioning Group (CCG): 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 Keith Mans, Hampshire County Council: Councillor, Hampshire County Council

Shirley Anderson, Business South: Nil

Council of Governors' attendance record 2018/19

Governor	Meeting attendance				
	17 May 2018 (Extra)	10 July 2018	9 October 2018	24 January 2019	12 March 2019
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	✓	✗	✓	✗	✗
Colin Bulpett Elected, Rest of England and Wales			✓	✓	✗
Ian Ward Elected, Southampton City			✗	✗	✗
Rob Chambers Elected, Southampton City	✓	✗	✓	✗	✓
Tony Havlin Elected, Southampton City	✗	✓	✗	✓	✗

Governor	Meeting attendance				
	17 May 2018 (Extra)	10 July 2018	9 October 2018	24 January 2019	12 March 2019
Diane Eldridge Elected, Southampton City (from 01/10/17)	✗	✗	✗	✗	✗
Edward Osmond Elected, Southamton City			✓	✓	✓
Andrew Grapes Elected, New Forest, Eastleigh and Test Valley	✗	✓	✓	✓	✓
Anne Murphy Elected, New Forest, Eastleigh and Test Valley	✓	✓	✓	✗	
Reuben Pengelly Elected, New Forest, Eastleigh and Test Valley	✓	✓	✗	✓	✓
Jade Young Elected, Rest of England and Wales			✗	✗	
Max Jonas Elected, medical and dental staff	✓	✓	✓	✓	✓
Tina Baker Elected, nursing and midwifery staff	✗				
Emil Bica Elected, other clinical staff	✓	✓	✗	✗	✓
Amanda Turner Elected, non-clinical and support staff	✓	✓	✓	✓	✓
Ellen McNicholas Appointed, West Hampshire CCG	✗	✗	✗	✗	✓
Mark Kelsey Appointed, Southampton City CCG	✗	✗	✓	✗	
Helen Eggleton Appointed, Southampton City CCG					✓
Cllr Keith Mans Appointed, Hampshire County Council (from 01/10/17)	✗	✗	✓	✓	✓
Cllr Sue Blatchford Appointed, Southampton City Council	✓	✓	✗	✗	✓
Michelle Cowen Appointed, University of Southampton	✗	✓	✓	✓	✗
Shirley Anderson Appointed, Business South	✓	✓	✓	✓	✗
Aimen Maksoud Under 21 representative	✗	✗	✗	✓	✗
Lorna Cotter Under 21 representative	✗	✗	✗	✓	✗

In 2018/19 the Council of Governors considered a number of items including:
- Membership engagement
- Performance of the Trust
- Review of the draft Quality Account including Patient Improvement Framework
- Updates on non-executive director (NED) recruitment and extension to the contract of one NED
- Approving the appointment of the Trust's new chief executive officer in May 2018
- Review and approval of the Trust's constitution
- Approval of the chair's remuneration
- Review of the Council of Governors terms of reference and business programme

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 three occasions during 2018/19 and considered the following topics:
- Approval of the recommendation to appoint a chief executive officer
- Chairman's pay and expenses for 2018/19
- Non-executive director appraisals, including appraisal of the Trust Board chair
- Re-appointment of the Trust chair
- Non-executive director recruitment for 2019/20

Governor elections

Governor elections were held in August 2018 for four constituencies: Southampton City (two seats), New Forest, Eastleigh and Test Valley (one seat), Rest of England and Wales (two seats) and Staff – nursing and midwifery (one seat). Four newly appointed governors started in their roles from 1 October 2018 as one left the Trust so was no longer eligible for the staff governor position and another position remained vacant.

September 2019 will bring an end to the second term of office for one elected governor and the end of the first term for four elected governors. There are also four vacant positions. Plans are being developed to run elections throughout the summer with a view to appointing to all vacancies by 1 October 2019. 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	2,866
New Forest, Eastleigh and Test Valley	3,438
Rest of England and Wales	1,390
Isle of Wight	772
Out of Trust area	16

Ethnicity	Number
White	7,727
Mixed	42
Asian/Asian Black	240
Black/Black British	89
Other (inc Chinese)	62
Not stated	322

Age range	Number
16	2
17-21	27
22+	8,170
Not known	283

Engagement with members

Communicating and engaging with our members, whilst offering a variety of opportunities for members and the public to interact with the Trust and Council of Governors, remains a key priority. In order to achieve this we are offering a programme of activities both within the Trust's hospitals and externally by joining existing events or organising our own throughout or constituencies. In the past year we have held five members' evenings at Southampton General Hospital plus our annual general meeting. Topics we have covered at these events include a celebration of women working within UHS, a behind the scenes look at the Channel Four 'My Baby's Life who Decides?' documentary featuring staff and patients from our paediatric intensive care unit, and a look at the future of UHS. All of these events have given members the unique chance to find out more about developments within the Trust.

Membership levels have reduced naturally, but work is being done around encouraging new members to join and increasing their involvement with the Council of Governors. Members continue to receive an e-newsletter and invitations to events.

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 again a great success and has been nominated for awards outside the Trust. To mark 70 years of the NHS, events were held throughout the year including a party at Southampton General Hospital (which was also celebrating 70 years of its name), a celebration service at Winchester Cathedral and a multi-Trust event at Westquay shopping centre where UHS hosted different trusts all showcasing what makes the NHS so special.

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. The formal Council of Governors meeting 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. Attendance at these groups was reviewed during March 2019. 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.

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

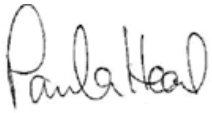
The Trust Board engages with the Council of Governors through the chair and senior independent director. Non-executive and executive directors engage with sub-groups of the council where these are related to their portfolios. Board members meet regularly with governors and have an open invitation to 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 £662.40.

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



Paula Head, chief executive officer
28 May 2019

Annual remuneration statement

Executive changes

On 31 March 2018 Fiona Dalton left her position as chief executive officer (CEO) to take up a role in Vancouver, Canada. A national search commenced for a new CEO and Paula Head took up this position on 1 September 2019, having previously been the chief executive officer of Royal Surrey NHS Foundation Trust.

David French (chief financial officer) became interim chief executive officer from 1 April 2019 to 31 August 2019 while we recruited a new CEO, and Paul Goddard (director of finance) acted up to cover the position of chief financial officer from 1 April to 17 June 2018. Paul left UHS to become the substantive executive finance director at Dorset County Healthcare NHS Trust.

On 1 November 2019 David French was appointed deputy chief executive officer as an additional responsibility to his existing board position as chief financial officer.

New non-executive directors

Catherine Mason left the Trust on 31 March 2019 to take up a position as chair of Solent NHS Foundation Trust. A national search is underway to recruit into this non-executive director role.

Simon Porter (senior independent director) was extended until July 2019 following approval from the Council of Governors.

Increases to executive pay

Cost of living increases

The remuneration and appointment committee awarded the executive team a pay rise mirroring the nationally recommended NHS Improvement pay award of £2k to the executive team.

Derek Sandeman and Caroline Marshall received uplifts to their consultant contracts in line with the nationally agreed pay awards for medical staff of 1.5% from 1 October 2018.

Specific pay changes

David French's additional responsibility of deputy chief executive officer has attracted a responsibility allowance. This pay level was agreed with the remuneration and appointments committee and was consulted with NHS Improvement, as per the Trust's regulatory obligations.

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 and appointments 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	£200-205

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.

Notice periods

All executive directors have a contractual notice period of six months.

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 include a provision to enable 'claw back' of a proportion of salary in the event of sustained and or substantial serious under performance or misconduct.

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).

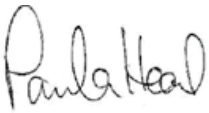
The salaries of executive directors are outlined on page 55. There are five individuals with salaries over this threshold, as outlined below:

Role	Rationale
Chief executive officer	Consistent with salary benchmarking and market rates for a large acute teaching hospital. Within expected norms for NHSI salary benchmarking for a large acute trust with a turnover of more than £500m.
Deputy chief executive officer and chief financial officer	
Director of transformation and strategy	
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	

Role	Approximate time commitment	Fee type payable	Bands of 5k (amount £000)
Chair	2.5 days per week	Annual fee	£45-50
Senior independent director (SID)	4 days per month	Annual fee Additional annual payment for SID role	£10-15 £2,500
Non-executive director (NED)	4 days per month	Annual fee	£10-15
Chair of audit and risk committee	1 day per month	Annual payment in addition to NED salary	£2,500
Chair of quality and performance 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

On 1 April 2019 the salaries of the non-executive directors and the chair were increased marginally to include expenses that were being paid for travel to main base of work. Non-executives can now only claim for additional expenses incurred in the course of their duties (for example travel to London for meetings). The changes were agreed with the Council of Governors.



Paula Head, chief executive officer
28 May 2019

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	15 May 2018 Extra	26 July 2018 cancelled	29 Nov 2018	31 Jan 2019 Extra	28 Mar 2019
Peter Hollins Chair	✓		✓	✓	✓
Simon Porter non-executive director (senior independent director and deputy chair)	✓		✓	✓	✓
Mike Sadler non-executive director	✓		✓	✓	✓
Jenni Douglas-Todd non-executive director	✗		✓	✓	✗
Jane Bailey non-executive director	✓		✓	✓	✓
Cyrus Cooper non-executive director	✓		✗	✓	✓
Catherine Mason non-executive director	✓		✗	✓	✓

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 objectives agreed at Trust Board. 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 and deputy chief executive have terms which can take back a proportion of their 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 chair?

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	Chair	1 April 2016	31 March 2022
Simon Porter	Non-executive director/ Senior independent director	1 June 2015 (This is his second term. His first term was 1 June 2011 to 31 May 2015)	Extended by agreement with COG to 1 June 2019
Mike Sadler	Non-executive director	1 September 2014	31 August 2020
Jenni Douglas-Todd	Non-executive director	1 April 2016	31 March 2022
Jane Bailey	Non-executive director	1 January 2018	1 January 2021
Catherine Mason	Non-executive director	1 March 2018	Left Trust on 31 March 2019
Professor Cyrus Cooper	Non-executive director	1 January 2018	1 January 2021

Payments for loss of office during 2018/19

There have been no payments to executive directors for loss of office during 2018/19.

Remuneration of senior managers 2018/19

	2018-19					
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**
Ms J Bailey	10-15	n/a	n/a	n/a	n/a	10-15
Ms G Byrne	140-145	n/a	n/a	n/a	45-47.5	185-190
Prof C Cooper	10-15	n/a	n/a	n/a	n/a	10-15
Ms F Dalton	15-20	n/a	n/a	n/a	0-2.5	15-20
Ms J Douglas-Todd	10-15	n/a	n/a	n/a	n/a	10-15
Mr D French	185-190	n/a	n/a	n/a	37.5-40	225-230
Mr P Goddard	25-30	n/a	n/a	n/a	0-2.5	25-30
Ms J Hayward	145-150	n/a	n/a	n/a	0-2.5	140-145
Ms P Head	130-135	n/a	n/a	n/a	137.5-140	270-275
Mr P Hollins	45-50	n/a	n/a	n/a	n/a	45-50
Dr C Marshall	185-190	n/a	n/a	n/a	0-2.5	185-190
Ms C Mason	10-15	n/a	n/a	n/a	n/a	10-15
Mr S Porter	15-20	n/a	n/a	n/a	n/a	15-20
Dr M Sadler	15-20	n/a	n/a	n/a	n/a	15-20
Dr D Sandeman	200-205	n/a	n/a	n/a	0-2.5	200-205

Ms F Dalton, chief executive officer until 17 April 2018
Ms P Head, chief executive officer from 1 September 2018
Mr P Goddard, interim chief financial officer until 17 June 2018

Comparison with 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

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**
Ms G Byrne	2.5-5	7.5-10	50-55	160-165	1263	870	90
Ms F Dalton	0-2.5	0-2.5	50-55	115-120	861	743	2
Mr D French	2.5-5	0-2.5	30-35	0-5	403	309	60
Mr P Goddard	0-2.5	0-2.5	40-45	110-115	858	751	15
Ms J Hayward	0-2.5	0-2.5	55-60	155-160	1237	1077	106
Ms P Head	2.5-5	5-7.5	60-65	175-180	1368	1085	127
Dr C Marshall	0-2.5	0-2.5	65-70	205-210	0	1571	0
Dr D Sandeman	0-2.5	0-2.5	70-75	220-225	0	1658	0

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

Median remuneration

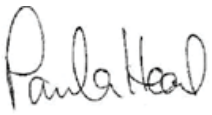
The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce.

Figure for 2017/18 are show in brackets

- The banded remuneration of the chief executive, who was the highest paid director for the year to 31 March 2019, was £130k-£135k. As she joined the organisation in September 2018 this equated to banded remuneration in a full year of £225k - £230k (210k - 215k). This was 7.6 (7.2) times the median remuneration of the workforce which was £29.9k (£29.1k).

- For the year 2018/19 no employees received remuneration in excess of the highest paid director.

- Remuneration ranged from £17.1k to the pay of the chief executive (£15.4k upwards).



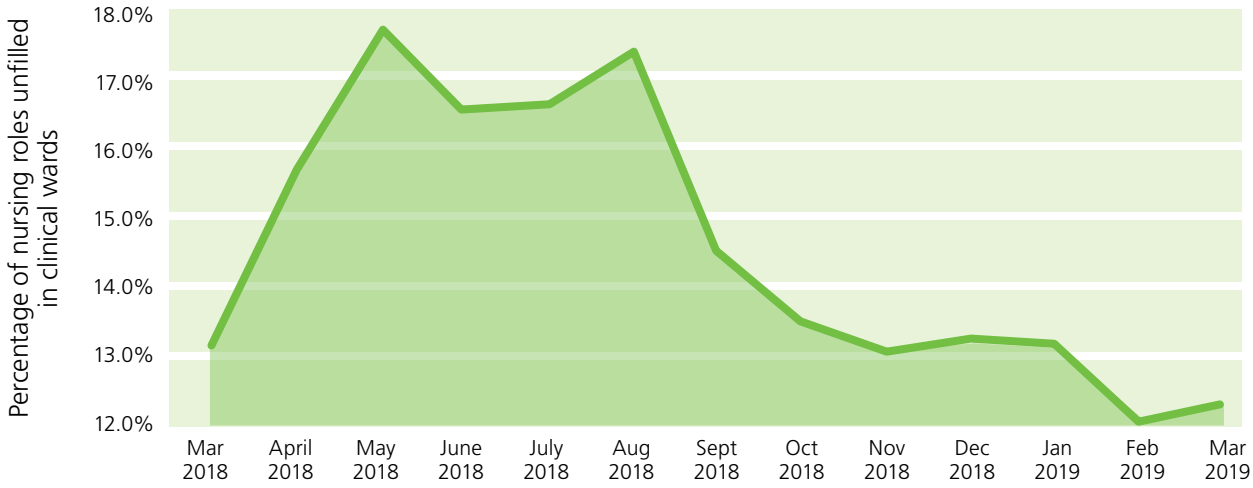
Paula Head, chief executive officer
28 May 2019

Staffing report

Performance

In 2018/19 recruitment remained steady including the annual surge for newly qualified recruitments in September. Nursing vacancy rates and staff turnover in 2018/19 are shown in the charts below.

UHS nursing vacancies 2018/19



We employ in excess of 11,900* 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 2019

Staff Group	FTE	Headcount
Additional professional scientific and technical	354.31	402
Additional clinical services	1812.23	2,113
Administrative and clerical	1732.57	1,960
Allied health professionals	537.52	621
Estates and ancillary	439.44	478
Healthcare scientists	310.01	336
Medical and dental	655.88	695
Nursing and midwifery registered	3099.98	3,551
Grand Total	**8941.94**	**10,156**

Average number of staff employed during 2018/19

Staff Group	FTE	Headcount
Additional professional scientific and technical	343.92	389.08333
Additional clinical services	1712.27	1986.0833
Administrative and clerical	1684.83	1911.8333
Allied health professionals	523.29	605.16667
Estates and ancillary	432.88	471.25
Healthcare scientists	293.31	318.41667
Medical and dental	646.26	683.83333
Nursing and midwifery registered	3049.59	3491.3333
Grand Total	**8686.35**	**9857**

Table 2: Staff employed through bank, fixed term and honorary contracts as at 31 March 2019

Staff Group	FTE	Headcount
Additional professional scientific and technical	14.00	18
Additional clinical services	91.20	88
Administrative and clerical	179.75	268
Allied health professionals	12.43	28
Estates and ancillary	10.00	29
Healthcare scientists	6.42	12
Medical and dental	878.94	1,313
Nursing and midwifery registered	51.75	77
Grand Total	**1244.50**	**1,833**

Average number of staff engaged through bank, fixed term and honorary contracts during 2018/19

Staff Group	FTE	Headcount
Additional professional scientific and technical	14.90	19.083333
Additional clinical services	80.21	96.583333
Administrative and clerical	182.00	271.66667
Allied health professionals	15.17	33.333333
Estates and ancillary	9.43	29.25
Healthcare scientists	10.49	16.333333
Medical and dental	839.29	1282.0833
Nursing and midwifery registered	60.38	89.916667
Grand Total	**1211.88**	**1838.25**

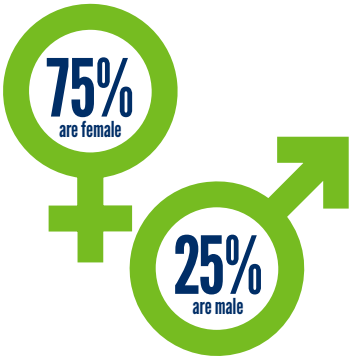
Staffing costs

	Group		Trust	
	Year ended 31 March 2019 Total £000	Year ended 31 March 2018 Total £000	Year ended 31 March 2019 Total £000	Year ended 31 March 2018 Total £000
Salaries and wages	**373,982**	350,852	**373,625**	350,534
Social security costs	**38,409**	36,190	**38,402**	36,165
Apprenticeship levy	**1,856**	1,740	**1,856**	1,737
Pension cost - Employers contributions to NHS Pensions	**45,109**	42,293	**45,109**	42,287
Pension cost - other contributions	**39**	18	**39**	18
Temporary staff - external bank	**23,791**	19,394	**23,791**	19,394
Temporary staff - agency/contract staff	**12,950**	11,610	**12,827**	11,606
NHS Charitable funds staff	**158**	882	**0**	0
Recoveries from Other bodies in respect of staff cost netted off expenditure	**(12,760)**	(9,253)	**(12,760)**	**(9,253)**
Total Net Staff Costs	**483,534**	**453,726**	**482,889**	**452,488**
Employee Expenses - Staff	**481,259**	451,699	**480,772**	451,343
NHS Charitable funds: Employee expenses	**158**	882	**0**	0
Total Employee benefits excluding capitalised costs	**481,417**	452,581	**480,772**	451,343

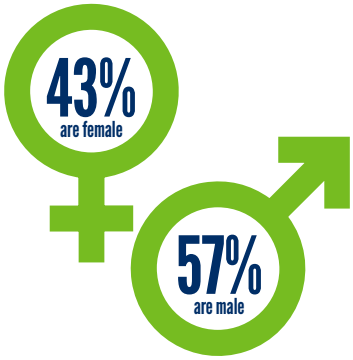
Gender equality

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.

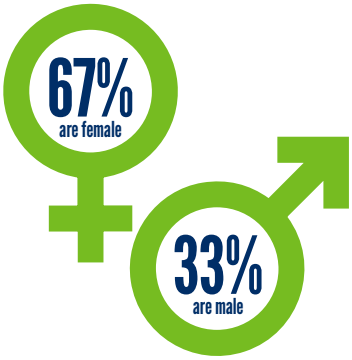
UHS workforce



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.

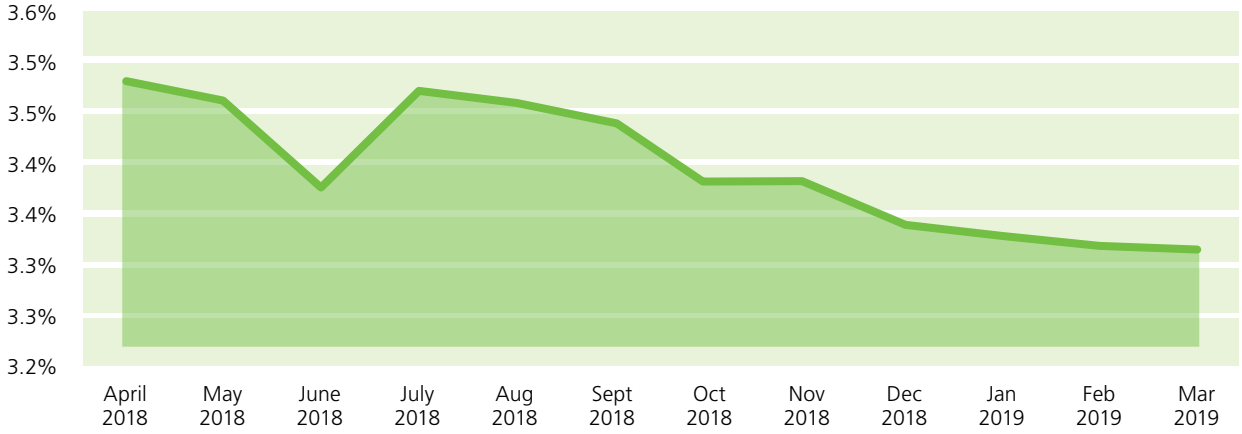
UHS has worked as one of the exemplar sites for NHS England's Healthy Workplace project. Our 'Live well and inspire' programme has promoted and delivered a range of activities, which include providing health checks for all staff. We have also installed a mini health check machine in the front entrance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

During the year we have introduced additional support for staff who have experienced difficult and traumatic incidents. We have trained 16 individuals to provide support to colleagues using the Trauma Risk Management (TRiM) methodology.

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.

UHS sickness rate (12 month rolling) 2018/19



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.

There is an active long term illness and disability group who work in partnership with the Trust to drive improvements. In September 2018 the Trust ran a week long equality and diversity event which included events specifically focused on disability.

The Trust has run masterclasses for line managers on supporting disability in the workplace and has sponsored disabled staff to participate in national leadership development programs.

The Trust will be responding to the requirements of the new NHS Workforce Disability Equality Scheme (WDES) during 2019/20, including meetings its commitments on publication of data.

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 monthly blog from the CEO. Our internal staff website (staffnet) also provides regular updates and a range of information on policy and procedure.

We also use Facebook Workplace as an engagement and communication tool for staff. Over 2,600 staff are users of the tool and use the forum to share practice, provide updates and celebrate achievements.

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 Christine Mbabazi was appointed 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.

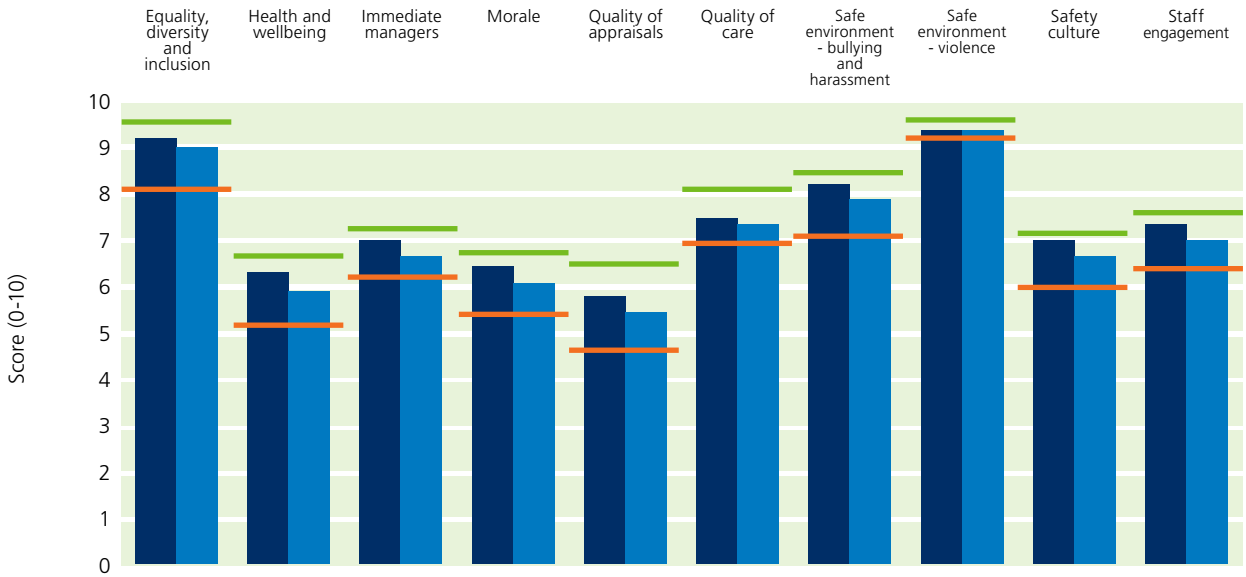
The Trust has implemented the recommendations from the National Freedom to Speak up Guardian. It has also selected 15 Freedom to Speak Up Champions from diverse roles across the organisation. These roles are designed to promote the FTSU agenda and support the FTSU guardian in the delivery of her role.

Responding to the staff annual attitude survey

UHS faced a challenging year in 2018 with significantly increased financial pressure, service demands, and challenges in achieving our key constitutional targets. The staff survey results, however, have remained similar to 2017 with all 10 survey themes remaining above the acute Trust average.

Staff survey results

2018 NHS staff survey results - theme results overview



Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.2	6.3	7.0	6.4	5.8	7.5	8.2	9.5	7.0	7.4
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4

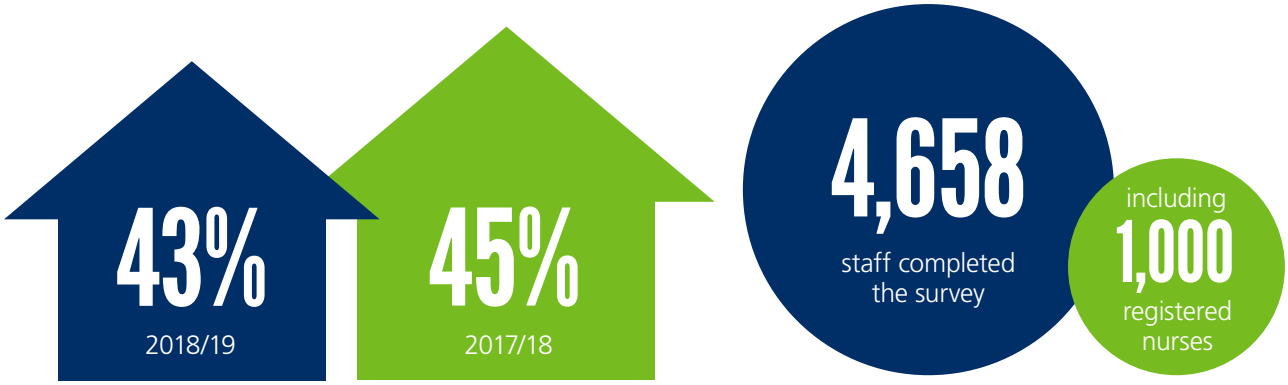
2018 NHS staff survey results – year on year comparison

	2018/19		2017/18		2016/17	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.2	9.1	9.1	9.1	9.2	9.2
Health and wellbeing	6.3	5.9	6.4	6.0	6.4	6.1
Immediate managers	7.0	6.7	7.0	6.7	7.0	6.7
Morale	6.4	6.1				
Quality of appraisals	5.8	5.4	5.5	5.3	5.4	5.3
Quality of care	7.5	7.4	7.5	7.5	7.5	7.6
Safe environment - bullying and harassment	8.2	7.9	8.3	8.0	8.2	8.0
Safe environment - violence	9.5	9.4	9.4	9.4	9.5	9.4
Safety culture	7.0	6.6	7.0	6.6	7.0	6.6
Staff engagement	7.4	7.0	7.4	7.0	7.4	7.0

The two areas of significant change were Health and Wellbeing and Quality of Appraisals:

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity and inclusion	9.1	4532	9.2	4453	Not significant
Health and wellbeing	6.4	4598	6.3	4488	▼
Immediate managers	7.0	4569	7.0	4505	Not significant
Morale		0	6.4	4399	N/A
Quality of appraisals	5.5	3851	5.8	3791	▲
Quality of care	7.5	4183	7.5	4067	Not significant
Safe environment - bullying and harassment	8.3	4484	8.2	4423	Not significant
Safe environment - violence	9.4	4475	9.5	4419	Not significant
Safety culture	7.0	4555	7.0	4434	Not significant
Staff engagement	7.4	4711	7.4	4622	Not significant

Participation rates



Ranked scores

Top/ bottom			
Top five scores (compared to average)	Q21d	If friend/relative needed treatment would be happy with standard of care provided by organisation	85%
	Q21c	Would recommend organisation as a place to work	74%
	Q28b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	82%
	Q21a	Care of patients/service users is organisations top priority	87%
	Q5h	Satisfied with opportunities for flexible working patterns	60%

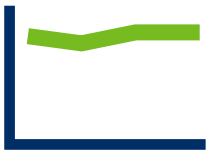
Bottom five scores (compared to average)	Q22b	Receive regular updates on patient/service user feedback in my directorate/department	60%
	Q19b	Appraisal/review definitely helped me improve how I do my job	23%
	Q4e	Able to meet conflicting demands on my time at work	46%
	Q11g	Not put myself under pressure to come to work when not feeling well enough	8%
	Q16b	In last month, have not seen errors/near misses/incidents that could hurt patients	69%

Things to celebrate

The UHS results are above the Acute Trust average in all 10 themes.

NO.5

UHS is ranked number five in acute trusts for staff recommending the Trust as a place to work or receive treatment



Staff engagement at UHS has remained consistently high (7.4) compared to the NHS average (7).

NO.2

UHS is ranked as second in acute trusts for staff satisfaction with the opportunities for flexible working

NO.7

UHS is ranked seventh in acute trusts and third best university teaching hospital for staff engagement overall

UHS has seen statistically significant improvements in the 'Quality of Appraisal' theme. This has increased from 5.5 to 5.8 - driven by the survey question relating to whether the Trust's values are definitely discussed during appraisals, which has increased from 28.4% to 40.2%

Areas of challenge

- UHS has seen a statistically significant decrease in the 'Health and Wellbeing' theme. This has decreased from 6.4 to 6.3 - driven by the survey question relating to whether the Trust definitely takes positive action on health and wellbeing, which has reduced from 41.3% to 32.5% (-8.8%). The NHS acute trust average has also decreased from 31.9% to 27.8%.
- WRES scores for BAME staff have not shown any significant improvement, and have deteriorated in perception of equal opportunities for career progression.
- Experience of staff who have stated that they have a disability still reported consistently lower across most metrics.
- Administration and clerical staff engagement showed a marginal improvement, but is still an area of concern that the Trust will be focusing on.

Moving forward

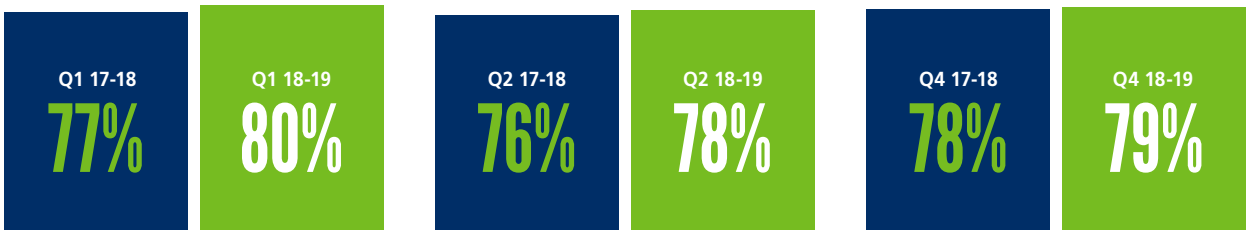
Area of focus	Key actions	Measure of improvement
Response rates	• To review the methods of obtaining survey responses and review the incentives for completion.	To improve return rates to at least in line with acute average (45%).
Improving communications with staff	• Review how communication with staff can be improved, including how best to engage with different demographics role types and professions, and dispersed staff (not on-site). • Increase mechanisms for quality two way communication in the organisation. • Engaging staff on the long term vision for UHS in the context of the long term plan. This is to be led by the CEO.	Increase in staff reporting effective communication from senior managers to 50%.
Administration and clerical (A&C)	• Focus on increased use of apprenticeships to offer education and training opportunities to staff, and increase new career routes into the Trust. • Introduce a new training package for A&C team leaders to support development in a range of leadership skills. • Target specific areas of very low experience and engagement with local listening sessions with staff.	Improvements in administration and clerical staff engagement from 7.1 to 7.4.
Health, wellbeing and safety	• To review the range of support offered by LiveWell and Inspire programme and ensure this is well publicised. • To continue existing work on staff safety through the Trust violence and aggression group. • To target specific areas of concern in low health and wellbeing using the assessment process set out in the Trust Mental Health Policy.	An improvement in staff reporting the organisation 'takes a positive interest in health and wellbeing'.
Equality and diversity	• To deliver the first year of the new Equality and Diversity Strategy, including implementing the key actions set out for BAME and disabled staff. • To monitor progress through the equality and diversity steering committee and report progress six monthly to TEC.	Improvement in WRES scores in 2019 staff survey. Improvements in results in disabled staff in 2019 survey results.

Staff friends and family survey results

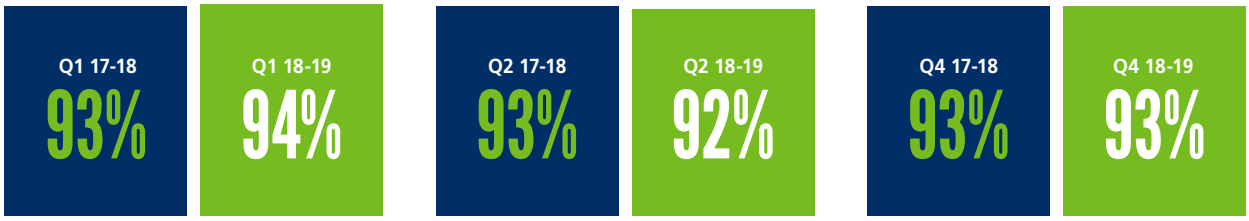
Staff experience is of great importance to UHS and in 2018 the friends and family test results showed that UHS was fifth best nationally for our proportion of staff saying that they would recommend the hospital as a place to work or to receive care.

UHS Friends and Family Test 2017 and 2018

Percentage of staff who would recommend UHS as a place to work



Percentage of staff who would recommend UHS as a place for care or treatment



Trade union facility time

University Hospital Southampton NHS Foundation Trust (UHS), trade unions and professional organisations share a commitment to working in partnership to ensure that our common long-term objective is ensuring the success of the Trust for the benefit of our patients, employees and the community we serve.

As part of our collective delivery of the core UHS value of 'working together' the Trust management and staff side partners work in partnership on a range of strategy, policy, employee engagement and employee relations issues.

Under the Trade Union (Facility Time Publication Requirements) Regulations (2017) UHS is required to publish annually information on its utilisation of trade union facilities time.

The tables below set out key information to satisfy this new statutory requirement. The information is also recorded and published on Gov.net.

Table 1
Relevant union officials
What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
54	41

Table 2
Percentage of time spent on facility time
How many employees of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1-50%	54
51-99%	0
100%	0

Table 3
Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

Item	Figures
Provide the total cost of facility time 17/18	£136k
Provide the total pay bill 17/18	£454,445K
Provide the percentage of the total pay bill spent on facility time 17/18, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.03%

Table 4
Paid trade union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	6.03%

Expenditure on consultancy
The Trust spent £166,000 on external consultancy during 2018/19.

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 2019, for more than £220 per day and that last for longer than six months

Existing engagements as of 31 March 2019	Nil
Of which nil have existed for less than one year at time of reporting	

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	4	2	6
£25,001 - £50,000	1	0	1
£50,001 - £100,000	0	1	1
£100,001 -£150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	5	5	10
Total resource costs (£'000)	**96**	**104**	**200**

Non-compulsory departures payments

Type of exit	Agreement number	Total value
Voluntary redundancies including early retirement contractual costs	0	**0**
Mutually Agreed Resignations (MARS) contractual costs	0	**0**
Early retirements in the efficiency of the service contractual costs	0	**0**
Contractual payments in lieu of notice	5	**104**
Exit payment following employment tribunal or court orders	0	**0**
Non-contractual payments requiring HMT approval (special severance payments)	0	**0**
Total	5	**104**
Of which non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	**0**

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

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

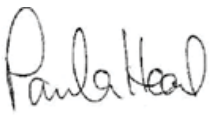
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospital Southampton NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The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

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

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

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

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



Paula Head, chief executive officer
28 May 2019

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, while 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 (UHS), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in UHS for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

We strive to provide 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 (whistleblowing) 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; and,
- Staff appraisal and development.

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 by:
- Working collaboratively with our Clinical Commissioning Groups;
- Engaging with Healthwatch;
- Consulting the Council of Governors on key issues and risks; and,
- Holding an annual members' meeting.

The risk and control framework

The Board of directors is responsible for the governance of the Trust. It delegates key oversight duties and functions to its committees. There are four Board committees 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 compliance are adhered to by 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 officer, 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.

The Board's Risk Strategy sets out the Board's risk appetite, and the principles of good governance it requires be applied to risk management. The 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 analysed 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 in local risk registers with monitoring undertaken through care group meetings.

Risks assessed as 'moderate' represent moderate levels of threat which may have a short-term impact on organisational objectives. Risks in this category were recorded in 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 into the Trust's Operational Risk Register and are 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 the 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 continue to be managed within future years.

Principal risk	How they are managed / mitigated
Failure to maintain appropriate 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. The Interim Medical Examiners Group (IMEG) conduct reviews of all unexpected deaths. Medical director and director of nursing have oversight of all Never Events. 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	Additional funds have been made available as part of 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 e.g. virtual clinics, reduced follow-ups.. Attend planned workshop Southampton City GPs Participate in national improvement programme on frailty and ambulatory emergency care. Performance against targets is 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.
Failure to deliver financial plan as agreed with NHS Improvement - £29.4m surplus	The Trust manages the financial position by: Having a robust budget setting process signed-off by each division. Having a Programme Management Office to support development and measure success of CIP schemes. Strong management controls to restrict unauthorised expenditure and reduce usage of agency/interim staff. Regular contract reviews with commissioners. Clear monitoring of the financial position at Trust executive committee, strategy and finance committee and Trust Board. Regular divisional financial reviews with chief executive and chief financial officer. In-year response to financial pressures of developing and implementing Financial Recovery Action Plans for each division. Monitoring and action plan to maximise receipt of Provider Sustainability Fund (PSF).
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.

In addition to these principal risks managed locally, the NHS has liaised with central government to prepare for and manage risks associated with Brexit, including the availability of medicines and workforce resourcing.

Developing workforce safeguards

The Trust has a strong governance framework that systematically monitors short, medium and long term staffing systems through the education and workforce steering group up to and including Trust Board.

The National Quality Board guidance is fully embedded for nursing and midwifery and includes:

- Annual review and re-setting of nursing establishment and skill mix using triangulated methodology and approved tools reported to Board – refreshed six monthly and reported to Board.
- Availability of staffing information for the public via ward displays and on the public website
- Dynamic staffing risk assessments and formal escalation processes
- Implementation of new roles such as nursing associate, apprentices, advanced practitioners accompanied by strong quality impact review

The Trust completes an annual top level workforce plan as part of the wider operational and financial planning process and is working to embed this further and combine with a bottom-up service approach.

We regularly monitor all staffing metrics, using a variety of sources including data from the Model Hospital, and these are reported monthly with a six monthly focus by the quality committee and Trust Board. Staffing metrics are combined with the wider integrated performance dashboard to ensure quality impact is reviewed as a whole.

eRostering is well embedded within the Trust, having been introduced in 2009. It is used across the professions and integrated with other workforce systems. We are working to embed this further for medical staff and expand job planning for all staff where this is appropriate in 2019/20.

There is formal quality impact assessment sign off from the nursing and medical directors at Board on major workforce change.

Information security and governance

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.
We became aware of an opportunity to improve our data collection on cancer treatments, and will do so through additional training of staff, and spot-checking.

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 award from NHS Digital of additional cyber resilience funding for Major Trauma Centres, has enabled us to invest further in the latest generation of security system 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. It ensures our technical and risk management and reporting policies are updated regularly 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 refer 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.

There were no serious incidents involving information governance, including data loss or breaches of confidentiality in this reporting period.

Quality governance and the 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.

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 and quality governance agenda.

The QGSG has several 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 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. This on-going process to assess compliance with the CQC's essential standards and regulations 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. This indicates that the Trust remains compliant with the registration requirements of the Care Quality Commission.

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 (now known as Our Quality Priorities Framework) 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'.

Leadership – the well-led assessment

As part of the ongoing drive for continual improvement, the Board engaged KPMG in 2017 to carry out a developmental review of our leadership and governance using the well-led framework to benchmark performance. KPMG's report confirmed that "there are sufficient arrangements in place to ensure that University Hospital Southampton NHS Foundation Trust is well-led. Our view is that the Trust is high performing against each domain." The Board noted and responded to the eight low level recommendations during 2018/19.

A well-led inspection conducted by the Care Quality Commission towards the end of the 2018/19 found that the Trust continued to be well-led and made recommendations on how to achieve the highest rating for leadership in 2019/20. The Board has responded to these recommendations by conducting a full and thorough review of its arrangements for divisional performance management and governance, for financial oversight, risk management, and Board performance. These reviews have utilised independent external advisors in addition to the expertise available from the body of non-executive directors.

This action plan is to set out robust and unequivocal arrangements for ensuring the constant and continuing compliance with the Trust's NHS foundation trust licence condition FT4 (FT governance) and will include actions identified to mitigate these risks, particularly in relation to:

- the effectiveness of governance structures,
- the responsibilities of directors and committees;
- reporting lines and accountabilities between the Board, its committees, and the executive team;
- the submission of timely and accurate information to assess risks to compliance with the Trust's licence; and,
- the degree and rigour of oversight the Board has over the Trust's performance.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The cost improvement programme

In 2018/19 the UHS Transformation Board have kept oversight of, and driven forward, the following transformation priorities:

1. Quality improvement
2. Patient flow
3. Outpatient transformation
4. Efficiency and productivity
5. Cost improvement and demand management
6. Business intelligence

The Board is chaired by the chief executive, attended by the senior leadership team and supported by the Trust's Project Management Office (PMO).

The Trust has a formal strategy to embed quality improvement across the organisation and provides a programme of nationally accredited training. Focused work to remove delays and improve patient flow has reduced length of stay. We are working closely with commissioners to introduce new models of care in outpatients, including 'virtual appointments' supported by the 'MyMedical Record' IT system.

The cost improvement programme (CIP) delivered approximately £31m of efficiency in 2018/19, made up of pay and non-pay savings, productivity improvements and associated income. Productivity and pay savings are supported by business intelligence, including the NHS 'model hospital' and GIRFT reviews. Non-pay savings are supported by the procurement function who negotiate savings with suppliers.

2019/20 priorities will be refreshed as part of the strategic planning process and will be aligned to our strategic goals.

Review of effectiveness of the system of internal control

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:

- NHSI: Single Oversight Framework Segmentation
- Care Quality Commission registration and the results of CQC inspection reports;
- Internal audit reports;
- External audit reports;
- Clinical audits;
- Accreditation and peer reviews;
- Patient and staff surveys;
- Benchmarking information; and,
- Reports by the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

I have also 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, including an independent report by Deliotte PLC on divisional performance management and governance, which I commissioned in 2018.

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, the quality committee, and the strategy and finance committee and a plan to take advantage of any scope for improvement is in development at the time of reporting.

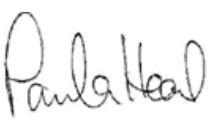
The Head of Internal Audit's Opinion (HoIAO) is that governance, risk management and internal control in relation to business critical areas is generally satisfactory. There are some areas of weakness and/or non-compliance in the framework which potentially put the achievement of objectives at risk. I note the Head of Internal Audit's advice that some improvements are required in those areas to enhance the adequacy and/or effectiveness of the framework of governance, risk management and internal control.

Risk management has been identified as a 'high risk' due to there not being a dedicated risk management team. The Internal Auditor noted that not having a dedicated risk management function has been the underlying root cause contributing to the other findings raised, including the two elements identified as medium risk overall (Business Continuity Management and Major Incident Planning – Follow Up; and Key Financial Systems).

Prior to receiving the HoIAO, I commissioned an independent review of risk management which has provided me with a comprehensive action plan to address any potential for shortcomings. This will be affected in 2019/20.

Conclusion

Having assessed the evidence available to me, I have concluded that the system of internal control is generally satisfactory, and concur with the Head of Internal Audit that some opportunities for strengthening and improvement exist. These opportunities will be acted upon in the forthcoming reporting year.



Paula Head, chief executive officer
28 May 2019

Voluntary disclosures

Equality, diversity and inclusion

UHS is wholly committed to creating a diverse and inclusive environment. We see it as vital to our future success as a leading organisation in which our people and patients thrive.

We have always set high standards with regard to diversity and inclusion, but recognise that we have not yet achieved these standards in all aspects of our people practices and in the delivery of patient care. Our Equality, Diversity and Inclusion strategy has been approved by Trust Board and includes four goals which are as follows:-

1 Understanding our local population and reducing heath inequalities
2 Measuring, monitoring and improving patient experience
3 Building inclusive leadership and talent
4 Delivering a representative workforce

The strategy will be underpinned by an overarching action plan and will include improvement on Workforce Race Equality Standards and Workforce Disability Equality Standards.

UHS has established 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 experience outside of working hours. UHS promoted inclusion through participation in National Inclusion Week, providing a range of activities which seek 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 fourth 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 participated 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. We are now on the third cohort of this inclusivity programme which has been 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. Additionally, the Board and senior managers have received EDI training from the same experts.

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.

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 in 2019. The WDES is a set of specific 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, UHS again participated in the annual Southampton Pride Event. Its stand was well attended and provided 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 continued investment in energy saving initiatives and staff awareness campaigns that focus on promoting sustainability.

The Trust's focus on sustainability has previously been limited to quantitative data, such as energy or travel related emissions. Although this data is essential to inform future action, it only tells part of the story. There are other aspects of sustainable development, such as social value and community engagement, for which progress can be difficult to quantify. To address this, our goal for 2019/20 is to complete a sustainable development assessment across UHS activities to help understand where good progress has been made and to highlight areas that require further focus. This data will then inform our priorities that form part of the Sustainable Development Management Plan (SDMP).

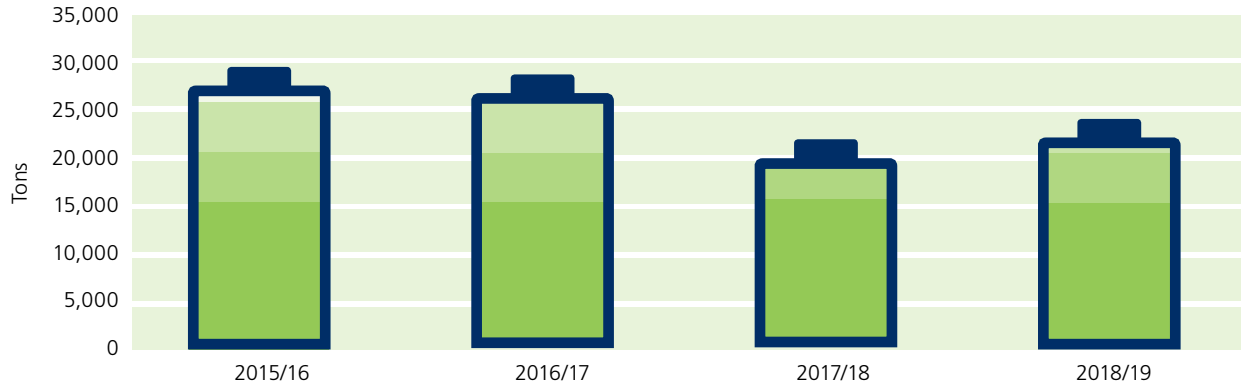
In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. According to a report published in 2016 by the Sustainable Development Unit, an 11% carbon reduction was achieved by the NHS between 2007 and 2015. The carbon reduction target has been updated and the new goal for the NHS is to reach a 34% reduction by 2020 and 80% by 2050.

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 2018/19 we used 39,232,960 kilowatt hours of electricity. The following graph tracks carbon emissions over the last four years.

Carbon emissions - energy use



Co2e	**29,275**	**29,018**	**21,661**	**23,351**

The Trust's carbon management policy was introduced in April 2013 and set out our plans and processes to meet these NHS targets. The Trust has successfully secured funding to upgrade both Princess Anne Hospital (PAH) and Southampton General Hospital (SGH) light fittings into more energy efficient LED lights. In addition the single glazed windows in Princess Anne are being replaced with high performance double glazed windows. Automatic internal doors have been fitted to reduce heat loss on the B-level corridor in the SGH main building. New building energy management system (BMS) controls have been introduced in theatres. We will continue to invest in energy saving schemes.

Sustainability awareness campaign

During this year the Trust also embarked on a major staff awareness and engagement programme in sustainability. We have recruited twelve staff members who are committed to supporting our sustainability initiatives across various channels.

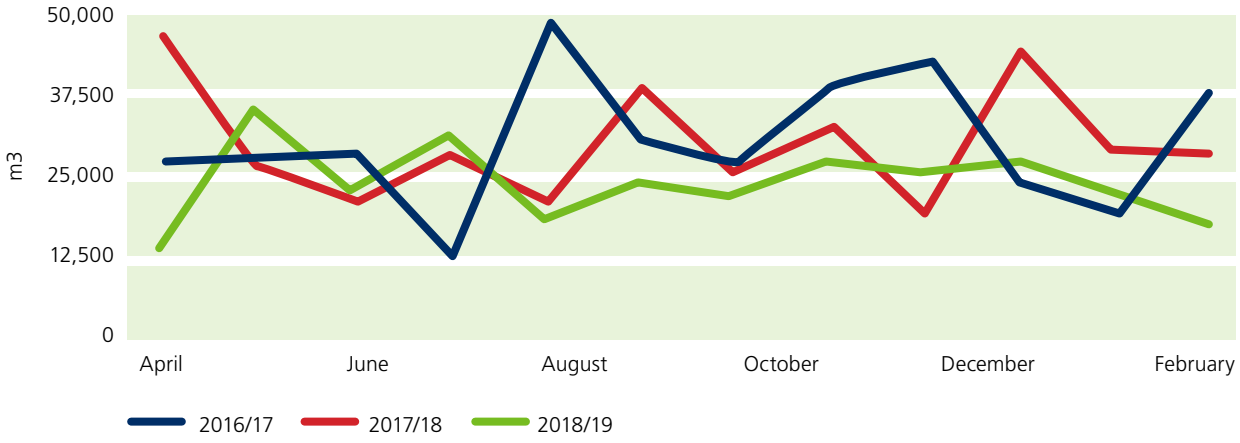
- Sustainability newsletter: our first quarterly newsletter was published in March 2018. The aim of the newsletter was to update readers on news, advice and statistics focusing on our efforts to reduce carbon consumption and local pollution, as well as health, wellbeing and sustainability events.

- Sustainability awareness event: we took part in the nationwide NHS Sustainability Day celebration on the 21 March 2019. We hosted an event at Southampton General Hospital to raise awareness of the impact our organisation has on our environment.

- The Easter Switch Off competition: The Trust launched its first 'Switch Off' campaign over the Easter Bank Holidays. Using posters, energy facts, and switch off checklists, we were able to encourage staff to turn off lights and non-essential equipment in their respective buildings before leaving for the long Easter weekend.

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.



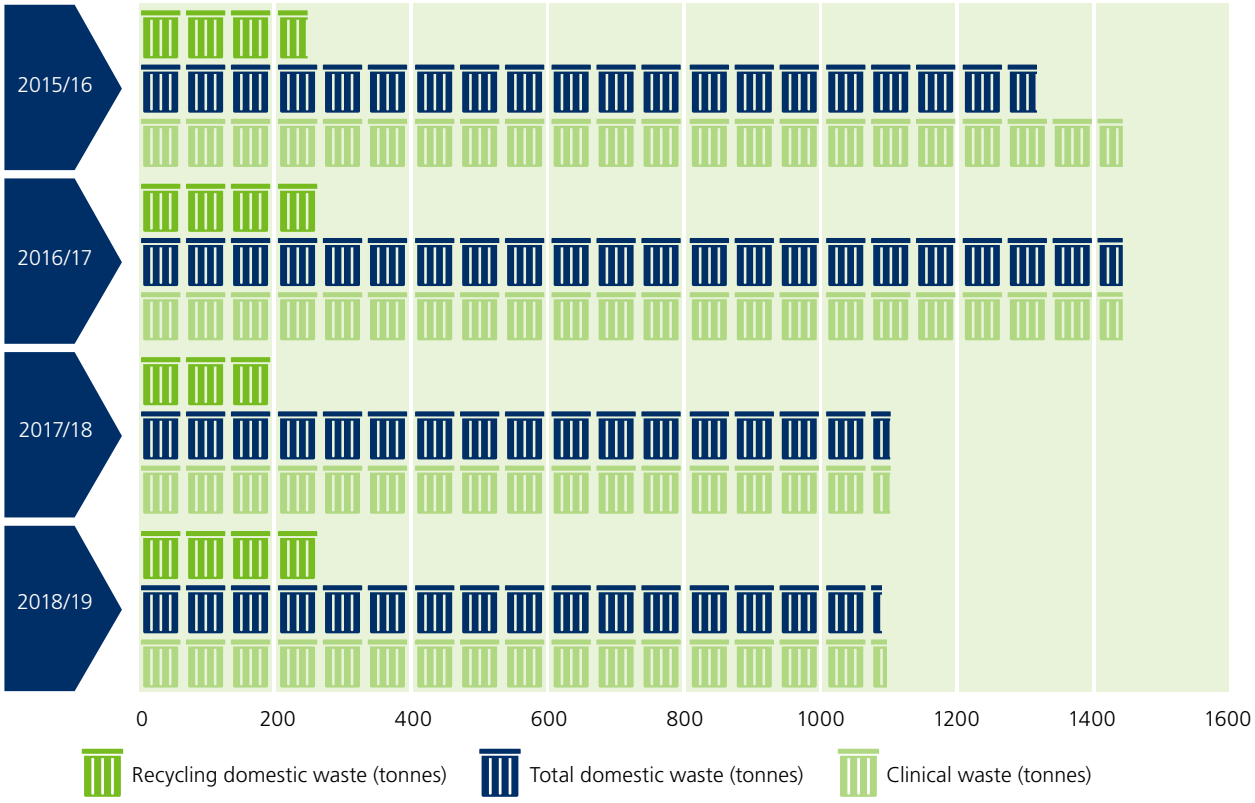
Waste management

The Trust is committed to reducing its carbon footprint and improving the understanding of waste management within the health service. Recycling is widely encouraged. Our mixed recycling includes paper, cardboard, plastics, tins and glass. The waste management team also recycle ink cartridges and batteries.

Two new waste mainstreams have been introduced this year to help us manage what we throw away: reusable sharps bins and the Tiger stripe bags.

Over 70% of the Trust has moved over to the new bio bin solution. Previously, sharps bins were collected by the waste management team and incinerated. In the new Stericycle process, full bins will be taken off site to be emptied and decontaminated for reuse. No plastic is burnt and only the contents are sent to be incinerated.

There has been an increase in the number of staff-led recycling initiatives with many departments now taking action to increase the amount they recycle. This has resulted in a 20% year on year increase in our recycling rate. The total amount of waste generated by the Trust was 3,258 tonnes with carbon emission equivalent to 69 tonnes.



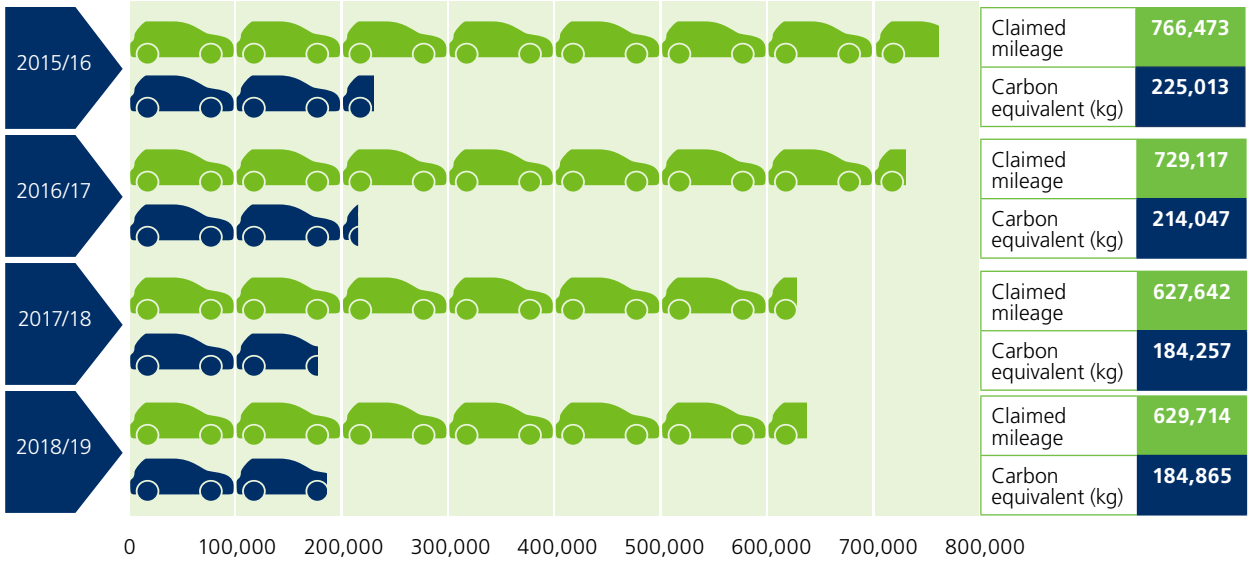
Sustainable travel

We are committed to improving the local air quality and improving 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) output and improve staff wellbeing.

In 2016/17 the Trust introduced a new system which allows greater control and processes claims according to the Agenda for Change expenses claiming policy. This drop led to the 13% reduction in the amount of claimed mileage. We will continue to encourage staff to organise teleconference meetings whenever possible and indicated.

We encourage staff to cycle to work and offer a cycle to work scheme. We also organise regular Dr Bike clinics and offer 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 respects with applicable environmental and social law requirements in force from time to time in relation to the goods. Where the provisions of these 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.

- 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 over £4 million. This money was raised largely through the generosity and tireless efforts of donors and supporters in the local community as well as the Trust's own staff.

Highlights for this year included:

£5.1m
raised to finish thecampaign for the children's emergency and trauma department early and also raising an additional £70,000 for distraction equipment

£450,000+
received in income from people leaving gifts in their wills

£180,000
funding for the first year of a three-year project to provide patient Wi-Fi access Trust-wide

£57,000
raised to upgrade rooms for non-invasive and paediatric cardiology

£20,000
secured from the True Colour Trust to refurbish a parents' room on G3 ward

For more information about SHC visit www.southamptonhospitalcharity.org

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

The Charlotte Francis May Foundation

The League of Friends of Southampton Eye Unit

Where There's a Will

Developments in informatics

In 2016 UHS was recognised in a programme of 16 digital exemplar trusts. This programme started in 2017 and we are now benefiting from national investment in digital technologies, such as secure real time messaging for clinical staff.

We have continued to invest in a strategy for information technology and are working towards a paperless environment. The digitisation of paper records is now complete and all paper notes are now scanned into an Electronic Document Management System (EDMS), and filed under clinical context tabs.

The scanning of documents is not the end point, but rather the start of a process that takes us through to direct digital data entry. Patients' temperature, blood pressure and respiratory rates are now collected by mobile devices across the Trust and collection of fluid balance data is underway.

The outpatient function has continued to modernize with many clinics now being paperless using The Clinical Handover and Record of Treatment System.

The digital display of the ward 'white board' has continued to be developed into a system that is helping improve patient flow, indicating bottlenecks in patient care and helping to progress resolution of issues.

Patients and visitors can now take advantage of the free NHS WiFi using their own device, which is proving to be very popular. Future projects include greater use of barcode and tracking devices to improve the service that we offer digitally.

My Medical Record

The My Medical Record system which supports patients online is now in use by multiple organisations. Test results and letters are now routinely sent into this record, and the registered users have grown to around 15,000 in the past year. The system is hosted in the Microsoft Azure Cloud service.

You can find out more about the informatics projects that are driving quality improvements on page 96 of the quality account.

Leading research into better care

You can find detailed information on our developments in research in our quality account on page 101.

Investing for the future

The Trust continues to invest in our hospital sites through refurbishment and creation of additional capacity where required.

Investments in 2018/19 have included:

- The Imaging Infrastructure Support Service (IISS) project which continues to replace and update radiology equipment
- Significant investment in information technology with NHS Digital (external funding), for example the electronic patient document management system
- The new children's emergency department - phase 1 opened
- Phase 2 refurbishment of F1 ward - completed
- Phase 2 refurbishment of E4 ward - completed
- Refurbishment of Princess Anne Hospital's four theatres - phase 1 completed
- The creation of a new general anaesthetic procedure room in Southampton General Hospital's west wing
- Detailed design work underway to expand the general intensive care unit
- Created a GP streaming suite to improve the flow of patients through the emergency department
- Created a larger GP hub next to the emergency department
- Created additional space for same day emergency care
- Commenced the project to create a new theatre on E level centre block
- Started the project to create additional capacity in neurology for IAT medical thrombectomy
- Created a new park and ride facility for staff
- Opened the new Cancer Centre for Immunology
- Continued investment in the infrastructure of the site through the strategic maintenance programme
- Design underway to create a new urology centre
- Installed a new surgical robot
- Continued replacement of the linear accelerators
- Continued investment in new and replacement of medical equipment

Investments planned for 2018/19 include:

- Creating a new adult resus area which will enable improvements to the current area used to treat 'majors'
- The new children's emergency department phase 2 will open
- Working with the Maggie's charity to build a new centre
- Phase 2 refurbishment of Princess Anne Hospital's theatres

QUALITY ACCOUNT AND QUALITY REPORT 2018/19

Chief executive's welcome

It is my pleasure to present the Quality Account for 2018/19. 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 2018/19 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 ranked as seventh best acute trust and the third best university teaching hospital for staff engagement overall.

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 December 2018 and January 2019. The report has provided us with some really positive feedback about "many areas of outstanding practice" and inspectors highlighted that they found a 'strong patient-centred culture with staff committed to keeping people safe'. As a result of the visit, all sites and services across the organisation are now rated as 'good' in the effective and caring domains, with Southampton General Hospital 'outstanding' in these areas.

The inspection focused on the quality of four core services – urgent and emergency care, medicine, maternity and outpatients – as well as management and leadership and effective and efficient use of resources. Urgent and emergency care received an overall rating of 'good', with 'outstanding' scores for effective and caring services. Medicine – including medicine for older people – was rated 'good' overall with 'outstanding' for caring and responsive services.

Maternity received a 'good' rating overall and in all individual categories other than safety which recorded a 'requires improvement' rating, while outpatient services were rated 'requires improvement' – both largely due to the quality and age of the estates and facilities.

Southampton Children's Hospital remains 'good' overall and 'outstanding' for care.

Of course the inspection has also highlighted some areas in need of improvement, particularly around the difficulties of an ageing estate and increasing volume of patients, but the report also acknowledges how our staff work hard to mitigate any risks presented.

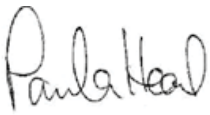
This has been my first CQC inspection since being chief executive at UHS and I was so impressed with the way it was managed and so proud of how our staff came together to support each other. The longer I have been in post, the more examples I have seen of staff displaying this kind of behaviour every day and really living our values of putting patients first, working together and always improving.

We've faced significant challenges and pressures over the last few months and this result is a real testament to our staff. Our ambition now 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.

This quality report shows how we performed against our 2018/19 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.



Paula Head
Chief executive officer
28 May 2019

Our approach to quality assurance

Always improving is a key vale 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. Derek Sandeman (medical director) and Gail Byrne (director of nursing and organisational development) are the lead executive directors for quality, while Jane Hayward (director of transformation) is responsible for quality improvement.

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 and experience. Last year we changed our approach to focus on fewer key priorities, but structured these under the Care Quality Commission (CQC) domains of safe, effective, responsive, caring and well-led. This was named the 'quality improvement framework' (QIF). This year we have changed the title to 'our quality priorities' (OQP) to further focus our staff's minds on improving quality, rather than solely quality assurance. The OQP can be found in appendix one.

Our OQP framework is underpinned by strategies on safety, experience and engagement, clinical effectiveness and our staff strategy. These set out our longer term vision and 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 feedback, complaints and compliments to a senior clinical panel. Patient representatives also undertake unannounced visits to the ward or department.

Successes are celebrated and shared across the organisation, and areas for improvement are agreed where necessary.

Clinical quality reviews (CQRs) of nominated services are conducted in each division based on the Care Quality Commission (CQC) inspections and their identified key lines of enquiry. The CQR provides an internal assurance process which is proportionate, risk based, professionally informed and linked to what matters to patients and staff. This information includes 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 metrics are used throughout the Trust from ward to board.

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) is 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.

Our commitment to staff

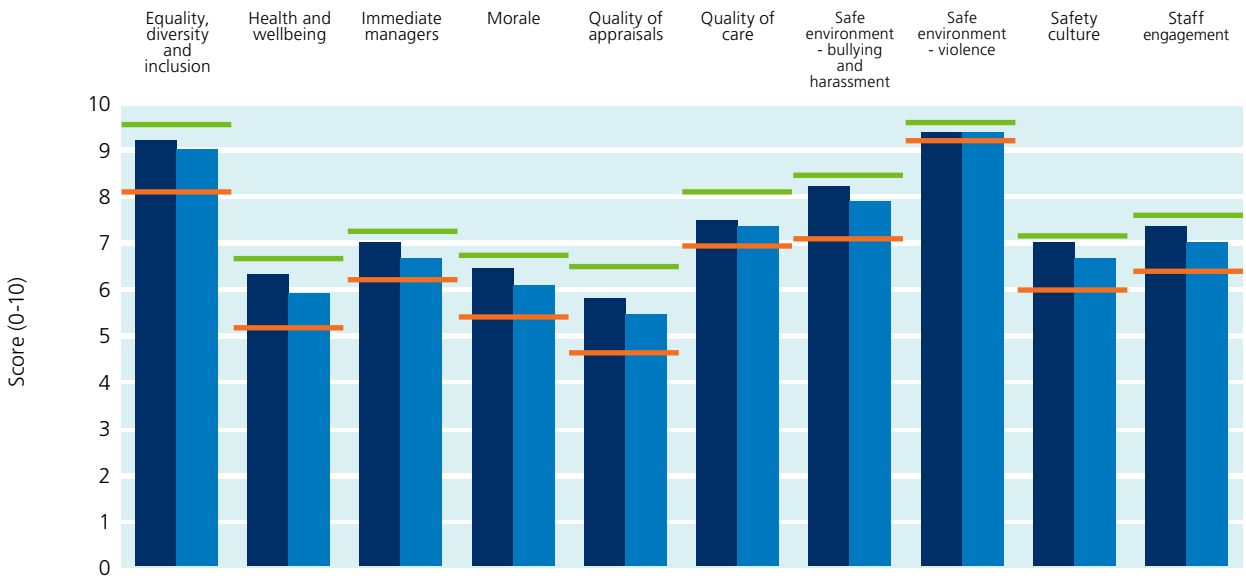
UHS has a growing reputation as a top teaching hospital in the UK and overseas. It attracts candidates locally, nationally and internationally and is also one of the largest employers in Southampton. With over 11,900 staff and 1000 volunteers working in a diverse range of healthcare related fields, we believe the Trust offers an exciting and rewarding place to work. In 2019 the Trust was awarded 'good' 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.

The staff survey is based on a series of nationally set questions on aspects of working life in the NHS. The most recent survey was conducted between the 8th October and 7th December 2018 and at UHS 4658 people responded, which equates to 43% of eligible staff.

Out of the 10 survey themes (see below), the Trust scored above the acute average for all themes. Other results to celebrate were:

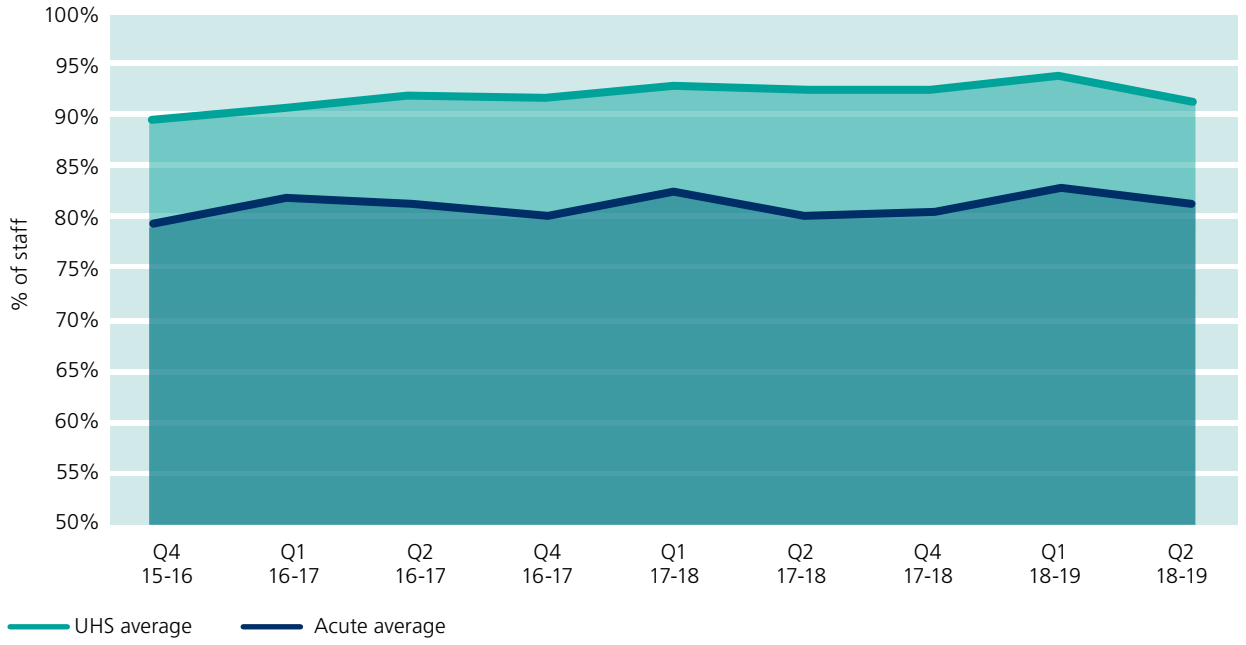
- Staff engagement at UHS has remained consistently high (7.4) compared to the NHS average (7).
- UHS is ranked as seventh best Acute Trust and the third best university teaching hospital for staff engagement overall.
- UHS has seen significant improvements in the 'Quality of Appraisal' theme. This has increased from 5.5 to 5.8.



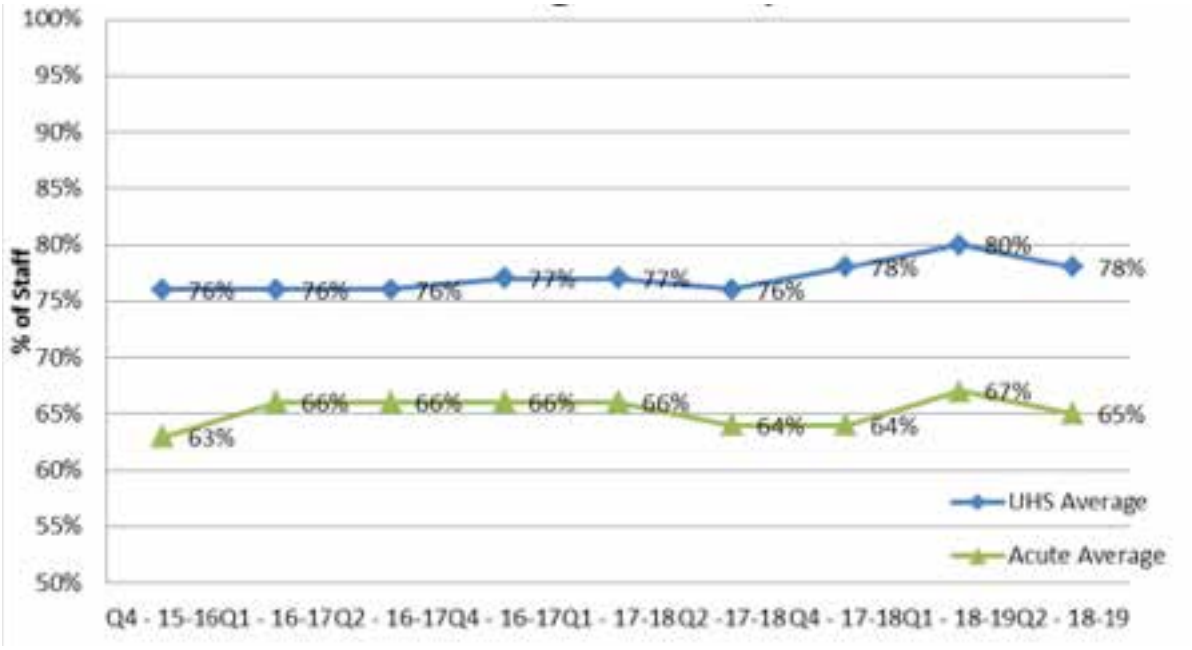
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.2	6.3	7.0	6.4	5.8	7.5	8.2	9.5	7.0	7.4
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4

The Friends and Family Test asks every quarter (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 2018/19, the Trust achieved a 92% result for question 1 (against an acute average of 81%), and a 78% result for question 2 (against an acute average of 65%). The Trust continues to improve in both areas as can be seen below:

Staff recommending UHS as a place for care or treatment



Staff recommending UHS as a place to work



Over the next 12 months we will continue to promote the NHS staff survey and Friends and Family Test to encourage as many staff as possible to respond. 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 2018 survey:

''This is currently a challenging time for healthcare but I believe that UHS, within the constraints, strives to provide high quality care, recruiting and developing a workforce to deliver this.''

''I love my job and when I get up in the morning for work, I'm always happy to see what the day holds.''

''Thank you for being part of this amazing organisation. I love the NHS and UHS in particular for the daily service it provides to the public and to its employees. I am equivalently proud that I'm now able to help and mould the future of this service.''

''Love being able to cycle to work, lock my bike up in a secure facility, shower and change ready for the day.''

''I am happy and proud to be part of my team, organisation and my Trust. I believe that we deliver a very high standard of care to our patients and a very high standard of work ethic. I believe my team makes significant contributions to make the life of our patients better and we have the support of our colleagues and our management team.''

Freedom to speak up

The Trust is committed to continuing to promote an open, honest and transparent culture which allows staff to 'speak up, speak out'. In response to recommendations by Sir Robert Francis in his Freedom to Speak Up review, UHS has generated a Raising Concerns (whistle blowing) Policy which contributes to developing a more open and supportive culture that encourages staff to raise any issues of quality of patient care, bullying and harassment or patient and staff safety.

This policy establishes clear lines of escalation for concerns to be raised:

1. Raise the matter with your line manager
2. Contact the FTSU advisor
3. Contact the executive director
4. Contact the non-executive director
5. Raise the concern externally

It also explains how staff will be supported through the process and makes clear that the Trust will ensure staff who speak up do not suffer detriment by stating:

> **'If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns'.**

It also outlines how feedback will be given:

> **'We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others)'.**

In addition, Christine Mbabazi has been appointed as the Trust's freedom to speak up (FTSU) guardian. She meets quarterly with the CEO and every six months with the executive and non-executive team. We have a FTSU policy and have appointed and trained FTSU champions across the organisation to make sure that staff have easy access to support to raise concerns.

Auditing of compliance and effectiveness is the responsibility of the FTSU guardian in conjunction with the executive and non-executive leads for Whistle Blowing and the raising concerns steering group (chaired by the executive lead).

Our commitment to education and training

This year our training, development and workforce team have successfully led and contributed to many initiatives and workstreams that aim to ensure we have a fit for purpose workforce providing the highest quality patient care in a supportive and developmental working environment. Whilst there have been many achievements across 2018/19 the following have been identified as key.

The Trust has started 50 nursing degree and 30 nursing associate apprenticeships which includes pharmacy support and senior healthcare support worker apprenticeships. The clinical engineering department have also been successful in creating a career pathway using the different levels of apprenticeships available and now have 12 apprentices. This will help with recruitment and retention of a workforce which has, at times, been difficult to recruit to. These apprenticeships have enabled widening participation opportunities for the healthcare support workers in the Trust. This is part of the Trust's approach to building a sustainable nursing workforce.

UHS Talent Management strategy has recruited four graduates who are undertaking a management apprenticeship to help develop their skills whilst rotating through various managerial roles in clinical divisions. UHS has developed partnerships with higher education providers (HEI's) over the course of 2018/19 including the:

- Pre-registration physiotherapy programme - University of Winchester
- Pre-registration adult nursing programme – Solent University
- Pre-registration adult nursing programme (apprenticeship) – BPP University

Advanced practice has continued to be supported with an increasing demand for the UHS in house history taking and physical assessment (HTPA) programme linking to the ongoing work streams around advancing practice in non-medical professions; 108 staff received HTPA education during 2018/19 with further capacity added for 2019/20. There is continuing collaboration with HEIs to ensure there is capacity for academic accreditation of staff who wish to proceed with further master's level education in the future.

In medical education there has been a year on year increase in overall satisfaction on the General Medical Council (GMC) survey of post medical trainees. UHS was ranked 44th in 2015, 11th in 2017, and 6th in 2018 for acute hospital trusts. The only similar sized hospital ranked higher that UHS in the 2018 survey was Newcastle-Upon-Tyne. This result has been supported by a culture of listening to trainees and actively seeking their views.

There has been continued investment in medical education leadership throughout 2018/19 following the appointment of divisional directors of medical education in 2014. These roles are aimed at post medical trainees and will have contributed to the GMC survey outcomes.

There has been a clear focus on medical staffing as it is known that one of the impacts of vacancies is the reduced quality of training. There has also been continued investment in the medical fellowship programmes across UHS which supports improved recruitment and individual development.

Following the positive feedback from the first two cohorts of our Inclusive Leadership programme we commissioned a third one with our partners People Opportunities. An evaluation report using a range of methodologies was able to demonstrate how participants from the first two cohorts had benefitted in new skills, increased self-assurance and a greater appreciation of inclusivity and its role in creating healthy workplaces. Two participants have had positive changes in role.

We have continued the roll out of The Appraisal Conversation, our three-hour training module to accompany the launch of our new values-based appraisal. So far over 600 appraisers have attended the workshop. Our aim is to enable managers and staff to be able to have open, honest and informed conversations about potential, performance and careers. We expect to measure the impact through improvements in the appraisal based questions in the staff survey.

Many of our programmes are well established – our clinical leaders programme is now in its ninth year and, to date, 264 individuals have completed or are undertaking the programme. Currently, two of our four divisional heads of nursing are alumni, as are twenty of our thirty-nine matrons. 80% of alumni are still working at UHS.

Our UHS introduction to operational workforce planning' sessions ran between July and October in 2018 and were well received. These workshops were aimed at staff with workforce planning responsibilities throughout UHS. They introduced the Six Steps Methodology to integrated workforce planning (Skills for Health, 2008), an evidence-based tool supported by NHS Improvement (Developing Workforce Safeguards, October 2018).

UHS has launched our Virtual Learning Environment (the new learning dashboard) making it easier for staff to view their individual statutory and mandatory training requirements including current and future status of these learning requirements. The new system also enables staff to link directly to eLearning modules and course bookings for any specialised/specialty training pathways required. The system also enables improved customers surveys to gather evaluations and feedback to support the enhancing of learner experience.

In 2018 we launched two new mobile apps (AllocateMe and MyESR) which are designed to improve employee work-life balance by giving highly secure 24/7 internet access. UHS has introduced quarterly user forums targeted to the needs of attendees. This approach enables informal knowledge sharing and best practice, covering systems and processes for VLE, ESR, workforce planning and safe staffing deployment (rostering).

UHS has also developed one-off master classes to inform and prepare senior staff for new and important changes such as NHS Improvement workforce deployment requirements and assessment levels. There has also been work to streamline eLearning for managers and administrators for key business critical systems.

We have been involved in a number of career events with local schools and colleagues to help inspire the next generation to consider a career in healthcare. This has included hosting our annual event at UHS for local school children to come and meet professionals across a variety of Healthcare Science and AHP careers.

The team continue to provide high quality clinical skills training, preparation for examinations and organise the Observed Simulated Clinical Examinations (OSCEs) for University of Southampton medical students. Clinical skills and simulation training is also provided for UHS clinical teams, helping to ensure staff are safe to practice.

We continue to offer other learning interventions of a more bespoke nature, including 360 feedback, psychometrics and coaching.

Our commitment to staffing rota gaps and the plan for improvement to reduce these gaps

UHS has established a systematic, evidence based and triangulated methodological approach to reviewing staffing levels six monthly linked to budget setting to reflect requirements arising from any developments. A Staffing Status Report is submitted to the Trust executive committee (TEC) monthly and a consolidated annual report submitted to Trust Board and includes updates on rota gaps and the plan for improvement to reduce those gaps for all staffing groups.

The UHS medical vacancies position improved during 2018 due to the new contract which commenced in August 2018.

New junior doctors (including those in the GP lead education model) were employed, and vacant consultant posts decreased as per approved plans.

All consultant recruitment is controlled through business case approval.

Focused work to fill remaining gaps in rotas remains through transfer to the NHSP Bank platform.

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 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 2015-18. Two key work streams are also underway 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.

In the four years the service has been running over 14,000 patients have been registered across thirteen hospital sites. The wider rollout of My Medical Record now includes cancer, paediatric nephrology, paediatric cardiology, cystic fibrosis, multiple sclerosis, sleep teams (adult and paediatric), inflammatory bowel disease and rheumatology. These systems and the way clinicians and patients can now interact is delivering significant improvements in care provision.

In 2018/19 we have successfully continued the transition from traditional paper based records to an electronic programme known as Electronic Patient Record (EPR). This is a rolling programme with areas going live in a planned manner, but it now means we have been able to close down our off site paper records store. The benefits are significant with clinicians now able to access electronic records instantly.

We have also introduced a patient acuity monitoring system which is now live across all normal care wards throughout 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. This early warning score is now based upon the national early warning score (NEWS2) protocol which is recommended for use throughout the NHS – this standardising of a single protocol reduces risks.

Global Digital Exemplar projects have continued to be successfully developed and include the completion of the rollout of electronic whiteboards throughout the Trust. 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.

The Trust's instant messaging solution MedXnote is another example of technology assisting clinicians. Traditionally clinicians have been contacted via the inefficient and outdated process of being bleeped; this distracts them from the tasks they currently have in hand. MedXnote provides clinicians with a secure means of instant communication either as an individual or as a group. The message provides them with the information they need, for example the requirement to follow-up with additional diagnostic tests. Currently 60,000 messages are being transmitted per month but we expect this to grow exponentially.

MedXnote utilises what are known as 'bots' to help provide access to useful information, for example, a clinician who subscribes to the 'flu bot', will be notified of any of their patients whose pathology has tested positive for influenza. This allows staff to ensure the patient is isolated and receives appropriate treatment immediately. This is proving to be such a success it featured on BBC News in January 2019.

Our commitment to the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Partnership Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against the Trust during 2018/19.

The Trust has not participated in a special review by the CQC during the reporting period.

The registration details are available on the Care Quality Commission website.

The Care Quality Commission inspected the Trust in December 2018. The inspection focused on the quality of four core services – urgent and emergency care, medicine, maternity and outpatients – as well as management and leadership and effective and efficient use of resources. In January 2019 NHS Improvement completed a Use of Resources (UoR) inspection and the CQC completed their inspection.

The report was published on the 17 April 2019 and the Trust was rated as 'good' overall and 'outstanding' for providing effective services.

All sites and services across the organisation are now rated as 'good' in the effective and caring domains, with Southampton General Hospital 'outstanding' in these areas.

Urgent and emergency care received an overall rating of 'good', with 'outstanding' scores for effective and caring services. Medicine (including medicine for older people) was rated 'good' overall with 'outstanding' for caring and responsive services.

Maternity received a 'good' rating overall and in all individual categories other than safety, which recorded a 'requires improvement' rating, while outpatient services were rated 'requires improvement' – both largely due to the quality and age of the estates and facilities.

Southampton Children's Hospital remains 'good' overall and 'outstanding' for care.

As part of the report, the CQC also published the Trust's UoR report, which is based on an assessment undertaken by NHS Improvement of how effectively and efficiently trusts are using resources.

UHS was rated as 'good' in the well-led category and for using its resources productively, with its combined UoR and quality rating now 'good'.

"There is so much for us to celebrate across the organisation in this report given the challenges facing the NHS and our 'good' rating is testament to the quality and commitment of our staff, who continue to work tirelessly to provide the best possible services" said Gail Byrne, director of nursing and organisational development at UHS.

"We are particularly pleased all of our services are now rated either good or outstanding in the effectiveness and caring domains and to receive such positive feedback regarding the culture across teams and departments.

"The inspection has highlighted some areas in need of improvement, particularly around the difficulties of an ageing estate and increasing volume of patients, but the report also acknowledges how our staff work hard to mitigate any risks presented."

Dr Nigel Acheson, the CQC's deputy chief inspector of hospitals for the south, said: "Our inspectors found a strong patient-centred culture with staff committed to keeping their people safe, and encouraging them to be independent. Patients' needs came first and staff worked hard to deliver the best possible care with compassion and respect.

"Inspectors saw many areas of outstanding practice, with care delivered by compassionate and knowledgeable staff. Several teams led by example with a continuous focus on quality improvement.

"The Trust did face some challenges especially with the ageing estates. Some patient environments were showing significant signs of wear and tear – but again staff were doing their utmost to deliver compassionate care.''

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	Outstanding	Good	Requires improvement	Good

Our commitment to improving the environment for our patients

UHS has been involved in patient-led assessments of the care environment (PLACE) since 2013.

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public. The assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia and with disabilities. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

During 2019 the format of these assessments is to be changed by NHS Improvement. Staff and patient assessors from UHS have been involved in the steering group looking at the changes and UHS has recently undertaken a pilot 'mini PLACE 'assessment to evaluate the new forms and process.

Area	2017 Score	2018 Score	2018 National average
Cleanliness	98.5%	98%	98%
Food	84%	89%	90%
Privacy, Dignity and Well Being	75%	76%	84%
Condition, Appearance and Maintenance	94%	90%	94%
Dementia	62%	59%	79%
Disability	68%	63%	84%

In response to our feedback

- We have formed a new PLACE task and finish group to address this and additional funding has been secured to support this.
- The reduction in the dementia scoring is a concern but is consistent with many trusts who found a similar decrease in their dementia scores. This may be due in part to the fact national dementia standards were reviewed and updated.
- The concerns of patients with a physical disability have been partly addressed by providing new wheelchairs for the main entrance that have a deposit system. We have plans to roll this out for other entrances.
- The PLACE system identified an issue for patients with hearing problems and the existing hearing loops have been updated and are now installed in all the main reception areas. Additional hearing loops are available in outpatient areas and other key locations throughout the hospital, including portable loop systems that can be made available as required.
- The disabled toilet in the main entrance has been refurbished to a high specification.
- There are plans to install seating and improved handrails along some of the long corridors.
- There are also plans to identify areas across the hospital for staff to have private conversations with patients.

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.

UHS provides local acute and elective care for around 700,000 people living in Southampton, the New Forest, Eastleigh and Test Valley. We also provide care for residents of the Isle of Wight for many services. As the major university teaching hospital on the south coast, UHS provides the full range of tertiary medical and surgical specialties to nearly 4 million people in central southern England and the Channel Islands.

UHS was not subject to the Payment by Results clinical coding audit report 2018/19 by the Audit Commission. 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 improve people's lives and health through world-leading clinical research studies and trials across most medical specialties. As a result, patients at UHS have some of the best access in the country to the latest medical advances, diagnoses, therapies and treatments.

The number of patients receiving relevant health services provided or subcontracted by UHS in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 20,000, making UHS consistently one of the top 10 centres for recruitment in England, and top five when taking study complexity into consideration.

Embedding clinical research

In 2018/19 we secured over £20 million of external funding to support and further expand our research activities in collaboration with the University of Southampton.

With over 850 studies active at any one time, research is embedded across all clinical services at UHS, allowing us to understand more about the conditions we treat and improve healthcare services for our patients.

This includes research delivered through the NIHR Southampton Biomedical Research Centre, which specialises in respiratory medicine, critical care, nutrition, microbial science, data science and behavioural science, the NIHR Southampton Clinical Research Facility (CRF), a dedicated centre for experimental medicine.

Delivering pioneering research

2018/19 saw a number of significant discoveries recorded across many clinical areas. This includes discovering a link between two conditions that commonly affect children – attention deficit hyperactivity disorder and asthma – and research that has shown even low levels of psychological distress can increase the risk of developing chronic diseases, such as arthritis and cardiovascular disease.

A range of world-first studies were also led by the Trust, including an international trial to test a new, three-part treatment for children with neuroblastoma (one of the most common childhood cancers). The study, known as MiNivAn, aims to boost the body's immune system to kill off cancer and will be one of many to be conducted at the University of Southampton's Centre for Cancer Immunology.

A pioneering trial of a new nose drop containing a type of modified 'friendly' bacteria to help prevent meningitis saw its first participant recruited at the NIHR Southampton CRF in November 2018. As part of this world-first study, researchers have inserted a gene into a harmless form of bacteria to help it remain in the nose and cause an immune response. It is hoped the enhanced 'friendly' bacteria will protect against the strain responsible for causing a severe type of meningitis.

Driving technological advances

A number of new and innovative technologies were developed and tested at UHS throughout the past year – pushing the boundaries of research and helping us improve how we treat conditions and shape the future of healthcare.

This includes a surgically-implanted electronic device to treat chronic lower back pain, a digital app to predict the risk of asthma in children, and a pioneering wireless monitor to measure the environment inside the womb and better understand issues relating to fertility.

Also, a Southampton-led international study using state-of-the-art digital imaging to better understand the common eye condition, age-related macular degeneration (AMD), received nearly £4 million funding from the Wellcome Trust.

This five-year research project involves teaching computers to analyse high resolution images of the inside of the eye to help identify what changes appear in patients with early AMD and those who go on to develop the later stage of the condition.

Always improving

As well as the day-to-day delivery of clinical research trials and studies, Southampton has recently been involved with a national project to introduce research in Care Quality Commission (CQC) inspections of NHS trusts.

This is a major, positive step forward for clinical research on a national level and signifies the value it brings to improve health and care for NHS patients.

We are pleased to have contributed towards this work and to have recently been inspected. We are now awaiting feedback from the CQC and how UHS can develop further to bring even more of the latest discoveries into the clinic to improve people's lives and health.

Review of services

During 2018/19 UHS provided and/or sub-contracted 107 relevant health services (from Total Trust activity by specialty cumulative 2017/18 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 2018/19 represents 100% of the total income generated from the provision of NHS services by University Hospital Southampton NHS Foundation Trust for 2018/19.

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 the quality of services, better outcomes for patients and to 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 2018/19 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 Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The conditional income in 2018/19 upon achieving quality improvements and innovation goals was £14,182,000. This compares to the 2017/18 figure of £13,821,000.

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 2018/19 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 2018 - March 2019 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2018 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number were:
- 99.3 % for admitted patient care
- 99.7 % for outpatient care
- 95.3 % for accident and emergency care

Which included a valid General Medical Practice Code were:
- 100 % for admitted patient care
- 99.6 % 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 V14.1 2018/19 was 71% and was graded green (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.

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

- Generating clear responsibilities for data domains (e.g. customer, product, financial figures), as well as roles (data owner, operational data quality assurance / data stewards).
- Use benchmarking tools such as the Model Hospital data to compare performance against peers
- Use of electronic white boards on wards benefitting data accuracy and patient flow.

Participation in national clinical audits and confidential enquiries

During 2018/19 55 national clinical audits and four national confidential enquiries covered NHS services that UHS provides.

During 2018/19 UHS participated in 98% (54) 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 2018/19 were:

- Acute bowel obstruction (start 2018/19)
- Long term ventilation in children, teenagers and young people (start 2018/19)
- Pulmonary embolism (start date Feb 18)
- Peri-operatives Management of Surgical Patients with Diabetes Study complete. Awaiting for report winter 2018 – data collection ongoing into 2018/19 year

The national clinical audits that UHS participated in, and for which data collection was completed during 2018/19, are listed in table 1 in appendix four 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.

The locally selected quality indicator our Council of Governors chose for 2018/19 was avoidable Hospital, Acquired 33* Grade III and IV Pressure Ulcers.

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

The Trust currently meets all four of these standards and delivers comprehensive seven day service. This helps keep patients safe seven days a week and helps with flow through the hospital.

Priority clinical standard 1: patients should not wait longer than 14 hours for initial consultant review
We have achieved this by investing in our consultant and clinical teams to deliver services seven days a week. The teams are supported to work together across the 24 hour period by excellent IT ensuring clear task management. We measure this achievement in an annual audit and are currently compliant with this standard.

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. This has allowed the department to restructure its on-call service into a full shift system and for specialty advice to be available on a seven day basis. Occasional gaps in specialist radiology have been bridged by working in partnership with other organisations, this situation is now improving.

Priority clinical standard 3: patients should get access to specialist, consultant-directed interventions
We are achieving this by investing in our specialist departments including radiology, cardiology and stroke thrombectomy.

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
We are achieving this standard as 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 is not captured in the national data set.

Learning from deaths

In the first three quarters of 2018/19 and the first six weeks of quarter 4 there have been 2,030 deaths for patients under the care of UHS, of which 1,677 died at Southampton General, while 346 of our patients died at Countess Mountbatten House. The total figure of inpatient deaths for University Hospital Southampton NHS Foundation Trust, for the financial year of 2018/19, to date (01/04/2018-14/02/2019) equates to 2,023. A further seven patients died whilst under our care, within the community.

Quarter	SGH+PAH	Countess Mountbatten	Outside organisation	Total
Q1	481	108	2	591
Q2	417	107	2	526
Q3	483	88	3	574
Q4	296	43	-	339

Between 1 April 2018 to 14 February 2019, 2016 cases have been reviewed through our Internal Medical Examiners Group (IMEG). The remaining 14 cases were paediatric deaths, which went for review through their own scrutiny group, Child Death and Deterioration (CDAD). You may note that CDAD reviewed 20 cases for the year 2018/19, the difference of six were children who died in the paediatric Emergency Department (ED) who also came through our ED IMEG.

A further 24 deaths occurred that have not been included in the above figures; these are attributed to neonatal deaths. All neonatal deaths are subjected to internal review processes, such as Neonatal Morbidity and Mortality / Child Death Review Meeting, and are reportable to MBRACE and the Perinatal Mortality Review Tool. All the neonatal deaths that occurred within the Trust were deemed to be either good care where death was inevitable / unpreventable or, good care with one or two minor areas of improvement, but not likely to have influenced the outcome.

Further to the IMEG reviews, 285 cases were sent for further clarification or review.

- 112 cases were sent to a sub-speciality Morbidity and Mortality (M&M) for further questions/clarification
- 47 cases went on to have a detailed case note review at the Trust Mortality Review Group (TMRG) using the nationally approved structured judgement review (SJR) methodology
- 46 cases were sent for an urgent case review (Scoping) with the patient safety team
- 18 cases were reviewed by the Child Death and Deterioration group (CDAD)
- 8 cases were further reviewed by the Learning Disabilities Mortality Group (LeDeR)

Quarter	M&M	TMRG	Scoping	CDAD	LeDeR
Q1	40	16	19	6	3
Q2	28	12	10	5	0
Q3	30	11	14	7	2
Q4	14	8	3	2	3
Total	112	47	46	20	8

29 cases, representing 1.4% of patient deaths during the current reporting period, are judged to be more likely than not to have been due to problems in care provided to the patient.

In relation to each quarter this consisted of:

Quarter	Amount	Percentage per quarter
Q1	8	1.35%
Q2	13	2.47%
Q3	8	1.39%
Q4	N/A	N/A

These numbers have been established using the Structured Judgement Review (SJR) and Root Cause Analysis (RCA) methodologies. In both types of review, a multidisciplinary meeting takes place to examine the details of the case, where a classification score is given. Within the RCA process the next step is to 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 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	
Human factors	3
Involve other specialities	1
Process	5
System	2
Communication	7
Documentation	6
Anticipatory care plans	2

The Learning from our RCA's, indicate that communication is a key issue in the failings identified in cases where there were care concerns or avoidable features related to their death. Lack of clear oversight and ownership of patients has been a feature in a small number of cases; however these have also been the cases where the death had the highest likelihood of being avoidable. There is no evidence of a clear pattern of this occurring within any specific subspecialty groups; individuals involved in such cases receive face-to-face feedback from senior members of the patient safety/leadership development team as part of a reflective and developmental process to embed learning.

Explicit documentation of plans for care, in particular anticipatory care plans and treatment escalation plans remains, an issue. The delays in the introduction of a national or regional treatment escalation plan have contributed to this. We are now in the process of introducing a Trust-wide internal treatment escalation plan which will assist clear documentation of decision-making. This will work in harmony with the nationally approved Respect form which is being introduced within the community medical practice and which is best suited to decision-making in primary care. This will help inform decision-making and guide management decisions, particularly out of hours when cover is provided by on-call teams who may be less familiar with the patient and require a readily available source of key information in respect of treatment escalation.

Human factors are identified as a contributory factor in a high proportion of root cause analysis cases, but are specifically identified as being a principal root cause in a smaller number as documented here. This year has seen the introduction of the enhanced serious incident requiring investigation (SIRI) process which involves a facilitated whole team debrief as part of the investigation process. This enables an open discussion of cases where it is likely that the complex interaction between team members has been the principal human factor root cause behind the unfolding sequence of events. Where applicable, learning from such cases is shared widely with similar teams (e.g. theatres/IR/endoscopy).

Where systems and processes are found to be the principal areas of concern learning focuses on improving these and introducing appropriate changes or developing new pathways, processes or guidelines to improve direct care and provide better safety netting for patients accessing our services.

The broad themes for actions (from the RCA's reporting during 2018/19) are:

- Individual learning and reflection
- RCA's to be shared at sub-specialities morbidity and mortality (M&M) meetings
- RCA's to be given/shared with the Divisional Governance team and named clinician
- Trust-wide learning
- Clearer guidance
- Development of pathways, processes and guidelines

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 anonymises case study and links in with themes from complaints and litigation.
- Organisational Wide Learning (OWLs) – a practical based article, addressing recurring safety issues for example delaying antibiotics for patients with sepsis
- Patient Safety Alerts – actions that come from a serious adverse event case review or RCA which immediately needs implementation across the Trust and require notification of all clinical staff or relevant non-clinical staff

For the next reporting period the implementation of the medical examiners system will further enhance the scrutiny provided by our already robust mortality system. The medical examiners will have improved access to primary care records and healthcare records within other neighbouring trusts and will be able to provide a summary of their concerns to the other mortality review groups within the Trust such as Trust mortality review group and morbidity and mortality groups.

We aim to improve the way we share learning points from all the mortality panels with relevant clinicians and morbidity and mortality leads so that they can feed back to as many colleagues as possible with better triangulation between these processes.

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

Ongoing themes are considered and reviewed by the patient safety team and the Trust mortality Review Group (TMRG). Quarterly reports are submitted to the Quality Governance Steering Group (QGSG) and the Trust Board about the continued strive for improvement.

Due to the prospective review of deaths through the Internal Medical Examiners Group (IMEG) almost all cases with safety concerns are now identified within three working days of death, thereby largely eliminating late investigations of deaths with concerns. Unlike other trusts, the implementation of the Medical Examiners System will not see a further reduction in this timing as we already achieve this. All cases are provisionally graded according to avoidability and quality of care within three working days of death, although subsequent information may adjust this grading during the investigation, the majority are correctly attributed through IMEG.

Figures for 2018/19 period:

Total number of deaths at UHS	**2028**	**-**
Total number reviewed (including IMEG)	2016	99.4%
Number that was sent to TMRG	47	2.3%
Number sent to a serious adverse event root cause analysis	46	2.2%

Progress against 2018/19 priorities

This section outlines how we have performed against the delivery of our 2018/19 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 the experience of discharge

Our aims were:

Our aim in 2018/19 was 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.

What we achieved in 2018/19

We have embedded the SAFER patient flow initiative to improve the safety and effectiveness of our discharge process within eight care groups across the four divisions. This equates to 39 level 1 adult inpatient wards and five level 1 child health inpatient wards.

The SAFER initiative ensures a senior review, an agreed discharge date to aim for, focus on patient flow, early discharge where possible and systematic multi-professional review if discharge is delayed. The aim of the bundle is to improve clinical outcomes for patients and reduce unnecessary delays.

We have achieved an improvement in the recording of estimated date of discharge (EDD) from 47% to 95% and the number of patients discharged home before lunch has been on average 25%. We have not achieved our 30% target but we have seen some weeks of excellent performance during 2018 with figures at 29%. We have been unable to sustain this reliably.

We have continued to reduce the Trust average length of stay (LOS) in the rolling 12 months the average is down by 0.44 days which equates to 6%. We achieved the NHSE target in reducing the number of patients staying over 21 days to 200 from a baseline of 270.

To actively encourage patients to be involved with their discharge planning, on admission we provide patients with a checklist of things they need to organise for their discharge. The checklist is provided in a new inpatient welcome booklet due (launched in 2019) which provides patients with information about their stay.

We know some patients do not have family support, so we are exploring developing a discharge volunteer role. These volunteers would 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 already have volunteers visiting discharge lounges to offer support and advice.

We have improved our collaborative working with local care and nursing homes, to ensure a coordinated approach to discharge to homes. We have had 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. UHS and commissioners meet regularly to develop and deliver action plans to improve discharges.

We have been part of a commissioner-led pilot of the national red bag initiative for care home residents. Innovative 'red bags', which contain key paperwork, medication and personal items (glasses, slippers and dentures), are handed to ambulance crews by carers and travel with patients to hospital where they are then handed to the hospital team. This simple initiative helps in integrating care, to create a seamless pathway for patients so they only have to tell their story once and helps patients to be discharged more quickly.

We have been working on improving the timeliness and safety of dispensing tablets for our patients to take home (TTOs). Partly this is about making it easier and faster for doctors to write discharge summaries and prescriptions for TTOs. We have worked with patients, UHS staff, GPs and commissioners to understand what information is required in our discharge summaries. We want to make these much simpler to read and understand and less time consuming for medical staff and supporting teams to complete. A new discharge summary will be piloted in March 2019.

Once tablets have been prescribed it is important that these are safely dispensed to the patient with appropriate information on how to take them. We have developed an electronic 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. The checklist is quite simple in design. It pulls the medicines aspects from the discharge summary and presents those alongside other key safety questions. It is currently being piloted in two surgical wards.

Many of our patients' discharges are complex. We have revised the Managing Complex Discharge policy and provided training to discharge offices and ward staff. We have increased the number of discharge officers to be a visible support on the wards, attending as many board rounds as possible.

While we have made many improvements we know in some cases we are still not delivering a timely and safe discharge where patients leave fully informed and prepared for their discharge. Concerns from our partner providers, commissioners and from patients show that we still need to focus on this key quality improvement priority next year. We have therefore chosen to continue our work in the coming year as presented in priority one 2019/20.

Feedback

From a care home:

> "Mr X was discharged from ward Y this morning after being with you for 6 days. The care home was not contacted to say he was on his way, and when he arrived he did not have any of his medication or a discharge letter with him. Although we have been working with the ward to plan a smooth discharge, we were not expecting Mr X and so were unprepared to settle him in properly. After ringing the ward it was another 6 hours before the medication arrived by transport , and the discharge summary didn't come until the next day".

From a daughter:

> "Thank you for making my mother's discharge so easy. The nurses started planning with us almost as soon as she arrived on the ward , and gave us good advice about things we hadn't thought of like who could pick her up, who could stay overnight and having food in for lunch. The physios were brilliant at getting her ready to use the stairs which we were worried about and we moved furniture about to make her walking about downstairs easier. When we came to get her she was ready and it all went smoothly".

PRIORITY 2 Improving end of life care

Our aims were:

- Staff will be competent and compassionate in caring for patients and their families at the end of life.
- 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
- Whenever possible we will support patients to be cared for in their preferred place of care.
- The needs of families and others identified as important to the dying person will be actively explored, respected and met as far as possible.
- Each adult patient will have an agreed individual plan of care (IEOLCP) which includes food and drink, symptom control and psychological, social and spiritual support.
- Sensitive communication will take place between staff and the dying person, and those identified as important to them.
- The National Care of the Dying Audit results will have improved from the previous National and UHS audits.

What we achieved in 2018/19

End of Life Care Education

We have developed a programme of face to face education focusing on care of patients towards the end of life which is accessible by all staff groups through VLE. We continue to build a strong link nurse network and aim to further strengthen this by providing development opportunities by working directly with the hospital palliative care team (HPCT).

Oncology junior doctors are taught how to talk with patients and families about uncertainty and dying regularly as are all University of Southampton fifth year medical students. The FY1 and FY2 doctors receive teaching about this as part of their mandatory training programme.

The HPCT continue to influence the care of far more patients than they see by role modelling and situational teaching which form part of their day-to-day clinical practice.

Individualised care at the end of life (IEOLCP)

Revision of IEOLCP is in progress with input from bereaved families. An initial draft was presented to the End of Life Care Operational Group and a second draft has been developed for further consideration. It is anticipated the plan will be piloted in medicine for older people (MOP) in the first quarter of 2019/20.

Our spiritual care team continue to provide a comprehensive 24/7 spiritual and religious care service, particularly for those requiring end of life care. In terms of specific faith provision, the team is a diverse one, covering most of the major faith/belief groups and has contacts within the local faith communities as an additional resource. Currently, there is a gap in provision for Sikh patients and the service is currently engaged in conversations to meet this need. Whilst there is always a generic chaplain on call, Roman Catholic provision has proved challenging over the past six months, in terms of local Catholic priests being available to cover on call when the chaplain is off duty, but the R.C Diocese is in the process of addressing this.

Survey of bereaved relatives

There is now a rolling survey of bereaved relatives providing a formal mechanism to feedback their experiences either in paper or electronically to the Trust. Results are collated quarterly highlighting themes for learning across the divisions and specific clinical areas. This is fed back to the UHS end of life care operational and strategic groups, as well as to senior ward leaders across the organisation. The results form the basis of a key performance indicators (KPI's) which is reported to Trust Board.

Learning from complaints

The Trust's patient relations department is actively working to ensure that any complaint relating to end of life care is recognised as such even if the complaint has not been coded as end of life care. We are also seeking to ensure the Trust reduces the time that patients and families wait for the Trust's response to a complaint. The work with families in the review of the IEOLCP arose from informal concerns about aspects of care whist dying.

National Audit of Care at the End of Life (NACEL)

We have participated in the 2018 National Audit of Care at the End of Life. The provisional results indicate improvements in many of the aspects of end of life care, including recognition of dying where we appear to be performing significantly above the national average. Definitive results are expected in May 2019. These will be widely shared across the Trust and with the joint Southampton City and West Hampshire End of Life Care Steering Group.

Proactive palliative and end of life care

In the last year the palliative care team have been able to focus on developing a more proactive approach with the appointment of an additional two palliative medicine consultants. The developments in the work at the front door of the hospital; ED, AMU and MAOS is intended to promote decision making for patients approaching the end of life to facilitate their end of life care preferences and early management of effective symptom control. We have developed a palliative heart failure clinic and palliative renal clinic and in addition, we are working closely with General Intensive Care Unit, the cystic fibrosis and TYA units to promote advance care planning and provide specialist Palliative care input to situations where clinical decision making is particularly complex.

A quality improvement programme between medicine for older people and surgery has identified that older patients with frailty and co-morbidities need extra support during admissions and have a length of stay three times longer than younger patients. This quality improvement project is trying to improve the care of patients many of whom are in the last year of life and enable them to return to their preferred place of care more quickly.

A five bedded frailty unit was opened in December 2018 seeing around 25 people aged over 80 at UHS with medical emergencies every 24 hours. Until December these patients would have been assessed and treated in the emergency department prior to admission to a ward. They are now moved on arrival to the new frailty unit, where they receive rapid assessment by a team led by consultant geriatricians. This is a quieter and much less disruptive environment for the patients, many of whom are in the last year of life. Following assessment, some patients are able to be discharged immediately to their preferred place of care with appropriate support. Others can be admitted direct to medicine for older people wards, rather than to AMU, which also reduces the number of bed moves they experience.

We have co-designed a system to highlight all patients who are prescribed an individualised end of life care anticipatory drug bundle and in addition the UHS SafeTrack system is being modified to allow patients who are at the end of life and who are no longer for NEWS activation to be identified. These innovations will contribute to the palliative care team providing earlier interventions for patients who may require their specialist input for symptom control and facilitation of end of life care preferences. This is also affording extra educational opportunities for ward staff.

Strengthening UHS commitment to end of life care

We have embedded within the Trust's already established clinical accreditation scheme a review of end of life care as an essential part of this quality review. This reviews the quality of documentation IEOFLCO, the record of daily assessments of condition and needs, evidence of patient and family involvement in preferences and decision making and evidence of appropriate anticipatory end of life care medication prescriptions in line with NICE Quality Standard 144.

We have identified themes from the reviews carried out since May 2018. The availability of single rooms to improve privacy, dignity and a peaceful environment continues to be a challenge and is mirrored in other metrics such as our rolling bereavement survey. We fall below the national mean for adult single patient occupancy rooms 21.3% compared to 27.1% nationally.

The CAS reviews have also shown the following;

- An improved culture of involving carers in care
- When possible pet visits at patient request in last few days of life
- Good use of debrief and staff support
- End of life care plans being used well
- Family feedback is actively sought
- Patient choice is culturally improving
- Excellent feedback about working relationships with palliative care team

We have restructured the executive end of life care strategic group, strengthening the commitment of Trust HQ and executive and non-executive leads for end of life care and that this is a priority for all divisions.

Care after death

An online education tool for ward staff has been created with the mortuary team to improve care of the patient after death.

The CQC recognised the crucial role of IMEG and commented that learning from deaths is very strong within UHS.

Feedback

From a relative:

"Thank you so much for all your support and kindness to dad… and his family. You made an unbearable time bearable. Because of you Dad was able to have a graceful exit. Please keep up the excellent work - it does not go unnoticed".

From a sister:

"I wanted to say a huge, huge thank you for the amazing care you gave (patient's name) during his time on the TYA. You are truly a brilliant bunch of people and supported us all through the most difficult time of our lives. You made every effort to make… time in hospital as comfortable as it could be and took the time to explain everything to us so we all understood. Always with a smile and quite often a laugh. He was so lucky to have been cared for by your team and I really can't thank you enough".

From a mother:

"…for the kindness, the care and the support you gave him and indeed all of us, his family. I know this sometimes meant going the extra mile and I thank you for that. (Patient's name)… certainly appreciated the times that the doctors, (Specialty CNS) and the palliative care team dropped in to check on how he was and gave him the time to raise any worries that he or we had. I was very impressed by this".

From a relative:

"We just wanted to express our heartfelt thanks to all the lovely staff who cared for our son… and for us during his stay… it is the staff who really make the difference. We can't remember all your names but pleased be assured that each of you did a wonderful job - in direct care… in explaining things, in arranging his swift move home. In particular, the holistic approach to coordinating all the relevant services was very impressive. You all treated (him) as an individual. Thank you".

From a relative:

> "Thank you so much for all your support and guidance on Mum's final journey. You do such a very difficult job with sensitivity and tenderness and it very much appreciated".

From a brother:

> "We were so pleased at the care given to our dear brother… Doctors and nurses were excellent… having a Catholic priest present to attend to his spiritual needs was a great comfort to us his close family and to him".

From a son:

> "The ward and facilities were such a blessing at a difficult time… but it is the staff who really make the difference. We can't remember all your names but please be assured that each of you did a wonderful job, in particular the holistic approach. You all treated him as an individual".

PRIORITY 3 Shared decision making (SDM)

Our aims were:

NHSE asked us to carry out the shared decision making CQUIN for two years, with year one focusing on transcatheter aortic valve implantation (cardiology) and neuro-oncology and neuro-surgery teams.

What we achieved in 2018/19

A working group was established to agree which parts of the pathway (decision nodes) present different treatment options and review tools.

An implementation plan was then written and submitted to commissioners. This included a team building and training plan for staff, and agreeing a plan for the mechanisms used to gather and analyse information about decisions made to ensure evaluation.

We then completed a pilot to test and evaluate the use of our SDM tool and further develop it to meet shared patient and service needs. Results can be found in appendix eight.

The results from both the original cohort of patients surveyed prior to using SDM methodology, and the results for the cohort of patient's surveyed following implementation of SDM were in the final report for the 2017/18 financial year. For implantable cardioverter defibrillators this will be provided in the final report for the 2018/19 financial year.

Recruitment has continued for neuro-oncology and TAVI and questionnaires continue to be collected. Although the CollaboRATE questionnaire was felt to be less useful than the SDM-Q-9 questionnaire we are continuing to use it in both of these teams. We took the decision to continue to use both questionnaires to ensure that we can continue to compare our new results meaningfully with the results from the original cohort of patients.

In summary, we have passed the CQUIN for the entirety of 2017/18 and the first half of 2018/19 so NHSE consider we have met all our targets so far and introduced shared decision making with patients in neurosurgery and cardiology.

Feedback

Feedback from a patient:

> ''I really didn't want to just be told what the doctor was going to do – I wanted to know what my choices were and had read a lot about my condition online. I went with a list of what I wanted to talk about but I wasn't sure if they'd listen. In the end the doctor let me talk through all of my worries and I felt we made the decision together''.

Feedback from a son:

> ''I was pleased about how much the doctor wanted to know about what my mother wanted. She's elderly and used to being told what to do by her doctor. I think she was a bit surprised, but I was happy he listened and she was able to say she didn't really want to be taking drugs after the operation and he went with her decision''.

Patient safety

PRIORITY 4 Recognition and management of the deteriorating patient

Our aims were:

In 2017/18 we sat as an outlier across the region for not adopting the Royal College of Physicians National Early Warning System (NEWS) tool.

Our aim during 2018/19 was to introduce this tool in order to:

- Improve our ability to track deterioration more precisely
- Have a whole systems approach to deterioration, escalation and response.
- Ensure better outcomes for patients – reduction in higher scoring acuity levels.
- Standardise NEWS 2 across Trust.
- Improve our ability to facilitate early detection, diagnosis and escalation.
- Reduce safety errors.
- Share key patient information.

What we achieved in 2018/19

In November 2018 we implemented the national early warning scoring system NEWS2, developed by the Royal College of Physicians (RCP) across UHS. This was an extensive roll out to all adult patients (excluding paediatrics and obstetrics).

Education was accessible through differing avenues – face to face, via the RCP webpage, resuscitation training, acute care training and local training. Education and communication was provided to medical, nursing, allied health professional teams. We achieved our target of 80% of staff having received training and awareness in the implementation of the NEWS2 tool prior to roll out. Local records were maintained to demonstrate assurance of meeting this target.

We worked closely with our partners in IT and the Safetrack team to develop the electronic platform to support NEWS2 via our electronic observations monitoring system. This enabled NEWS2 input at point of care, instantly alerting staff to patients who were reaching a threshold figure for clinical escalation. We developed ways for this information to be transferred and networked onto the whiteboards and Symphony to improve wider awareness and facilitate remote viewing.

Collaboration with partner organisations occurred through the Wessex Academic Health Sciences Network. This included South Central Ambulance Service; representatives from general practitioners, care homes, private sector and acute care hospitals within the region. This approach supported learning, and communication of the project status.

Since the introduction of the system we have started initial data gathering of NEWS2 escalations.

For January 2019 the data shows:

Clinical group	NEWS score 5 or above	NEWS score 6 or above	Number of patients
Surgery	1392	487	205
Medicine	2069	824	461
Neuro/CVT/T+O	1200	345	231
Gynae	77	22	11
	4738	**1678**	**908**

Based on previous MEWS escalations (the early warning system previously used at UHS) the data demonstrates an increase in the number of lower scored escalations; however direct comparisons cannot be made and we await future NEWS2 data to gain trends.

The outreach referral data demonstrates that there has been an encouraging increase in the number of patients being referred to the critical care outreach team since NEWS2 implementation, evidencing improved detection of deterioration:

The data also demonstrates that whilst there has been an increase in referrals to the outreach team, there is a steady reduction in those being transferred now into a level 2 or 3 facility evidencing more effective treatment being introduced at an earlier point of care.

For cardiac arrest perspective whilst the figures are small, the trend is a reduction in pulseless activity cardiac arrest (those where there are preventable causes) over the last year.

Initial feedback from our partner organisations who have implemented NEWS2 is that this is a positive transition to having a whole system approach where we all acknowledge, and recognise deterioration using the same tool.

For the next year we aim to continue to monitor and gather information relating to the implementation of NEWS2 and the effect on recognising and responding to the deteriorating patient. It is anticipated that with further work we will be able to participate in wider research and audits in relation to this area of clinical practice. We also plan to focus on improvement initiatives to the process of escalation of clinical deterioration.

Feedback

Feedback from a staff members

- "I've really noticed how much easier it is to pick up when a patient is starting to deteriorate with the NEWS2 tool. I think it guides us more".
- "NEWS2 is easier to follow than MEWS was, and I can see changes much more quickly".
- "It's easier to explain to the doctors what is happening and why I want the patient reviewed".
- "I felt the education was comprehensive and the tool is easy to use".
- "We seem to be able to care for the patients on the ward now rather than sending them to high dependency. This seems better for the patient and the families as we have already got to know them".

PRIORITY 5 Keeping patients eating, drinking and moving

Our aims were:

Eat, Drink, Move is part of a national initiative linked to #endpjparalysis and #last1000days. The #EndPJParalysis movement is a global project adopted by nurses, doctors and therapists to get suitable patients out of bed and into their own clothes rather than pyjamas or nightgowns. The initiative, which is headed up nationwide by Professor Brian Dolan, has taken on great momentum.

Our aims in 2018/19 were to align UHS with the national initiative and also link into the SAFER ward rounds, ensuring that a patient's hospital journey was moving forward at all times.

We called our version of the initiative Eat, Drink, Move as we also wanted to focus on the importance of eating and drinking well while in hospital. We aimed to improve our patients' experience and their safety, as well as promote physical activity of patients in hospital to reduce the risk of de-conditioning.

What we achieved in 2018/19

During 2018/19 the initiative was successfully rolled out in medicine for older people (MOP) and AMU and we have seen a significant change in culture in these areas, where patients being dressed in their own clothes and moving around the ward is the norm now and not the exception.

The majority of patients who are well enough are up, dressed and moving around the ward safely. All patients are offered snacks and drinks at intervals throughout the day with a variety that will meet the patients' dietary needs. We are working closely with the dietitians and Serco (our meal provider) to ensure this is happening.

We have seen measurable improvements in patient safety (pressure ulcer and falls rates), improved reports of patient satisfaction, more timely discharges, reduced length of stay and reduced laundry costs where hospital gowns/pyjamas are used. In addition, there is evidence the initiative can help improve 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.

In 2018/19 we looked at developing the role of patient support volunteers who are multi-trained, enabling them to undertake the roles of mobility volunteers, meal time assistants and time for you involvement. This volunteer role is enhancing the work undertaken through the Eat, Drink, and Move initiative.

Key indicators of improvement have been collected on MOP every month for a period of five months and will now be monitored quarterly. Progress is reported to the Eat Drink Move working party and the clinical area. Clinical accreditation scheme reviews have noted how well the initiative has bedded into the culture of the pilot wards, and feedback from patient representatives during the reviews has been very positive.

In June 2018 Professor Brian Dolan visited UHS after hearing about our work. Following the visit he commented: 'the team is an incredible inspiration to all. They carry with them the passion and vision to end PJ paralysis and later in the year the MOP therapy team was named 'most inspiring team' at the #EndPJParalysis awards.

The initiative will be introduced to surgery, orthopaedics and stroke in 2019. Training sessions will be offered to all ward staff to encourage them to embrace the change.

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.

Feedback

BBC South Today ran a story about our initiative https://www.bbc.co.uk/news/av/uk-england-hampshire-42578494/southampton-hospital-volunteers-help-patients-exercise

Feedback from patients on MOP:

"Wearing my own clothes I feel better, and my family told me I look better".

Feedback from patient on AMU:

"Wearing my own clothes makes me feel like me".

Feedback from daughter:

"It was nice to see mum looking like her. Even her hair looked nice. I felt like it was still my mum, and I brought the kids to visit which I might not have done".

Feedback from husband:

"She comes in a lot and it really worries me. When I visited this time she was always sat in the chair wearing her clothes and we even went for a cup of tea together. She just didn't seem so ill and said she felt more herself. I can't believe what a difference it made".

Feedback from staff:

"I love the Eat, Drink, Move plan. I can relate to my patients so much better as people and see them for who they are not just 'a patient'. They are so much more independent, I don't know why we didn't do this years ago – it's so simple but so effective. I'm proud of being part of the pilot and pleased it's going to roll out in the hospital. It makes a big difference".

PRIORITY 6 Delivery of the national safety strategy for maternity care

Our aims were:

- Have a greater focus on leadership
- Improve the culture in learning
- Ensure data is reviewed and acted on when there is variance
- Review safety processes
- Have a focus on patient safety and ensure that there is openness and honesty
- Ensure that we were professionally and publicly accountable
- Acting responsibly when thing go wrongs
- To recognise that all incidents can be learnt from and would be the drive to reduce future risks
- To provide support to women, staff and anyone who may suffer as a consequence
- To continue to drive quality improvement by becoming part of the Wessex learning networks which provide a forum to profile QI and patient safety in support of the local maternity systems (LMS) programme

What we achieved in 2018/19

Have a greater focus on leadership

- There has been a restructure of the midwifery managers to ensure there are correct lines of accountability, responsibility and leadership for all areas of the service
- The continued development of the professional midwifery advocate (PMA) role both within the local service and across the local maternity System (LMS)
- The LMS have implemented and supported a community midwives leaders programme to improve leadership in the community setting
- The maternity service has a safety improvement plan in place
- Locally we run manager development programmes (which included elements of leadership)
- A 'head of midwifery' development programme was established across the LMS
- A 'consultant midwife' programme was established across the LMS
- Continued development of the maternity safety champion roles

Improve the culture in learning

- The maternity service undertook a nationally run safety culture survey (SCORE) run by safe and reliable care – which gave a better understanding of the services culture of safety and learning
- The maternity service runs a 'work afterthoughts' service for staff to support and increase resilience
- Clinical supervision is in place for staff who look after vulnerable women and families
- There are a number of Wessex wide learning systems in place to increase learning from incidents i.e. Wessex stillbirth review group or the Wessex antenatal pathways group.
- There is a Wessex learning system in place that considers and learns from quality Improvement projects from across the region
- Ensure data is reviewed and acted on when there is variance
- The maternity service shares information nationally through the maternity services data set (MSDS)
- The maternity service is part of the newly formed regional 'digital maternity' group
- Data from national learning systems i.e. MBRRACE, each baby counts, saving babies lives and NHS resolution are all reviewed and gap analysis completed. Where there is variance or gaps these are reviewed.

- Data from national agencies such as get it right first time (GIRFT) and The national maternity and perinatal audit paternity (NMPA) is reviewed and investigated and processes put in place where required
- The maternity service is developing a local maternity system dashboard which will have data available to the public on key indicators
- The service uses the nation perinatal mortality review tool (PMRT) to review deaths and receive learning where appropriate.

Review safety processes

- The maternity service has reviewed the reporting structures for differing types of incidents including stillbirths, neonatal deaths, intrapartum brain injury and maternal deaths
- Learning from incidents is shared through a number of both local and Wessex wide learning forums.

Have a focus on patient safety

- The maternity service have put in place three 'safety champions' at both local and at an executive level who work together to review outcomes and safety within the maternity services.
- The maternity service has an aim as part of the Trust's OQP framework to deliver the 'maternity safer care strategy'
- The maternity service has professional midwifery advocates (PMA) in place and will increase numbers of PMA across the service over the next year. One of their functions is to work with the service to improve safety.

Ensure that we are professionally and publicly accountable

The LMS is the mechanism through which it is expected that a sustainability and transformation plans (STPs) will collaboratively transform maternity services, with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families. The LMS is currently on track to deliver:

- The implementation of the better birth recommendations
- Improving safety through the implementation of saving babies lives bundle
- Improving 'continuity of care'
- Improving support for perinatal mental health
- Improve digital /IT approaches to maternity services
- Increasing numbers of smoke free pregnancies
- Increasing and supporting learning networks
- Improving postnatal care pathways and support

Acting responsibly when thing go wrongs

- The maternity service is working closely with the healthcare safety investigation branch (HSIB) in investigating maternity serious incidents. These incidents are completed in collaboration with the family
- All serious incidents have a rapid review and a pathway for processing to ensure they are reviewed appropriately
- The service has an action tracker in place to ensure actions from incidents are monitored.
- To recognise that all incidents can be learnt from and would be the drive to reduce future risks
- The maternity service actively encourages the reporting of all incidents including 'favourable event reporting'.

To provide support to women, staff and anyone who may suffer as a consequence

- The service has a 'birth afterthoughts' service for women who have questions or concerns regarding their pregnancy
- The service will be working closely with the maternity voices partnership
- Safety champions are raising concerns (brought to them by staff) through a monthly meeting and any actions will be monitored through the risk group

To continue to drive quality improvement by becoming part of the Wessex Learning Networks which provide a forum to profile QI and patient safety in support of the Local Maternity Systems (LMS) programme

The service is an active member of the Wessex learning networks and collaboratively works with other maternity and neonatal services in the introduction of quality improvement projects. The service has an NHS Improvement agreed QI action plan in place. The key drivers for QI projects have been :

- Having a 'fresh eyes' review during intrapartum care to ensure the correct pathway and that the management is appropriate
- CTG of the day training sessions
- The drive for smoke free pregnancies
- Improve the care of diabetic women on labour ward

Feedback

Staff Feedback

"I attended one of the management leadership programmes and learnt so much I can take back to my workplace. I feel more confident as a manager".

"I appreciate the 'work afterthoughts' – it's a place where we can go and talk over stressful situations and it's good to hear other people's experiences and get their perspective. I feel much less stressed''.

"I've noticed we get more feedback from incidents now".

Clinical effectiveness

PRIORITY 7 Antimicrobial resistance (AMR)

Our aims were:

Our ultimate aim in 2018/19 was driven by the 2020 UK AMR goal to cut inappropriate prescribing of antibiotics by 50%.

Inappropriate overuse of antibiotics contributes to AMR and other clinical adverse events. In 2016/17 NHSE introduced an AMR CQUIN for all acute trusts in England centred around reducing the overall consumption of ultra-broad spectrum antibiotics (piperacillin-tazobactam [Tazocin] and carbapenems [Meropenem]) and reducing total antibiotic consumption (all antibacterials).

In 2018/19 our aim was to achieve the target reduction in Meropenem, secure £60K of income and achieve the CQUIN.

What we achieved in 2018/19

We are very close to achieving our target reduction in total antibiotic consumption although we will not know whether this element has been achieved until the antibiotic consumption and patient admissions data for March 2019 has been verified and analysed.

In 2018/19 we :

- introduced new Trust 'Sepsis' antibiotic guidelines reflecting up to date local bacterial resistance data, helping to reduce use of ultra-broad spectrum agents such as piperacillin-tazobactam
- provided a bespoke programme of face-to-face training with foundation year 1 and 2 doctors and with select consultant groups
- introduced a pre-72 hour antibiotic review tool in doctors' work list to prompt clinicians to de-escalate or stop antibiotics where appropriate and enabling generation of a formal electronic record of the stewardship decision
- developed a local antimicrobial stewardship e-Learning package now available free to clinicians
- developed an app decision support system to guide clinicians to appropriate antimicrobial selection from the Trust's electronic antimicrobial guideline ('MicroGuide') which is available on the Trust network and also as a free App on all mobile phones and tablets
- continued to provide focused antimicrobial stewardship ward rounds
- continued to provide pharmacy-led HAPPI (Hospital Antimicrobial Prudent Prescribing Indicator) audits throughout the Trust
- developed a range of defined antibiotic course lengths within e-prescribing to encourage appropriate course durations
- introduced a five day auto-stop for antibiotic e-prescriptions in JAC: unless a prescriber specifies a shorter or longer duration of antibiotic course than five days, the prescription automatically stops at day five. There is mounting evidence for the efficacy and safety of shorter course of antibiotics (e.g. five days for moderate-severity community acquired pneumonia, three days for uncomplicated lower UTI [cystitis] in women).

In line with the vast majority of acute Trusts in England, UHS will not achieve the increase in proportion of 'access' antibiotics which in the main are oral, relatively narrow-spectrum agents (such as Amoxicillin, Doxycycline and Nitrofurantoin).

This was a new target for 2018/19 which forms one of the three antibiotic 'consumption' goals. It remains to be seen whether our commissioners will accept that the 'access' target has proved to be unachievable for acute trusts across England. Once the data has been verified for UHS and other acute trusts for 2018/19 there may be a strong case to negotiate with our commissioners regarding the approximately £60K of the Trust's income associated with this particular target.

Most importantly, and in line with our overall commitment to patient safety, our improvements in reducing inappropriate antibiotic use has coincided with falling mortality for infection diagnoses including for sepsis.

Feedback

Feedback on the journey so far from a consultant:

"UHS was one of a small minority of trusts (<20%) to achieve all three of the 2016/17 antibiotic reduction targets. In fact, against a trend of relentlessly increasing antibiotic usage until early 2016 (total antibiotics and use of ultra-broad spectrum agents, the initiatives listed below led to a >6% reduction in total antibiotic use across the Trust and >12% reductions in carbapenems and piperacillin-tazobactam, usage compared with the previous financial year (2015/16).

These reductions were achieved whilst providing safe and appropriate management of infection and have coincided with falling mortality rates for UHS patient episodes coded as 'UTI', 'Pneumonia' and importantly, 'Sepsis'.

The financial gain to the Trust in 2016/17 was £668K for the AMR CQUIN and was £900K once the savings in the actual antibiotics (compared with the previous year) were taken into account.

For 2018/19 the AMR and Sepsis CQUINs were combined in a single two year 'Serious Infection CQUIN' with lower amounts of Trust income placed at risk for the three antibiotic consumption elements (~ £60K per element). UHS achieved two of the three antibiotic reduction targets (achieved for Piperacillin-tazobactam and Meropenem, and narrowly failed for total antibiotic consumption)".

PRIORITY 8 Every outpatient encounter adds value

Our aims were:

By following up patients based on clinical need rather than set periods of time we aim to provide better access to care and to avoid outpatient appointments which add no value.

What we achieved in 2018/19

Non-face to face appointments which negate the need for patients to journey to hospital have increased from 15% in February 2018 to 19% in February 2019. We have received some excellent patient feedback to evidence how much this is valued. Increasing non-face to face appointments has been achieved through implementation of:

- My Medical Record supported self-management which has been described in 'our commitment to technology' section.
- Virtual clinics, where diagnostic and imaging results are reviewed by health care professionals in order to inform treatment plans, without the patients physically attending. Specialties that have initiated virtual appointments this year include (but are not limited to): T&O, cancer care, endocrinology.
- T&O decreased their waiting time for fracture clinic from eight to three days.

Avoiding outpatient appointments that do not add value has been tested in two ways this year:

- Clinical criteria for discharge: respiratory medicine consultants have worked to agree outpatient follow up discharge criteria. These criteria will form part of the education and training of junior doctors as well as providing support to clinicians in outpatients, to discharge patients earlier in the pathway than previously experienced.
- Pathway redesign to remove unnecessary follow-up.

Working with NHSE as part of their elective care transformation program, radiology and sarcoma have worked to remove unnecessary follow-up following diagnostics and have reduced their pathway by >40 days for patients that have been through the new pathway.

In our cardio pulmonary exercise test (CPET) and high risk clinic we have achieved

- accurately predicting risk
- improved shared decision making
- reduction in high health-care and financial burden surgery
- directing pre-operative optimisation of co morbidities
- Enabling critical care triage based on risk

This contributed to 13% of patients being correctly assessed as not suitable for surgery due to risk. These patients were the offered alternative, safe treatment.

25% of patients received further workup ahead of surgery following CPET outcome (medication change/ cardiology input/ different procedure/ iron infusion/ additional tests) meaning they were clinically fit for surgery and decreasing their risk.

Over the next 12 months we will continue to develop our initiatives and work with patients and their families to improve their experience further by:

- wider testing +/- roll out of clinical criteria for discharge
- wider adoption of virtual follow up appointments
- implementation of Virtual First appointment (requires digital solution)
- digital pre-assessment
- digital One-stop
- One-stop street model

Feedback

From wife:

"Went to minor injuries at Lymington and was in and out in about 10 minutes, had x-ray done and was told he would get a phone call to discuss results – very happy with service".

From husband:

"More communication between consultants at each visit otherwise everyone was very informative and helpful and she is now receiving physio so was happy with how quickly it was all dealt with".

PRIORITY 9 Best use of resources

Our aims were:

- 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 we achieved in 2018/19

In January 2019 NHSI completed a use of resources inspection.
We were rated 'good' overall with 'outstanding 'for the effective domain.

Several areas of outstanding practice were identified:

- We were leaders in developing day case neurosurgery.
- A monthly pack for care groups setting out productivity and efficiency opportunities was produced.
- The Trust used dual qualified RMNs and RGNs on dementia wards.
- We spearheaded good practice in staff sickness management. The Trust evidenced good management of consultant job planning including use of local staff side representatives.
- Our pathology services benchmarked very well considering the complex range of tests they undertook.
- The Trust's soft FM contract with its suppliers was performance based with links to clear metrics.
- We used Patient Ambassadors to scrutinise the domestic and catering services from a patient perspective.

The following have been identified as key areas where the Trust has opportunities for further improvement:

- There were several areas within the clinical services key lines of enquiry where the Trust did not benchmark favourably compared to other trusts nationally:
- UHS did not meet any of the constitutional access standards and need to consider what further actions it needs to take to address patient access issues.
- Readmissions rates and pre-procedure bed day's rates are high partly driven by coding issues which needed to be resolved.
- We have a high day case to inpatient conversion rate and need to reduce this where possible.
- The Trust could consider widening the range of information it uses to assess its theatre productivity, in particular through external benchmarking.
- We need to improve our staff retention rate, continuing with the current actions and identifying new activities.
- The Trust should continue to switch to certain biosimilars to increase the level of savings it could achieve and reduce the number of medication incidents.
- The Trust should consider whether it requires further investment in its programme management office considering it is benchmarking very low compared to the national median and its continuous improvement and efficiency savings agenda.
- UHS' cost of the legal services function benchmarked above median and the Trust should consider the drivers of this higher cost and whether this represents an opportunity for further savings.

- The cost of supplies and services at the Trust benchmarks high and the Trust needs to continue to monitor and benchmarks its expenditure on supplies and services to ensure it achieves savings opportunities.

Priorities for improvement 2019/20

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 the 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 Our Quality 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 2019/20. Priorities are built around our ambitions and intention to deliver well-led, safe, reliable and compassionate care in a transparent and measurable manner.

"We have a comprehensive list of improvement priorities in the appendix, but we have chosen to highlight three in this part of the report."

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 Safe discharge and transfer of care

What we aim to achieve

Reduce harm to patients and avoidable readmissions due to a failure in continuity of care for patients discharged from secondary to primary, community and social care.

Improvement measures

- Reduce medication errors at discharge
- Reduce avoidable readmissions
- Increase patient and carer satisfaction with the discharge process
- Improve completion of discharge checklists
- Develop a set of standards for discharge and improve staff training around discharge processes

What will success look like

- Patients will be discharged with adequate and timely communication of essential information at the point of handover to all relevant staff and teams in primary and social care.
- There will be reduced medication errors when patients transition between healthcare providers.
- There will be continued joint working between partners in the system to improve the transfer of information at admission and discharge.
- Staff will understand their roles in the discharge process and be able to deliver care to the standards agreed.

How we will monitor and measure progress

We will monitor progress through our medicines helpline and concerns and complaints from our partners and patients.

Patient safety

PRIORITY 2 Staff are competent and confident in applying Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

What we aim to achieve

- Compliance with the legal framework under the mental capacity act (MCA 2005)
- Confidence in completing mental capacity assessments and DoLS paperwork
- Embedding knowledge following completion of eLearning
- Challenging poor practice
- Supportive measures (drop-ins, bespoke training to clinical areas, newsletters, attendance at ward rounds)
- Responsive and reactive training programmes including lessons learnt from safeguarding adult reviews (SARS).
- Improve a significant gap in knowledge and understanding of the MCA process, such as poor or no documentation, no use of DoLS, decisions not being made or recorded
- Keep up to date with changes in case law and share the changes with staff in order to remain compliant with legal changes

Improvement measures

- MCA gap analysis will be completed annually and submitted to the local authority to provide assurance. Within this gap analysis as a Trust we have committed to having MCA champions in clinical areas.

- We will be compliant with the CQC - Key lines of enquiry - EFFECTIVE :

1. E6 Is consent to care and treatment always sought in line with legislation and guidance?
2. E6.1 Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance?
3. E6.2 how are people supported to make decisions in line with relevant legislation and guidance?
4. E6.3 how and when is possible lack of mental capacity to make a particular decision assessed and recorded?
5. E6.4 how is the process for seeking consent monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance?
6. E6.5 when people lack the mental capacity to make a decision, do staff ensure that best interest's decisions are made in accordance with legislation?
7. E6.6 how does the service promote supportive practice that avoids the need for physical restraint? Where physical restraint may be necessary, how does the service ensure that it is used in a safe, proportionate and monitored way as part of a wider person-centred support plan?
8. E6.7 Do staff recognise when people aged 16 and over and who lack mental capacity are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate?

What will success look like

- No patients will be detained unlawfully
- UHS will not be in breach European directive of human rights (The Human Rights Act (2007)
- Staff will feel supported in the application of Mental Capacity Act
- UHS will Remain up to date with legal changes such as with the pending changes to the MCA/DoLS currently being debated in the House of Commons

How we will monitor and measure progress

- Staff feedback
- Audits
- Quality of Mental Capacity Assessments

Clinical effectiveness

PRIORITY 3 Improved cancer performance standards

What we aim to achieve

We will achieve two national targets :

- Two week wait (from referral until first appointment for patients suspected of having cancer)
- 62 days to first treatment (from GP referral until first definitive treatment of the cancer).

Improvement measures

- Substantive appointments to key posts in breast and prostate services
- Purchase of an additional robot to undertake robotic assisted radical prostatectomy
- Increase our surgical capacity
- We have committed to achieving the 62 day target across all other specialities excluding Urology

What will success look like

Targets will have been achieved and evidenced

How we will monitor and measure progress

Benchmarking against internal and national data

Conclusion

We are proud of the advances we have made in the quality of services we provide. However, our mission is to be better every day, and we recognise that maintaining high quality services relies upon continual day-to-day improvements alongside longer term strategic developments. We are not complacent and know that we are still on a journey to achieve excellence in all areas.

This report enables us to qualify our progress comprehensively and demonstrate that in 2018/19 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 2019/20.

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 2018/19. The CCGs have over the past year continued to work with the Trust in monitoring the quality of care provided to the local population of Southampton and West Hampshire and in identifying areas for improvement.

The Quality Account is well presented and clearly demonstrates the Trust's values, approach and vision for quality and driving improvements.

The CCGs would like to congratulate the Trust on another year of positive results from the national staff survey, Friends and Family Test and positive informal feedback from the latest Care Quality Commission inspection. The CCGs are pleased to note (following April 2019) the overall rating by the Care Quality Commission of 'good' and 'outstanding' given under the effective domain and commit to working with the Trust to address the concerns raised that resulted in the safe and responsive domains being rated as 'requires improvement'.

The Quality Account provides a clear and detailed account of progress made against the 2018/19 priorities and it is positive to see the inclusion of examples of feedback from patients, carers and staff for each of the initiatives.

Key areas of note include:

- The continued work to improve patient's experiences of discharge from hospital with the Trust embedding the SAFER patient flow initiative; reduced length of stay and actively encouraging patient involvement in their discharge planning. Whilst recognising the progress made the CCGs agree with the continued work in 2019/20 to further improving processes and communication with care homes
- Improving end of life care and strengthening the commitment of the Trust Executive leads as well as collating and learning from the survey feedback received from bereaved relatives
- The continued work in the recognition and management of the deteriorating patient and the implementation of the national early warning scoring system, NEWS2, across the Trust
- The significant cultural change in medicine for older people and acute medical unit with the Eat, Drink, Move initiative that has supported patients to become more active and independent.

The CCGs are pleased to note the Trust's achievement of elements within the 2018/19 priorities and where further progress is required that these are carried over into 2019/20. The CCGs fully support the quality improvement priorities for 2019/20 around:

- Safe discharge and transfer of care
- Mental capacity Act and deprivation of Liberty Safeguards competency
- Improved cancer performance standards which are recognised system priorities.

The Quality Account continues to provide details and transparency of the learning from deaths reviews undertaken including areas identified for improvement and the CCGs are assured that the process is robust and focused on improvement. The CCGs look forward to working with UHSFT in 2019/20 around improving the timeliness of completion of other Serious Incident investigations commissioned by the Trust and in gaining assurance of organisation wide learning around Never Events and recurrent Serious Incident themes such as administration and booking.

The Quality Account includes the new requirements for 2018/19 on progress in implementing the priority clinical standards for seven day hospital services and filling staff rota gaps. It is good to note included are details of ways in which staff can speak up and how they ensure staff who do speak up do not suffer detriment.

The CCGs note that the Trust also continued with a number of other quality improvement activities during the year, which are to be commended. Examples of note were:

- The continuation of a Clinical Accreditation Scheme to ensure quality standards are embedded at ward level using key performance indicators, patient feedback and complaints and compliments
- Clinical Quality Reviews of nominated services in each division based on the Care Quality Commission inspections and their identified key lines of enquiry.

Commissioners look forward to the Trust continuing to work with system partners to demonstrate further progress in 2019/20 to continue improving the quality, timeliness and safe discharge or transfer of care for all patients. The CCGs also look forward to seeing significant progress against the achievement of the constitutional standards not met in 2018/19 including those for Emergency Department waits and cancer and the local network wide effectiveness including timeliness of managing 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 the Trust's continued ambition to improve the quality of services. The CCGs opinion is that it meets the minimum national expected reporting requirements and provides details of levels of achievement.

Southampton City and West Hampshire CCGs are satisfied with the Quality Account for 2018/19 and support the quality priorities identified for 2019/20. The CCGs look forward to continue working closely with the Trust over the coming year to further improve the quality of services.

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

The Governors have reviewed the quality report and we were pleased with the progressive direction that the report recognised. The areas of concerns were noted and the Governors are hopeful that the financial position allows the Trust to achieve the stated objectives. The growth in the health requirements of the population covered by the Trust will test the quality of service, as well as the quantity, and the Governors will continue to seek the assurances, on behalf of the public, of the Trust's ability to maintain and deliver the high standard that it has achieved.

Bob Purkiss MBE
Lead Governor 22 May 2019

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.

I am pleased to report that the Trust has continued to consult Healthwatch Southampton on many issues. We support the idea of renaming the 'quality improvement framework' as 'our quality priorities'. UHS staff already have a sharp focus on quality improvement and this change makes it even more meaningful.

The clinical accreditation scheme (CAS) has been revised and Healthwatch Southampton has two members of its strategy group participating as Patient representatives. This provides us with a good insight into the quality of patient care throughout the Trust. We also contribute to the clinical quality reviews.

The trust places great emphasis on duty of candour and Healthwatch Southampton is always given every opportunity for an open, honest and transparent discussion. The culture is also reflected in the freedom to speak up policy.

The staff attitude survey findings make good reading and its ranking reflects our observations when talking to staff members. The staff are well supported by the Trust and this in turn reflects in the care provided.

With the acknowledged problems of recruitment and retention in the NHS, it is good to read of the initiatives taken by the Trust for Education and Training and the plans to reduce staffing rota gaps.

Patients and staff are already beginning to see the benefits associated with the increased use of technology with developments such as 'My Medical Record' and the electronic whiteboards.

It is good to read the recent CQC report on the Trust which is to be congratulated on its ratings. However, the fact that the CQC stated "The trust did face some challenges especially with the ageing estates. Some patient environments were showing significant signs of wear and tear…" Confirms comments made by Healthwatch Southampton members during the 2018 PLACE inspections. Last year we commented that we would like to see specific mention made about the PLACE inspections and the comments made by the CQC confirms our view that the environment is an important aspect of quality. We are therefore very pleased that the Trust has included PLACE in this year's report.

The expanding use of clinical research is very welcome, and many patients now benefit from these trials.

The section dealing with the progress against the 2018/19 priorities is well set out giving the aims and achievements; the addition of the feedback comments is helpful. The addition of a symbol to indicate progress is simple but effective. We are pleased to see progress has been made on all nine priority areas.

Patient discharge continues to be a source of concern for some patients and Healthwatch Southampton has recently discussed this with the Trust. Whilst it is clear that some progress has been made, it is also clear that more needs to be done and we are pleased to see that it remains a topic for improvement in 2019-20.

We are aware that the Trust is working with care homes and that is welcomed. We ae also aware that there is pressure on the Trust to reduce length of stay but we remain concerned that patients living on their own are sometimes discharged without adequate provision or protection. Ideally, discharge should be suitable for the patient as well as for the Trust.

The objective to improve end of life care was welcomed; the frailty unit is particularly welcomed. Embedding end of life into the CAS has ensured greater emphasis is maintained. Similarly, the eat, drink, move initiative is now considered as part of the CAS process and we are pleased that this initiative is being extended to other care areas. Shared decision making is important and the implementation in these trial units has obviously proved successful. We would welcome an extension of shared decision making to be the norm wherever possible.

The future year's priorities are again clear and easily understandable. However, whilst we realise the Trust is only mandated to list 3 priorities, there may be some confusion as 'Our Quality Priorities' lists 10. We are pleased that the Trust once again took the opportunity to discuss it with us. The three listed priorities are all important and we hope that further progress will be made on discharge and that good progress is made on the other two especially cancer performance. We have discussed the other priorities listed as 'Our Quality Priorities' with the Trust and support them all. We are especially keen to see progress on responsiveness to complaints. This year, the Trust established a patient representative group to look at complaint handling and good progress was made in looking at complaint response letters. This now needs to be followed up by ensuring a good and timely response to concerns and complaints.

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

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support 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 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.
- the content of the quality report is not inconsistent with internal and external sources of information including
  - board minutes and papers for the period April 2018 to March 2019
  - papers relating to quality reported to the Board over the period April 2018 to March 2019
  - feedback from commissioners dated 10 May 2019
  - feedback from governors dated 22 May 2019
  - feedback from Healthwatch organisations dated 10 May 2019
  - The overview and scrutiny committee were offered the opportunity to comment on the quality account on the 11 April 2019 but have chosen to decline on this occasion
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 9 May 2018.
  - the 2018/19 national patient survey dated May 2019
  - the 2018/19 national staff survey dated April 2019
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 28 May 2019
  - CQC inspection report dated 17 April 2019

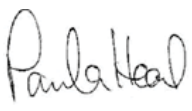
- The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the quality report is reliable and accurate.
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The quality report has been prepared in accordance with NHS Improvements' 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

28 May 2019

Chair



28 May 2019

Chief executive officer

Independent auditor's report to the Council of Governors of University Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of University Hospital Southampton NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospital Southampton NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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 2018/19 ('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 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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 10 May 2019;
- feedback from governors, dated 22 May 2019;
- feedback from local Healthwatch organisations, dated 10 May 2019;
- feedback from Overview and Scrutiny Committee, dated 11 April 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 patient survey;
- the 2018 national staff survey;
- Care Quality Commission Inspection, dated 17 April 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019; 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospital Southampton NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance. The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by University Hospital Southampton NHS Foundation Trust.

Basis for qualified conclusion

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on pages 70 to 77 of the Trust's Annual Report, the Trust currently has concerns with accuracy of data for the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator due to the accuracy of clock start and stop dates. In particular we found:

- Of 20 sampled patients classed as non-breaches, two cases were identified where the incorrect start date had been used to calculate performance. This resulted in the identification of one of the non-breaches which should have been classed as a breach. The remaining exception identified was still correct to be classed as a non-breach.
- Of 5 sampled patients classed as breaches, a case was identified where the incorrect start date had been used to calculate performance, however, was still correct to be classified as a breach.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

28 May 2019

QUALITY ACCOUNT APPENDIX

APPENDIX 1

Our quality priorities 2019/20

The UHS way

Our quality priorities have been developed following engagement and communication with staff and patients about transformation projects to improve the quality of care planned for 2019/20. The priorities have been chosen to reflect areas that are important to our patients and staff that need enhanced focus to realise improvements by year end.

- These priorities are not designed to replicate the detail in the Trust strategy and annual plan or cover all of the key performance indicators and workstreams for quality.
- The safety strategy, patient experience strategy and 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 the delivery of quality.

Well-led

- **Make equality diversity and inclusion the heart of our everyday practice and decision-making**
- **Develop our approach to understanding and acting risks**

Safe

- **Staff are competent and confident in applying Mental Capacity and Deprivation of Liberty Safeguards**
- **Ensure safe discharge and handover of care**

Responsive

- **Every outpatient encounter adds value**
- **Meeting the cancer performance standards**

Effective

- **Developing data to support decision-making**
- **Ensuring electronic records support staff to deliver care**

Caring

- **Improving our responsiveness to dealing with complaints**
- **Make health and care services better for people with a learning disability or autism**

APPENDIX 2

Quality performance data

The following agreed metrics used in previous years are no longer available as we do not collect this information any more:

- Patient Safety Indicator - Falls Assessment tool. Part way through the year the original falls assessment tool audit was withdrawn and a new audit system was put in place. As this new system is significantly different to the previous audits we feel that the compliance for each audit type cannot be compared or combined for a yearly total.

- Nutrition % of patients with nutritional screening in 24hrs (as average of monthly %). We have replaced this with: Nutrition- % Patients with a care plan in place.

- 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 2017/18. 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.

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 not yet 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	2017/18 full	Apr-Mar 2018/19
Serious Incidents Requiring Investigation (SIRI)	35	54	63	25	25 for whole year	41	49
Never Events	2	7	3	1	0	1	3
Healthcare Associated Infection MRSA bacteraemia reduction	5	3	1	1	0	2	1
Healthcare Associated Infection Census" (as average of monthly %)	357%	363%	361%	322%	100%	329%	324.18%
Healthcare Associated Infection Clostridium difficile reduction	37	35	38	27	43 for whole year	34	40
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	26	36	11	12	30 for whole year	25	20
20	9	3	0	5	1 a month. 12 for whole year	5	0
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.35%	95.18%	94.87%	93.77%	>=95%	93.65%	92.56%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	99.46%	97.75%	95.19%	93.55%	>=95%	93.25%	92.75%

	Apr - Sep 2015	Oct 2015 - Mar 2016	Apr - Sep 2016	Oct 2016 - Mar 2017	Apr - Sep 2017	Oct 2017 - Mar 2018	Apr2018-Sep2018
UHS							
Rate Incidents per 1000 admissions	31.50	41.40	44.50	43.90	44.55	34.67	35.55
Number Incidents	5911	7930	8519	8594	8364	6712	6631
Number Severe Harm	54	74	54	47	38	44	37
% Severe harm or death	0.91%	0.93%	0.63%	0.55%	0.45%	0.66%	0.56%
Highest scores (non-specialist trusts)							
Rate Incidents per 1000 admissions	74.70	75.90	71.80	69.00	111.69	124.00	107.37
Number Incidents	12080	11998	13485	14506	10016	11325	9467
Number Severe Harm	89	94	98	92	13	5	14
% Severe harm or death	2.92%	2.04%	1.73%	2.13%	0.13%	0.04%	0.15%
Lowest scores (non-specialist trusts)							
Rate Incidents per 1000 admissions	18.10	14.80	21.10	23.10	23.47	24.19	13.10
Number Incidents	1559	1499	1485	1301	1133	1311	566
Number Severe Harm	2	0	1	1	19	0	3
% Severe harm or death	0.07%	0.00%	0.02%	0.03%	1.68%	0.00%	0.53%
National average (non-specialist trusts)							
Rate Incidents per 1000 admissions	39.30	39.60	40.77	41.10	42.84	42.55	44.52
Number Incidents	4647.43	4817.60	4954.89	5122.38	5226.40	5448.89	5582.81
Number Severe Harm	19.98	19.43	18.50	19.29	18.39	18.82	18.91
% Severe harm or death	0.47%	0.43%	0.40%	0.40%	0.35%	0.35%	0.34%

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.

Cdiff per 100,000 bed days

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	2015/16	2016/17
UHS	9.74	11.82	9	11.3	18.9	25.8
National Average	14.91	15.04	14.7	17.3	22.2	29.7
Highest Trust Score	66	62.57	37.1	30.8	58.2	71.2
Lowest Trust Score	0	0	0	0	0	0
Lowest Trust Score (non-zero)	1.1	2.8	1.2	1.2	1.2	2.6

2018/19 data not available at time of publication.

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	2017/18
UHS	9	11.8	9.7	9.8	8.9
National Average	14.7	15	14.9	13.2	13.7
Highest Trust Score	37.1	62.6	67.2	82.7	91
Lowest Trust Score	0	0	0	0	0
Lowest Trust Score (non-zero)	0.9	2.8	0.8	1.2	1.4

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%

2018/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	YTD
Eligible patients	15161	16012	16573	16986	64732
Screened for MRSA	50479	54850	49538	54983	209850
% achieved	332.95%	342.56%	298.91%	323.70%	324.18%

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 these indicators, 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.

Patient experience indicators

Patient experience indicators							
	2014/15	2015/16	2016/17	2017/18 YTD (Jan Inclusive)	2017/18 benchmark		2018/19 YTD
National Friends & Family Test Response Rate							
Emergency department	37.94%	10.76%	6.21%	6.67%	>10%	5.34%	1.16%
Inpatients	25.15%	21.74%	20.28%	18.36%	>20%	17.75%	13.16%
Maternity		23.38%	29.07%	32.01%	>20%	31.16%	34.80%
Percentage of patients recommending UHS to their friends & family							
Emergency department		92.26%	95.42%	97.06%	>90%	97.08%	92.88%
Inpatients		96.16%	96.68%	97.10%	>90%	97.15%	96.96%
Maternity		95.81%	97.66%	97.50%	>90%	97.61%	98.88%
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%	No longer reported within monthly KPI board report	
Same Sex Accommodation (Non clinically justified breaches)	10	5	3	99	20 a month	177	828
Nutrition: % Patients with a care plan in place	88%	82%	80.4%	82%		82.11%	91.68%

Year	Period of coverage	Breakdown	Level	Level description	Indicator value
2017-18	Hospital stay: 01/07/2017 to 31/07/2017; Survey collected 01/08/2017 to 31/01/2018	Provider	RHM	University Hospital Southampton NHS Foundation Trust	68.3

Staff FFT

Staff Recommends Care %	2016/17 Q1	2016/17 Q2	2016/17 Q4	2017/18 Q1	2017/18 Q2	2017/18 Q4	2018/19 Q1	2018/19 Q2
UHS	91%	92%	92%	93%	93%	93%	94%	92%
Highest Score	100%	100%	98%	100%	100%	100%	100%	100%
Lowest Score	50%	44%	44%	55%	43%	36%	53%	39%

Inpatient Survey

	2015-16	2016-17	2017-18
UHS	71.70	67.40	68.30
Average (All Providers)	69.64	68.14	68.60
Lowest Score (All Providers)	58.90	60.00	60.50
Highest Score (All Providers)	86.20	85.20	85.00

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	Q1 201819	Q2 201819	Q3 201819	Q4 201819	201819
UHS	19.60%	14.30%	8.94%	4.81%	5.23%	9.52%	6.02%	4.39%	1.88%	15.50%	3.43%	0.21%	11.96%	6.21%	6.70%	0.20%	2.40%	1.20%		1.27%
National Average	21.15%	14.55%	13.05%	12.72%	12.99%	13.19%	12.18%	12.45%	12.66%	12.94%	12.41%	12.16%	14.90%	10.62%	10.48%	12.75%	12.60%	12.14%		9.57%
Highest Trust	100.00%	45.12%	44.57%	47.22%	44.43%	45.31%	45.03%	45.46%	44.85%	47.15%	58.73%	49.12%	100.00%	100.00%	100.00%	100.00%	45.20%	37.03%		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%	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	Q1 201819	Q2 201819	Q3 201819	Q4 201819	201819
UHS	22.66%	20.64%	21.22%	22.54%	20.79%	19.11%	19.87%	17.30%	20.76%	18.23%	16.23%	14.63%	21.74%	19.73%	18.40%	14.74%	11.47%	13.91%		13.32%
National Average	20.51%	26.08%	24.43%	24.43%	25.77%	25.12%	24.26%	24.32%	26.08%	25.97%	24.27%	23.26%	23.87%	17.29%	17.37%	25.24%	25.01%	24.78%		16.50%
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%	100.00%	100.00%	100.00%	109.08%		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%	3.03%	0.00%	0.00%	0.00%	1.50%	0.00%	2.17%		0.00%

Q4 data not available at the time of publication.

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	Q1 201819	Q2 201819	Q3 201819	Q4 201819	201819
UHS	2.10%	2.72%	3.12%	2.95%	3.03%	1.89%	2.49%	1.59%	1.81%	1.31%	1.65%	0.00%	2.54%	2.24%	1.42%	6.45%	0.97%	7.84%		2.98%
National Average	4.15%	6.09%	6.89%	8.37%	7.62%	7.61%	7.63%	7.01%	6.99%	7.22%	7.60%	7.67%	6.37%	5.31%	5.27%	7.36%	7.54%	7.63%		4.86%
Highest Trust	29.13%	26.11%	34.78%	37.23%	37.69%	33.31%	41.03%	32.28%	32.97%	31.03%	31.82%	20.41%	37.23%	41.03%	32.97%	30.00%	31.25%	33.33%		
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%	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	Q1 201819	Q2 201819	Q3 201819	Q4 201819	201819
UHS	1.33%	0.88%	1.41%	1.07%	1.08%	1.23%	0.75%	0.79%	0.72%	0.77%	1.14%	1.22%	1.18%	1.00%	0.89%	0.84%	0.84%	1.07%		0.91%
National Average	3.30%	1.43%	1.48%	1.47%	1.44%	1.56%	1.53%	1.51%	1.37%	1.52%	1.58%	1.62%	1.80%	1.24%	1.23%	1.52%	1.60%	1.62%		1.19%
Highest Trust	21.05%	9.34%	10.00%	11.11%	10.55%	13.01%	8.59%	9.54%	17.78%	12.50%	26.19%	12.97%	21.05%	13.01%	26.19%	8.55%	10.00%	8.21%		
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%	0.00%	0.00%	0.00%	0.00%		0.00%

Past annual figures benchmarked against their own FY Benchmark. Ongoing annual year benchmarked against latest month.

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 these indicators, and so the quality of its services; recruited a patient experience volunteer to help improve response rates. Supplemented the FFT data with focused qualitative surveys based on FFFT responses. Implemented QR codes in maternity to allow patients to leave feedback from home.

Patient outcome indicators

	2014/15	2015/16	2016/17	2017/18 benchmark	2017/18	2018/19 YTD (Apr-Feb)	
Emergency readmissions, within 28 days (as average of monthly %)	10.40%	10.10%	10.59%	<=10%	10.87%	11.39	
Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	105.19	102.5	95.4	100	89%	Can only get up to Jan 19 >	87
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	97.64	93.63	88.3	<100	82%	Can only get up to Jan 19 >	80.2
Hospital Mortality Rate (%)	1.76	1.63	1.7	1.61	1.7	Can only get up to Jan 19 >	1.5
						April-Sep	18/19 benchmark
Patient Reported outcome measures. PROMS hip replacement data contributed	74.10%	86.70%	74.00%	>=50%	63.40%	61.40%	>=50%
Knee replacement data contributed	105.90%	103.90%	104.40%	>=50%	59.30%	75.00%	>=50%

Past annual figures benchmarked against their own FY Benchmark. Ongoing annual year benchmarked against latest month.

SHMI

	January 15 - December 15		April 15 - March 16		July 15 - June 16		October 15 - September 16		October 16 - September 17	
	Value	OD Banding	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	0.95	2
National Ave	1	2	1	2	1	2	1	2	1	2
Highest Trust Score	1.17	1	1.18	1	1.17	1	1.16	1	1.25	1
Lowest Trust Score	0.67	3	0.68	3	0.69	3	0.78	3	0.73	3

	January 16 - December 16		April 16 - March 17		July 16 - June 17		July 17 - June 18		October 17 - September 18	
	Value	OD Banding	Value	OD Banding	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	0.96	2	0.95	2	0.94	2	0.95	2	0.94	2
National Ave	1.00	2	1.00	2	1.00	2	1.00	2	1.00	2
Highest Trust Score	1.19	1	1.21	1	1.23	1	1.26	1	1.27	1
Lowest Trust Score	0.69	3	0.71	3	0.73	3	0.70	3	0.69	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 in this quality account.

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%

	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
UHS	93.60%	92.78%	93.13%	92.91%	92.49%	
National Ave (Acute Providers)	97.34%	95.18%	95.62%	95.44%	95.65%	
Highest Trust Score (Acute Providers)	100.00%	100.00%	100.00%	100.00%	100.00%	
Lowest Trust Score (Acute Providers)	76.08%	67.04%	75.84%	68.67%	54.86%	

Q4 data not available at the time of publication.

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.

Hip

PROMS	2015/16	2016/17	2017/18
UHS	20.77	21.04	22.86
National Ave (All Providers)	20.88	21.38	22.16
Highest Trust Score (All Providers)	24.75	25.05	25.05
Lowest Trust Score (All Providers)	9.36	15.97	18.00

Knee

PROMS	2015/16	2016/17	2017/18
UHS	15.06	16.33	17.43
National Ave (All Providers)	16.20	16.39	17.05
Highest Trust Score (All Providers)	19.97	19.72	20.39
Lowest Trust Score (All Providers)	8.33	12.17	12.90

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

	October 16 - September 17	January 16 - December 17	April 17 - March 18	July 17 - June 18	October 17 - September 18
UHS	45.5	48.8	51.6	52.2	53.2
National Ave	31.5	32.2	32.5	33.1	33.8
Highest Trust Score	59.8	60.3	59.0	58.7	59.5
Lowest Trust Score	11.5	11.7	12.6	13.4	14.3

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 in this quality account. 2018/19 data not available at the time of publication.

		2016/17	2017/18	2018/19 up to Feb
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		92.0%	89.1%	86.6%
		2016/17	2017/18	2018/19
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		89.5%	87.9%	86.3%
		2016/17	2017/18	2018/19 up to Feb
All cancers- 62 day wait for first treatment from:	Urgent GP referral for suspected cancer	92.5%	89.8%	85.6%
	NHS Cancer Screening Service referral	96.1%	92.4%	80.4%
		2016/17	2017/18	2018/19
C.difficile variance from plan		-11.6%	-20.9%	-4.8%
		2016/17	2017/18	2018/19 up to Feb
Maximum 6-week wait for diagnostic procedure		99.3%	98.5%	97.8%

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	£178,000
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	£178,000
CCGs	1a - 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	£238,000
CCGs	1b - Staff health and wellbeing – healthy food	Maintain previous years changes and sign up to voluntary SSB reduction scheme and meet further reductions in pre-packed sandwiches, confectionery and sweets	National	£238,000
CCGs	1c - Staff health and wellbeing – flu vaccine	Achieve a 75% uptake on the flu vaccine for frontline clinical staff	National	£238,000
CCGs	2c - Antimicrobial Stewardship	Reduction in antibiotic consumption per 1,000 admissions	National	£179,000
CCGs	2d - Antimicrobial review	Empiric review of antibiotic prescription	National	£179,000
CCG's	6 - Advice & Guidance (A & G)	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	£714,000
CCG's	4 - Improving services for people with mental health needs who present to ED	Addition of another patient cohort and achieve reduction in previous years patient cohort 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. Continue to improve the quality of ED diagnostic coding	National	£714,000

Clinical	CQUIN Scheme	CQUIN Target	National or local scheme	Financial reward for achieving scheme
CCG's	9a – Tobacco screening	The screening and recording of adult patients smoking status	National	£36,000
CCG's	9b – Tobacco brief advice	The offering and recording of brief advice to those patients who smoke	National	£143,000
CCG's	9c – Tobacco referral and medication offer	The offering of and recording of referral to stop smoking services and offering of stop smoking medication to patients who smoke	National	£179,000
CCG's	9d – Alcohol screening	The screening and recording of drinking levels of adult patients	National	£179,000
CCG's	9e – Alcohol brief advice or referral	Offering patients who drink alcohol above low-risk levels either brief advice or offered a specialist referral	National	£179,000
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	£3,571,000
NHSE	GE3: Hospital 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	£755,000
NHSE	GE5 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 year's 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
NHSE	CA3 – Optimising Palliative 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	TR3 - Spinal surgery: Networks, Data, MDT Oversight	Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients. The scheme aims to promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review.	National	£169,000
NHSE	CA1/IM1 Enhanced Supportive Care	The scheme seeks to ensure that patients with advanced cancer and/or advanced Hepato-Pancreato-Biliary (HPB) disease are offered early referral to a Supportive Care Team, to secure improved outcomes and avoidance of inappropriate aggressive treatment. 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	£373,000
NHSE	IM2 - Cystic Fibrosis Patient Adherence	This scheme employs an electronic Cystic Fibrosis (CF) adherence indicator captured by an IT platform (CFHealthHub) to deliver a complex behavioural intervention that increases patient activation and adherence, thus delivering better patient outcomes and avoidance of costly escalations. Southampton are a data observatory site reporting trial findings to Sheffield data observatory who in turn report on CQUIN compliance.	Local	£195,000
NHSE	BI1 Improving HCV Treatment Pathways through ODNs	Extension of 2016/17 CQUIN to manage the infrastructure governance and partnership working across the healthcare providers. Management and co-ordination of Hepatitis C networks to ensure clinical and cost effective care is delivered with oversight from Hepatitis C centre's and MDTs. Ensure patients have access to both clinical expertise and local delivery of care.	Local	£4,081,000

Clinical	CQUIN Scheme	CQUIN Target	National or local scheme	Financial reward for achieving scheme
NHSE	CA2 Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)	Implementation of nationally standardised doses of SACT using the does banding principles and dosage tables published by NHSE. UHS supply monthly data to NHSE. Approach expanded in 2018/19 to include implementing standard doses for a new range of SACT agents.	Local	£323,000
NHSE	IM 3 Auto-immune Management	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	£169,000
NHSE	Dental	100% attendance at Oral Surgery Network meetings	Local	£40,000
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	£40,000
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	£124,000
			Total	£14,182,000

APPENDIX 4

Clinical audit and confidential enquiries data

The reports of [25] national clinical audits were reviewed by the provider in 2017/18 and UHS will take actions to improve the quality of healthcare provided.

	Total number of NCAs UHS were eligible to participate in (n=55)	Eligible (55)	Participated (54 = 98%)	% actual cases submitted / expected submissions
1	Adult Community Acquired Pneumonia audit	✓	✓	In progress
2	BAUS Cystectomy	✓	✓	98.7%
3	BAUS Nephrectomy Audit	✓	✓	121.6%
4	BAUS Percutaneous Nephrolithotomy (PCNL) audit	✓	✓	48 patients
5	BAUS Radical Prostatectomy Audit	✓	✓	99.3%
6	BAUS Female Stress Urinary Incontinence Audit	✓	✘	UHS Contributes to BSUG* instead
7	Elective Surgery (National PROMs Programme) hips and knees database	✓	✓	Continuous
8	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	Continuous 560 cases
9	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	Continuous 1500 cases
10	Feverish Children (CEM)18/19 audit	✓	✓	In progress
11	ICNARC case mix programme (CMP) audit	✓	✓	Continuous
12	Inflammatory Bowel Disease (IBD) registry - Biological therapies adult and paeds	✓	✓	Continuous 3510 patients
13	Learning Disability Mortality Review Programme (LeDeR) database	✓	✓	Continuous
14	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	Continuous 100%
15	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality	✓	✓	Continuous
16	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Mortality	✓	✓	Continuous
17	National Asthma & COPD audit programme (NACAP) (asthma in children and adults) *Adults started Nov 18	✓	✓	Continuous
18	National Asthma and COPD Audit Programme (NACAP) (COPD secondary care)	✓	✓	Continuous
19	National Audit of Breast Cancer in Older People (NABCOP) audit	✓	✓	Continuous 50%
20	National Audit of Care at the End of Life (NACEL)	✓	✓	Ongoing
21	National Audit of Dementia (NAD)	✓	✓	Complete
22	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	✓	✓	Continuous
23	National Cardiac Arrest Audit (NCAA)	✓	✓	Q2 & Q3 59 cases
24	National Cardiac Audit Programme (NCAP) - Adult cardiac surgery	✓	✓	Continuous 100%
25	National Cardiac Audit Programme (NCAP) - Cardiac Rhythm Management	✓	✓	Continuous

	Total number of NCAs UHS were eligible to participate in (n=55)	Eligible (55)	Participated (54 = 98%)	% actual cases submitted / expected submissions
26	National Cardiac Audit Programme (NCAP) - Congenital Heart disease (CHD) paeds	✓	✓	Continuous 100%
27	National Cardiac Audit Programme (NCAP) - Acute Heart Failure audit	✓	✓	Continuous
28	National Cardiac Audit Programme (NCAP) - Acute Coronary Syndrome or Acute Myocardial Infarction	✓	✓	Continuous 100%
29	National Cardiac Audit Programme (NCAP) - Percutaneous coronary interventions (PCI)	✓	✓	Continuous 100%
30	National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	✓	Continuous
31	National Comparative Audit of blood Transfusion- use of fresh plasma, management of massive haemorrhage	✓	✓	In progress
32	National Diabetes Inpatient Audit (NaDia)- Adults - foot care	✓	✓	Continuous
33	National Diabetes Inpatient Audit (NaDia) - in pregnancy	✓	✓	Continuous
34	National Diabetes Inpatient Audit (NaDia) - paediatric	✓	✓	Continuous
35	National Diabetes Inpatient Audit (NaDia) - reporting on inpatient harms	✓	✓	Continuous 40 cases
36	National Emergency Laparotomy Audit (NELA)	✓	✓	Continuous 93%
37	National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)	✓	✓	Continuous 297 patients
38	National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA) audit	✓	✓	Continuous 187 patients
39	National Joint Registry (NJR)	✓	✓	Continuous 100%
40	National Lung Cancer Audit (NLCA)	✓	✓	Continuous
41	National Maternity and Perinatal Audit (NMPA)	✓	✓	Continuous
42	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	Continuous 872 babies
43	National Ophthalmology Audit	✓	✓	Continuous 100%
44	National Prostate Cancer Audit (NPCA)	✓	✓	Continuous 872 babies
45	National Vascular Registry (NVR)	✓	✓	Continuous
46	Neurosurgical National Audit programme	✓	✓	Continuous
47	Non invasive ventilation - adults (BTS) audit	✓	✓	In progress
48	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	Continuous 100%
49	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit	✓	✓	Continuous
50	Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	✓	✓	Continuous
51	Serious Hazards of Transfusion (SHOT) UK National haemovigilance scheme database	✓	✓	Continuous
52	Seven Day Hospital Services self assessment	✓	✓	Complete
53	UK Cystic Fibrosis Registry	✓	✓	Paeds 218 active pts Adults 275 active pts
54	Vital Signs in Adults (CEM) 18/19 audit	✓	✓	In progress
55	VTE Risk in Lower limb Mobilisation (CEM) 18/19 audit	✓	✓	In progress

APPENDIX
5

BSUG - British Society of Urogynaecology

The reports of [32] national clinical audits were reviewed by the provider in 2018/19 and UHS intends to take actions to improve the quality of healthcare provided (See Appendix A).

The reports of [118] Trust-wide and local clinical audits were reviewed in 2018/19 and as result the Trust will take action to improve the quality of healthcare provided (See Appendix B)

APPENDIX 6

National clinical audit: actions to improve quality

The reports of [98] Trust-wide and local clinical audits were reviewed in 2017/18 and as result the Trust will take action to improve the quality of healthcare provided.

National audit title		Actions
1	National Maternity and Perinatal Audit (NMPA) (live births) (revised report published April 2018)	• To confirm with the NMPA that the unadjusted and adjusted results from the NMPA are as expected in view of the high deprivation in this area. • To review a subset of notes from this cohort of babies with 5-minute Apgar score less than 7, compare with electronic records National Neonatal Unit (NNU review of 10 sets of healthcare records). • Theme of the week to be distributed to staff stating that the attending midwife and neonatal practitioner should agree the Apgar score at 5 minutes before it is recorded on to the electronic systems (HICSS). • The Yellow Apgar sheet to be edited to reflect the times of 1, 5, and 10 minutes (the record is currently blank for the time of the score) by investigating current paperwork to make appropriate changes as required. • To have discussions with coding team to ensure inaccuracies in data are corrected. • To ensure UHS Communication team have been made aware of the findings of the report. • To review the data for UHS born therapeutic hypothermia cooling annually.
2	National Comparative Audit of Blood Transfusion (NCABT) re-audit of red cell & platelet transfusion in adult haematology patients (report published April 2018)	• To add section in blood transfusion policy regarding identifying patients at risk of Transfusion – Associated Circulatory Overload (TACO) risks and how to manage these patients. This includes a description of TACO and a checklist to be used by clinicians. • Transfusion practitioners investigating an upgrade to Blood track system to help improve compliance for electronic prescription and requesting of blood components. • To move towards electronic system for authorisation of blood components with mandatory fields would aid compliance. • Hospital Transfusion Committee PBM working group is currently reviewing the awareness of and adherence to the use of minimum number of red cell units with the absence of active bleeding. • The Platelet Action Group is reviewing compliance against the one adult therapeutic dose of platelets for prophylaxis.
3	British Thoracic Society (BTS) Adult Bronchiectasis Audit 2017 (report published April 2018)	• The adult bronchiectasis service needs to establish a nursing presence to assist in patient education and management. • UHS need to complete a bronchiectasis business case to support the nursing presence.
4	BTS Beyond Breathing Better (report received April 2018)	• To ensure all eligible patients for pulmonary rehabilitation (PR) are referred to therapy team. • To encourage all eligible patients to attend PR. • To review whether a low impact chair based exercise class is feasible for frail patients. • To update all therapy staff on what the service offers patients through Core team brief presentation. • To participate in PR week 2019. • To link in with local British Lung Foundation (BLF) groups.
5	Survey of Depression Reporting in Older Adults Admitted to Acute Hospitals Report (report received March 2018)	• To have a UHS co-morbid depression in older adults care pathway developed with Department of Psychological Medicine, Health Psychology and key stakeholders. • To improve clinical coding of depression and co-morbid mental health problems in older adults, initially focusing on Division B, UHS, and recorded on doctors work list. • To have better access to RIO and local Mental Health Record Systems by Division B, UHS staff to ensure better joined up physical and mental health care in older people (AMU, MOP, GIM, Specialist Medicine, Therapy)
6	BTS Bronchoscopy adults audit	• There are discussions currently ongoing re: expansion of service as UHS time from referral to procedure exceeds the national target.
7	ational Asthma & Chronic Obstructive Pulmonary Disease (NACAP) Exercise in improvement	• To ensure additional time during assessment to enable 2 6MWT to be completed unless this is deemed inappropriate. • UHS does not routinely prescribe intensity for walk but if walking becomes a bigger part of pulmonary rehabilitation then will review this. • To be more precise with provision of resistance training will start recording 1 repetition maximum for provision of hand weights.

National audit title		Actions
8	National Ophthalmology Database (NOD) - Adult Cataract surgery	• Need to maintain standard for variation of Endophthalmitis rate following cataract surgery from the NOD standard.
9	RCEM Severe Sepsis and Septic Shock	• To improve documentation of oxygen prescribing. • To ensure when sepsis patients are phoned through by the ambulance crew we find out whether they are allergic to anything so antibiotics can be drawn up ready. • Venous Blood Gas (VBG) results to be logged on e-Quest so as not to lose the results.
10	National Hip Fracture Database (NHFD) (report published September 2018)	• A Fragility Fractures group to examine our performance on surgery times each month, using a breakdown of reasons for delayed surgeries with a task and finish group is to be set up to review this. • The NHFD surgery clinical lead is to contact NHFD to discuss our outlier status for low rates of SHS for inter-trochanteric fractures • A prospective survey is going to be carried out during early 2019 on the reasons why early mobilisation is unable to be carried out in a proportion of patients. This will enable us to specifically look at analgesia and blood pressure as anecdotally these appear to be the two main problems. • One of the registrars is to examine our delirium assessments and to present findings and actions. • We currently collect and examine 120 day data but will focus on return to original residence on a quarterly review basis. • Our group focus has been on looking at the proportion of people from their own home that are back in their own home by 30 days and this is a metric we are also keen to keep on a quarterly review basis. • All hip fracture patients who die in hospital will be reviewed at a bi-monthly Mortality and Morbidity (M&M) meeting and, on an annual basis, all the mortality cases are compiled to look at trends in causes of death and time from admission to death to enable emerging themes to be seen more clearly.
11	Royal College of Emergency Medicine (RCEM) Fracture neck of Femur (#NOF) (report published December 2018)	• To improve the documentation of observations including pain score by having hot audits to review compliance. • To complete a quality improvement project looking at how this can be improved. • Ongoing work with radiology as part of #NOF pathway. • Ongoing work with #NOF protocol to try and improve time to admission.
12	UK Inflammatory Bowel Disease (IBD) Biologics audit and registry (report published May 2018)	• To continue to focus on engaging with clinical team to use the IBD patient management system (PMS) at the point of care. • To work with EMIS to improve the data extraction to ensure capture of all data entered.
13	National Maternity and Perinatal Audit - sprint audit on Intensive care (report published January 2019)	• To review the current process for the admission and ongoing monitoring to High Dependency Unit (HDU) locally,
14	Acute Coronary Syndrome (ACS) or Acute Myocardial Infarction (MINAP) (report published November 2018)	• The local ACS Committee for primary and secondary care will meet quarterly to review the figures. • The ACS Nurses at UHS have been reinstated 24/7 from 2019. We therefore expect to move back up into the upper quarter as our reperfusion times improve
15	Major Trauma: The Trauma Audit & Research Network (TARN) (report published December 2018)	• To re-design the rehabilitation prescriptions.
16	PICANet 2018 Annual report (report published November 2018)	• To open 15th and 16th commissioned beds. • To improve cubicle provision. • To develop more detailed morbidity data collection. • To develop stand alone extracorporeal membrane oxygenation (ECMO) capability.
17	Breast and Cosmetic Implant Registry (report published December 2018)	• To explore administrative help with the data inputting to the registry.

National audit title		Actions
18	National Asthma & Chronic Obstructive Pulmonary Disease (NACAP): COPD Best practice tariff (BPT) (report published November 2018)	• To increase respiratory specialist nursing during weekends. • To prioritise ICOPD team visits to Acute Medical Unit (AMU) every morning. • To introduce a twice daily work list review by administrative staff to identify patients. • To explore both nursing and medical education opportunities on AMU. • To link with AMU Medicine for Older People (MOP) liaison nurse to improve referral rate and speed of referral by MOP. • To identify a MOP consultant champion to raise awareness. • To follow up and meet with previous MOP practitioners. • To meet with IT to agree changes for urgent implementation in separating out nurse referral for supported discharge and care bundle. • To recruit further member of staff to support earlier review within 24 hours of admission to support the Normalisation Process Theory (NPT).
19	National Audit of dementia (NAD) (updated action plan January 2019)	• To provide annual teaching to junior doctors on dementia and delirium. • The dementia pathway requires a multidisciplinary team approach (MDT) approach. • Better coding of dementia patients is required. • To ensure ongoing training for dementia champions. • Review and audit the use of the "This is me" document across all areas of trust. • The Dementia working group to monitor all incidents, to collate themes and take any system wide actions. • A trust covert care plan to be approved for use within UHS. • Trust to appoint an Older Peoples Mental Health (OPMH) Consultant Psychiatrist to improve access to senior medical advice and assessment. • To submit a business case by the mental health teams to increase staffing to be able to provide mental health care in all medical areas rather than just MOP. • To have a front door geriatrician service to identify appropriate patients for direct admission to an enhanced dementia care ward. • To improve the number of patients titrated on to the appropriate does of memory medication when required. • To improve patient information as well as updating the UHS website. • For patients with complex needs to introduce a welcome meeting for their families and nursing care to improve communication. • All staff on dementia wards have enhanced training and to increase staff to 1:3 to enable high levels of care and monitoring. • E-learning is now live this is to be monitored through the divisional education leads and Dementia working group. • A super team is in construction, this will meet weekly. To start more integrated working prior to formal team structure. • To ensure all new refurbishments offer a dementia friendly environment. Estates attend the Dementia working group. • An enhanced dementia care ward with joint medical and psychiatric care for those acutely unwell with dementia and delirium to be opened. This will include a twice weekly MDT meeting. • To monitor the numbers of patients with dementia that die in hospital and try to give patients the opportunity to die at home if requested. • UHS to continue to complete the National Audit of Dementia.
20	National Audit of Inpatient Falls (updated action plan December 2018)	• To include the requirement of lying and standing blood pressure (BP)'s in the fall's policy. • To audit the completion of the BP's in all areas. • A quality improvement project is in process to address the issue with medications and to create a revised culprit medications document to support the fall's policy. • To ensure that mobility aids are in reach for patients with mobility problems. • To continue to contribute towards the national inpatient falls audit. • To review and audit the National Audit inpatient standards along with the UHS SIRFIT too requirements.
21	National Diabetes Inpatient Audit: Insulin pump (report published June 2018)	• To support patients to lower their HbA1c where clinically appropriate. • To initiate some training for General Practitioners (GP)'s on insulin pump NICE criteria. • To work with divisional management teams and UHS GIRFT leads to increase resource to support patients on insulin pumps.
22	National Diabetes Inpatient Audit: (NaDia) Transition from paeds to adults (report published January 2019)	• To work collaboratively by attending the Wessex regional workshops etc. • To continue to contribute to NaDia and the Royal College of Paediatrics and Child Health (RCPCH).
23	UK Cystic Fibrosis Registry (report published August 2018)	• To discuss with physiotherapy and medical specialities to raise awareness of the recommendation of DNase as first line treatment in NICE guidelines.

National audit title		Actions
24	Elective Surgery (National PROMs Programme) (report published in 2018)	• The IT department are currently investigating the possibility of using My Medical Record to collect national PROMs data which would allow us opportunity to increase the number of responses received. • To continue quality improvement related audits and projects for this group of patients.
25	National Joint Registry Annual Report (report published September 2018)	• To stop unsupervised weekend operating for non-consultant grade lists as a direct result of this report. • To ensure all additional operating by non-consultant grades, during the week, must be with the specific permission of the consultant in charge. • All trauma cases receiving a Total Hip Replacement (THR) by a trainee will have the case attributed to the admitting consultant. • To commence a monthly knee MDT meeting. • To commence annual knee and hip group meetings for presentation and discussion of individual 'funnel plots', '1 and 3 year revision rates' and hospital data to review any outlier patterns. • To continue with our weekly hip MDT meeting on Monday lunchtimes. • A service review to be held to discuss and review individual consultant revision rates.
26	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database (report published in 2018)	• There is ongoing development of service in conjunction with SCCCG, no engagement with WHCCG to date. • Currently recruiting to FLS nurse specialist post.
27	National Cardiac Audit Programme (NCAP) - Congenital Heart disease (CHD) paeds (report published in 2018)	• To expand the service by attracting more surgical cases from other referral areas.
28	National Cardiac Arrest Audit (NCAA) (Q2 & Q3 2018/19 report only)	• To present the results at Resuscitation Committee to review learning points and share with trust. • Results to be shared at Divisional Governance meetings and review learning points for specialities to take action.
29	National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA) audit (report published September 18)	• To continue to participate in prehabilitation program.
30	National Audit of Breast Cancer in Older People (NABCOP) (report published Nov 2018)	• To increase 1 stop clinic capacity with an appointment of a new consultant and recruitment and training of three specialists breast care nurse practitioners. • Radiology to expand capacity by creating new slots and to appoint a new consultant breast radiologist to cover part of the capacity. • To implement an alternative Friday afternoon theatre sessions.
31	National Inpatient Diabetes - I Care processes and Treatment Target report. (report published November 2018)	• To support patients above target to lower HbA1c where clinically appropriate. • To host a type 1 education master-class for General Practitioners (GP) s. • To send reminders of our service to GPs via the GP newsletter with NICE criteria for pump added, a reminder to go on to the GP tutorials and for GP's to invite the team to sit in on clinics. • To work with divisional management teams and UHS Get It Right First Time (GIRFT) leads to increase resource to support patients on insulin pumps.
32	RCEM procedural Sedation in Adults (report published October 2018)	• To identify barriers to capturing all data requested by the Emergency Department (ED) checklist. • To reinforce importance of using the procedural sedation proforma and adequate documentation. • To ensure ED / resuscitation nursing staff complete the documentation with all the appropriate information and observations until patients discharge. • To add a patient information sheet on procedural sedation, which can be printed out with the checklist.

APPENDIX 7

Local clinical audit: actions to improve quality

Audit title		Actions
1	Mental Capacity Act (MCA) (2005) audit report	• To review MCA policy in order to update the mental capacity assessment tool used to the 'Hampshire toolkit'. • To review and refresh mental capacity and Deprivation of Liberty (DoL) s training in order to reflect the new tools outlined in the updated policy. Training should be much more focused on how to apply the MCA in practice. • To explore setting up MCA forums for staff to discuss live cases / scenarios and reflect on learning from incidents relating to mental capacity within the Trust. • To develop a quarterly MCA newsletter in order to share updates around the Act and learning from incidents / safeguarding where mental capacity has featured, as well as case law updates. First letter to feature findings and learning from this audit. • To consider setting up a mental capacity awareness week in order to launch the new policy and training once this is completed and to raise the profile of the agenda. • Explore setting up some mental capacity & DoLS master classes for all staff which focuses on live scenario's and applying the Act in practice. • Meet with the Medical Director in order to discuss medical engagement and a medical lead for the agenda. • To raise awareness of all the above via governance forums, such as; * Safeguarding Governance Steering Group * Mental Health Board * Learning Disability Working Group * Dementia Working Group • To update the MCA & DoLS Staffnet pages to reflect updated tools, contacts and include useful resources and information for all staff. • To continue to work with patient experience in order to raise the profile of Independent Mental Capacity Advocates (IMCA's) within the Trust as referral numbers are currently low. This includes; updating the MCA policy, a presentation at CLG, a briefing paper to the Mental Health Board and updating of Staffnet pages.
2	Continuous electronic fetal monitoring audit	• To discuss the audit findings at the Intrapartum Care Committee (ICC) meeting.
3	Pregnant women in non - maternity clinical areas (re-audit)	• For the Division C Divisional Governance Manager (DGM) to re-circulate the policy and to discuss with DGMs from across the Trust to consider completing an audit in their areas to raise awareness of the policy. • Explore documentation options to allow clinicians to record visits / admissions in women's hand held notes. • To re-launch the policy across the Trust to raise awareness of referral process. • To explore with the new Hospital Integrated Clinical Support Systems (HICSS) Manager what data is available electronically to improve this audit.
4	Transfer in an Emergency: Women and Newborn Babies	• To generate 'Theme of the Week' highlighting documentation required i.e. transfer proforma and handover sticker. • To verbally feedback at team meetings and email to all other shift leaders regarding the importance of completing incident forms when delays. • To display a poster demonstrating transfer procedure and documentation to be completed in the New Forest Birthing Centre (NFBC) staff room
5	Improving the detection and management of sepsis	• To continue the secondment for band 7 sepsis clinical nurse. • To recruit a band 6 sepsis clinical nurse. • Sepsis tool to be rolled out Trust wide. • Sepsis tool to be developed electronically on the EPAMS system being implemented into the trust. • Sepsis screening tool to be developed electronically for all inpatients. • To include the initial part of the sepsis screening onto the electronic observations to improve screening compliance.

Audit title		Actions
6	Synovial Fluid Audit	• To implement new e-Quest request for synovial fluid investigations. • To present results at trauma and orthopaedic Mortality & Morbidity (M&M). • To email whole department for update of the new e-Quest available.
7	Orthopaedic Monitoring of Isolated Head Injuries	• To present findings to both neurosurgical and orthopaedic departments.
8	Enhanced recovery pathway - Elective Caesarean Sections	• To discuss with recovery team mobilisation at 6 hours. • To have a meeting to discuss pain relief. • To update the ER booklet.
9	Pelvic Trauma Thromboprophylaxis	• To present at the Trauma & Orthopaedics M&M meeting. • To develop a new departmental guideline for pelvic fracture VTE prophylaxis with pelvic consultants.
10	Is DVLA driving advice given to suspected TIA patients in Emergency Department (ED)?	• Additional training to ED SHO junior doctor's to improve compliance on documenting in patients notes that those with suspected TIAs should not drive until they are seen by the stroke team. • It will also be discussed with senior members of staff to see whether any TIA leaflets can be put onto symphony to aid compliance.
11	VTE prevention in pregnancy	• To liaise with e-prescribing team regarding an opt-out system for AES. • To liaise with e-prescribing team regarding creating an 'Add STAT order' functions for Low-molecular-weight heparin (LMWH). • Add an update as a "Theme of the week". • To add VTE risk assessment to Situation, Background, Assessment, Recommendation (SBAR).
12	Low Apgar score at 5 minutes of age in single term babies - accuracy of documentation	• "Theme of the week" to be distributed to staff stating that the attending midwife and paediatrician should agree the APGAR score at 5 minutes before it is recorded on to the electronic systems (HICSS). • From the findings of the audit any incorrect APGAR scores should be corrected on the electronic systems. • The Yellow APGAR sheet to be edited to reflect the times of 1, 5, and 10 minutes (the record is currently blank for the time of the score).
13	Re-audit of completion of Real – Ear – to - Coupler Difference (RECD) measurements on all children with a permanent childhood hearing impairment (PCHI) for under 5 year olds with hearing aids.	• To present results at the June staff meeting and highlight to staff that they need to complete the required measurements. • To add notes to patient records where RECD measurement is required to remind staff to complete at their next appointment.
14	AKI – Maintaining discharge information for primary care for patients with AKI	• Areas where compliance is low, training will be completed by the pharmacy team at the junior doctor teaching sessions.
15	Child Protection – Safeguarding children audit	• Safeguarding proforma to be reviewed by a Task and Finish Group. • Apex referral form to be reviewed to align with safeguarding proforma. • Revised Apex form and proforma to be trialled on PAU. Following trial forms to be presented to governance for ratification and roll out.
16	Do not attempt cardiopulmonary resuscitation (DNACPR) – pt medical notes where the DNACPR audit form recorded that there was no discussion with the pt	• Teaching to ensure that the reasons for a DNACPR not being communicated to the patient is documented in the patients notes.

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17	DNACPR - to review DNACPR sheet within pts medical notes to review if signed by consultant	• Consultants to be reminded that DNACPR forms are to be verified by a consultant within 48 hours. • Spot check of DNACPR forms to be completed during matron's walkabouts.
18	Ensuring all patients with AKI get a urinalysis test	• Audit to be repeated once a month with regular feedback to ward areas to ensure compliance is increased. • To escalate to Patient Safety Steering Group (PSSG) regarding patient safety of non compliance.
19	IPC – Hand washing facilities	• Areas scoring between 85% and 94% are to re-audit in three months.
20	UHS Isolation audit	• The 7 areas scoring between 85% and 94% will re-audit within three months.
21	Standard Precautions Audit	• 10 areas scoring between 85% and 94% to re-audit within three months
22	Audit of Surgical Hand Antisepsis	• One area required to complete a re-audit within one month.
23	Improving the detection and management of sepsis v.3	• To include the initial part of the sepsis screening onto the electronic observations to improve screening compliance.
24	The Trust-wide Record Keeping Audit v.2	• For next year's audit will need to consider the Electronic Document Management System (EDMS) project will have been rolled out across the Trust therefore some of the questions will need to be reviewed. • Consider a dedicated discharge planning audit, if deemed a key requirement). • Audit tool to be refined to capture relevant standards in-line with the information governance (IG) toolkit. • Each division should review their results locally and produce an action plan if required.
25	Blood glucose monitoring in adult inpatients using steroid treatment	• To distribute posters on monitoring glucose in adult inpatients on steroid treatment to all wards. • To receive approval for the monitoring tool to be used on all adult wards to assist with consistency and compliance to local guidelines.
26	Sharps safety audit v.2	• 29 areas that scored between 85% and 94% are to re-audit within three months.
27	Ventilated Patients Audit v.2	• The three non compliant areas will be required to produce an action plan and re-audit within one month.
28	Fetal blood sampling	• To discuss at Intrapartum Care Committee (ICC) whether midwifery review can be taken into account.
29	An Audit to establish MOP Therapy team are meeting Standards of Documentation (SOD) set out by Health and Care Profession Council	• To feedback current acute medical unit (AMU) comprehensive geriatric assessment (CGA) Proforma used for most initial assessments in the next month and review necessary changes and adaptations as needed in 3/12.
30	A prospective audit of compliance with measurement of urinary sodium in infants with congenital heart disease	• To develop a clinical guideline for the management of low urinary sodium levels.

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31	Audit of Blood Management Transfusion (BMT) patient Drug Errors from 2016 to 2018	• To plan a re-audit. • To start calling these as an incident rather than an error. • All drug related incidents to be discussed at the Quality Meeting.
32	Audit of labour documentation on K2	• To re-assess using same questions to assess whether refresher sessions and weekly top tips make a difference.
33	An audit of completion and accuracy of the Malnutrition Universal Screening Tool (MUST) and food record charts on the Wessex Spinal Unit	• Training and education sessions to include: - Key audit results. - Completion of MUST within 24 hours. - Alternate and subjective measures for MUST. • Dietitian to explore arranging provision of spinal collar / braces weight posters
34	Out-patient hand hygiene	• Area scoring below 85% is to re-audit within 3 months.
35	Early Mobilisation in a Specialist Neuro-intensive Care - A Six month review of safety	• To develop the service further. • To look into Length of Stay (LoS) and patient outcomes.
36	An audit of 'missed' cases of Small for Gestational Age (SGA) over a 6 month period.	• To develop and implement Aspirin eDocs letter. • To develop and circulate Aspirin posters to clinical areas.
37	Cystic Fibrosis (CF) admission proforma update	• To discuss with CF Care group Lead. • To discuss with Respiratory CE Lead. • To present audit report in CF Multidisciplinary Team (MDT) meeting. • To implement required changes.
38	Investigation of Neurophysiology Outpatients 'Did Not Attend' Rates.	• To undertake a patient survey as to why patients did not attend their appointment.
39	National Maternal and Perinatal Audit: Babies born with Apgar <7 at 5 minutes	• To request patient notes to analyse Apgar scoring.
40	Compliance with Paediatric Observation and Monitoring Policy (PEWS)	• To distribute the Observation Policy reminders & PEWS hotline reminder cards to be displayed on all wards. • To update the PEWS charts including removal of blood gas section from PHDU chart, addition of escalation prompt to front of chart (in place of urine output), addition of Outreach into Escalation algorithm and Nurse Response Box. New E1 High Care PEWS chart (currently not a PEWS chart as no escalation). • To continue to teach PEWS update at mandatory days for both band 2&3, and band 4 and above. PEWS teaching also included on all student and newly qualified nurse inductions. • To trial the alteration for oxygen scoring for children receiving high flow oxygen and Non invasive ventilation (NiV).
41	An audit of axial spondyloarthritis physiotherapy services against NICE guidelines	• To liaise with National Ankylosing Spondylitis Society (NASS) regarding a poster to be put up in Victoria House advertising the group. • To audit the 6 week physiotherapy advice and exercise group.
42	Immediate post-operative ABCDE assessment re-audit	• To obtain a teaching session from the tissue viability team in the assessment and documentation of pressure area care. Highlighting the importance of reducing the risk of avoidable pressure damage. • To feedback outcomes from the questionnaires with regard to layout of the post-operative care plan.

Audit title		Actions
43	An audit of the provision of community physiotherapy for patients on home IV antibiotics against the Association of Chartered Physiotherapists in Cystic Fibrosis Standards of Care 2017	• To restart the community service when staffing allows. • To redesign the community database to ensure patients are being effectively recorded when they have started home IV's. • To ensure patients who live a long distance away are being reviewed when they come for their start of IV appointment at the hospital. • To attend virtual ward round with the Consultant and Nurses to capture all home IV patients.
44	Management of hyperglycaemia in patients with STEMI and NSTEMI	• To present the audit to junior doctors and Coronary Care Unit (CCU) nursing staff.
45	An audit of completion and accuracy of the Malnutrition Universal Screening Tool (MUST) and food record charts on the Wessex Spinal Unit	• To add to the training and education sessions: key audit results, completion of MUST within 24 hours, alternate and subjective measures for MUST. • Dietitian to explore arranging provision of spinal collar / braces weight posters.
46	Time taken from newborn hearing screen 'referral' outcome to first diagnostic audiological assessment for children with permanent childhood hearing impairment.	• Results will be presented and discussed at the staff meeting in November.
47	To confirm use of Situation, Background, Assessment, Recommendation (SBAR) handover tool for all maternity transfers from/to all birth environments and inpatient wards. To confirm that all elements of the SBAR tool are completed.	• The birth centres to ensure the use of SBARs on all transfers to PAH and to demonstrate how this has been completed. • SBAR needs to be re-designed to be used specifically to facilitate transfer with the same midwife. • Re-design needs to be decided between birth centres, there will need to be a defined lead to move this forward. • It may be agreed that the best way forward is to use the K2 SBAR. • The risk assessment is to be completed for all transfers. This will then need to be updated on the Handover of Maternity Patients guideline. • Both Lyndhurst and Burley need to ensure the continued use of SBARS for any transfer, to be communicated at ward handovers. • All areas to be reminded to add date, time, to sign and fully complete all components • Theme of the week requested to remind all staff to fully complete an SBAR for all transfers. • To re-audit in 6 months time to see if there has been any improvement.
48	Outpatient Induction of Labour with Propess pessary	• To review and update the guideline.
49	UHS Hand Washing Facilities Audit	• 25 areas scoring between 85% and 94% to re-audit within 3 months. • 6 areas scoring below 85% to produce an action plan to address the issues and re-audit within 1 month.
50	Prospective Audit of paediatric Extravasations injuries and their management.	• To ensure that the UHS paediatric extravasations guideline is followed in all paediatric extravasations injuries. • To improve education of staff at induction and continuous development of skills through simulation. • To ensure that the extravasations management plan is followed in all high risk injuries. • To aim to reduce the number of out-of-hours extravasations injuries. • To continue education of staff to ensure that the high standards of venous access care during the day is maintained out-of-hours.

Audit title		Actions
51	Surgical Management and Outcomes of Necrotising Soft Tissue Infections (NSTIs)	• To formulate local guidelines for the management of NSTI's. • This management algorithm to be incorporated into a trust's SEPSIS 6 or clinical pathways in order to standardise our practice. • To re-audit and compare the outcomes with the ones prior to the intervention.
52	Avoidable antibiotic days of therapy: a university teaching hospital audit	• To implement a set of standard course lengths of antibiotics on e-prescribing.
53	Evaluate the effectiveness of medicines reconciliation and the communication of medicine changes on discharge	• To update and publish the medicines recompilation policy.
54	Audit of Analgesia for Elderly Fractured Neck of Femur Patients guideline	• To amend the current guideline in order to simplify it and clarify the essential aspects.
55	Pharmacy compliance with UHS Controlled Drugs (CD) Policy	• To share the audit results with both dispensaries and discuss areas where improvement is needed. • To identify a robust method to remind staff about which CD TTOs require a signed copy before they can be released from Pharmacy. • To share results with UHS CD accountable officer.
56	Audit on the Out of Hours (OOH) System	• To share the results with the relevant staff. • To send e-mails to the pertinent staff and provide information leaflets to the wards on how to use the OOH work-list. • To incident report non-compliance as an adverse event with possible negative implications to the patient, the trust and the doctors.
57	Medicines refrigerator temperature monitoring	• To inform ward managers of audit results. • To provide appropriate documentation for compliant monitoring. • To provide advice on request on how to reset thermometers.
58	Continuous electronic fetal monitoring audit (re-audit)	• To present findings at Intrapartum Care Committee (ICC). • Theme of the week/communication board.
59	Blood glucose monitoring on inpatients using Prednisolone treatment	• To distribute a poster on monitoring glucose in adult inpatients on steroid treatment, to all wards. • To receive an approval for the monitoring tool to be used on all adult wards, to assist with consistency and compliance to the local guidelines in monitoring glucose in adult inpatients on steroid treatment.
60	Infection Prevention & Control (IPC) - Hand washing facilities trust-wide audit (August 18)	• All areas scoring between 85% and 94% and are to re-audit within 3 months. • 6 areas scored below 85% and are to produce an action plan to address issues and send to Infection Prevention for monitoring.
61	Standard Precautions Audit (July 18)	• 7 areas scoring between 85% and 94% will be required to re-audit within 3 months.
62	IPC multi professional hand hygiene audit – in patient areas (Aug – Sep 18)	• All areas which scored below 85% will be required to complete an action plan and re-audit within 1 month.
63	IPC - Saving Lives HII 1 Central Venous Catheter Care. (September 18)	• Insertion Results - 2 areas scored below 85% which will be required to complete an action plan and re-audit within 1 month. • Ongoing care - 1 area scored below 85% which will be required to complete an action plan and re-audit within 1 month.

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64	IPC - Saving Lives HII 2 Peripheral Intravenous Cannula Care (August 18)	• Peripheral Intravenous Cannula insertion - 1 area scored between 85% and 94% which will be required to complete an action plan. • 2 areas scored below 85% which will be required to complete an action plan and re-audit within 1 month. • Peripheral Intravenous Cannula Ongoing - 2 areas scoring between 85% and 94% which will be required to complete an action plan. • 9 areas scored below 85% which will be required to complete an action plan and re-audit within 1 month.
65	IPC - Saving Lives HII 4 Surgical Site Infection. (26.07.18)	• Preoperative actions - Care groups to monitor their compliance and produce action plans. • Postoperative actions - Care groups to monitor their compliance and produce action plans.
66	IPC - Saving Lives HII 6 Urinary Catheter Care (Sep 18)	• Ongoing care - 3 areas scoring between 85% and 94% will be required to complete an action plan. • 4 areas scored below 85% will be required to develop an action plan and re-audit within 1 month.
67	IPC - Saving Lives HII 5 Ventilated Patients	• All care groups are to ensure work is ongoing in order to sustain 100% compliance. • 2 areas scored below 85% will be required to develop and action plan and re-audit within 1 month. • 3 areas did not complete the audit. A review by care group managers/care group clinical leads to ensure that all medical teams required to submit an audit do so as per the infection prevention annual audit programme.
68	Management of potassium levels pre and post harvest.	• To recommend that Apheresis staff are reminded to be vigilant in checking and noting potassium levels on the back of the collection sheet post harvest when K<3.5. • To add whether patient treatment has been given is required in patient records
69	Emergency Department (ED) record keeping audit 2017-18	• A leaflet to be produced for the junior doctors to have at induction to ensure they understand what is required on all documentation.
70	An audit of the Occupational Therapy (OT) service for end of life discharge planning with cancer patients across the cancer care wards at University Hospitals Southampton NHS Foundation Trust.	• To complete a poster for the UHS Always Improving Conference in November on results and findings.
71	Dietetic management of newly diagnosed paediatric type 1 diabetes patients under the care of UHS.	• To keep a spread sheet of newly diagnosed patient contacts to clearly visualise the level of dietetic support awarded to each patient and who needs to be seen. This will also help for with a re audit in 2019. • To record all patient contacts (attempted and successful) on e-docs, HICCs and access dietetic database. To train all dietetic staff how to complete this. • To work with the diabetes nurses at implementing the new UHS diabetes pathway for managing the newly diagnosed patients. • To deliver and record SEREN education to all newly diagnosed patients. • To have a single point of contact for the diabetes dietitians such as a mobile phone. This will ensure that the dietitians are aware of all new referrals as soon as possible. • To consider having an on-call dietitian at weekends to review newly diagnosed patients. However, as an interim measure to ensure that all patients diagnosed on a Friday evening or at the weekend are booked for a dietetic outpatient review or home visit on the following Monday if they have been discharged. • To re-audit the management of newly diagnosed paediatric type 1 diabetes patients in 2019 for the audit period 1/10/18 to 1/10/19.
72	MUST score screening and nutritional assessment in patient eligible for pancreato-duodenectomy.	• In accordance to our findings we propose a campaign to encourage doctors to refer for a nutritionist review for every patient undergoing surgery, and especially pancreatoduodenectomy. • To submit this data to the trust in order to consider hiring another dietician. • To monitor the Hepato-Pancreato-Biliary (HPB) Multidisciplinary Team (MDT) list.
73	Ventilated Patients Audit	• Intensive support meeting arranged for 16/11/2018 to provide feedback of the results.

Audit title		Actions
74	An audit of late evening snack provision for cirrhotic liver patients on the Gastroenterology and Hepatology wards	• To discuss outcome of audit with catering service and Hepatology team to try and find a solution to the problem. • To put together a list of 50g carbohydrate snack suggestions for patients whilst they are inpatients.
75	To audit the number of patients that were identified on body weight-walk-around who had their body weight measured on Acute Medical Unit (AMU)	• To discuss new equipment that could make weighing patients easier. • To provide an education session to staff on weighing patients and dietitian input on AMU.
76	Volume Based Feeding (VBF) in Critical Care Unit (ICU) Using MetaVision	• To continue to use VBF protocol to provide nutrition for ICU patients. • To educate nurses on protocol. • Dietitians to ensure adequate protein supplements are prescribed for those not meeting protein targets. • To feedback results at MetaVision conference.
77	Controlled drugs: safe use and management on the neonatal unit	• To keep drug order book to be kept in a suitable locked cupboard. • Staff education on signing drugs and create a one minute wonder board. • To create a model template of 'how to document and sign for controlled drugs' that can be placed in the drug cupboard. • To create rubber stamp templates 'checked and correct' for controlled drugs. • To educate Nurses through email and education team. To avoid crossing out.
78	Management of Postpartum Haemorrhage - Re-audit	• To discuss with relevant staff re: feasibility of adding proforma to K3 to ensure that it is followed and signed. • To consider changing proforma to include flowchart for lines of communication and signature of most senior clinician involved in management of patient care to ensure this is followed and filled out correctly
79	Radial Arterial Blood Gas (ABG) Expanded Scope of Practice (ESP) Cancer Care Audit	• To disseminate new ESP guidelines to ANP / ENP once approved at clinical governance. • To feedback to ENP / ANP changes that need to occur to improve practice and patient safety based on recommendations.
80	Are opportunities being missed to perform hysteroscopy's as an outpatient rather than in theatre under a general anaesthetic?	• To discuss the audit findings with care group manager. • To discuss the need and possibly design a proforma for hysteroscopy procedures.
81	Surgical Management and Outcomes of Necrotising Soft Tissue Infections (NSTIs)	• To formulate local guidelines for the management of NSTI's. • A management algorithm could then be developed and incorporated into a trust SEPSIS 6 or clinical pathways in order to standardise our practice. • To re-assess the impact by comparing the outcomes with the ones prior to our intervention.
82	A prospective audit of compliance with measurement of urinary sodium in infants with congenital heart disease	• To develop a clinical guideline for the management of low urinary sodium levels.
83	Ferinject Administration In Maternity - Audit of Practice and Adherence to Proforma	• To update the IV iron folder on MDAU and wards. • To ensure staff are aware of the information and proformas available. • To ensure availability of proforma, leaflet and forms in clinical areas. • To update the proforma as required.
84	Audit of Speech and Language Therapy signage above patient beds.	• To introduce a pink Speech and Language Therapy recommendations sign for above patient's bed.

Audit title		Actions
85	An internal audit of speech and language therapy (SLT) communication intervention in relation to the therapy outcome	• To feedback the results to SLT team at governance meeting. • To feedback the results to MDT member's as well as the wider team at M&M meeting. • To re-audit the outcome measures and to include patient reported feedback to improve the reliability of the data collected. • To look into ways of improving our service for patients with dementia and cognitive communication difficulties by consideration of pathway with MDT members.
86	Management of patients with Dysphagia on acute medical units	• To feedback findings to supervisor and discuss how to take the project forward. • SLT to display posters on AMU highlighting when to consider referring to SLT. • SLT to continue to provide a service to AMU for all patients with Oropharyngeal Dysphagia. • SLT to continue to offer to educate and support the MDT about the SLT service and how best to manage patients with Oropharyngeal Dysphagia.
87	UHS Trust wide Audit of Hand Hygiene In-patient areas Nov 18	• There were 16 areas with suboptimal compliance with an overall score of below 95% with 2 areas scoring below 85%. • Re-audit is required by areas of sub optimal performance as per Infection Prevention Audit Programme 2018/19. • Care group managers/care group clinical leads to provide support to areas scoring between 94% and 85%. • Areas scoring below 85% will be required to produce an action plan, re audit and will be referred for hand hygiene training.
88	UHS Trust wide Audit of Hand Hygiene Out-patient areas Nov 18	• There were 4 areas with suboptimal compliance for the overall score with 1 area scoring below 85%. • Re-audit is required by areas of sub optimal performance. • Care group managers/care group clinical leads to provide support to areas scoring between 94% and 85%. • Areas scoring below 85% will be required to produce an action plan, re audit and will be referred for hand hygiene training.
89	UHS Trust wide Audit of Preventing Surgical Site Infection	• All areas that did not complete the audit to be reviewed by care group managers/care group clinical leads to ensure that all medical teams submit the audit as per the infection prevention annual audit programme. • Areas scoring below 85% will be required to produce an action plan and re-audit within a month. • Care group managers/care group clinical leads to provide support to areas scoring between 94% and 85%.
90	Human Immunodeficiency Virus (HIV) Testing in patients under Infectious Diseases	• To put together a poster to highlight HIV screening indication. • The HIV team to further consult and decide on testing criteria in view of new HIV prevalence data.
91	Physiotherapists adherence to Cystic Fibrosis (CF) trust and The Standards of Care and Good Clinical Practice for the Physiotherapy Management of Cystic Fibrosis (ACPCF) clinical standards	• To feedback and discuss the audit findings with the seniors of the CF Physiotherapy team. • A re-audit will take place in 2018. Data collection for the re-audit will be of the period of time from January until June 2017.
92	Smoking prevalence and smoking cessation provision in a respiratory inpatient population clinical audit	• The results to be shared with the Chief Executive of UHS.
93	Audit of missed venous-Thromboprophylaxis doses.	• To improve the naming of missed doses in prescribing systems to ensure adequate options are available for nurses.
94	Patient care following dislocation of total prosthetic replacement of hip joints from presentation to discharge.	• To present in Trauma & Orthopaedics (T&O) departmental Morbidity and Mortality (M&M) meeting. • Discuss findings in Emergency Department (ED) departmental meeting. • To propose a pathway to relocate them in ED. • The pathway to Relocate Prosthetic hips in ED will require T&O Governance approval. • The pathway to Relocate Prosthetic hips in ED will require ED team approval. • To implement the Prosthetic Hip Relocation in ED pathway.

Audit title		Actions
95	Documentation of the preoperative Chest x-ray (CXR) result in preoperative clinic assessment	• To make medical staff aware of the issue of documentation of preoperative CXR. • To present findings at a local Cardiovascular & Thoracic (CV&T) meeting.
96	Are staff compliant with Record Keeping Standards within Medical Records?	• To remind all staff of key standards for documentation.
97	Unexpected Term admissions to the Neonatal Unit	• To introduce training and report number of clinical staff who have completed the e-learning package. This will be overseen and managed via the ATAIN working group.
98	Pre-term birth clinic audit	• Consultation for new referral criteria:- o 2 x Large Loop Excision of the Transformation Zone (LLETZ). o Any delivery or preterm rupture of membranes before 34 weeks o Uterine abnormality (didelphus or septum).
99	Audit of post mortem histology pathway	• To design Masterlab to be able to hold all the post mortem information. • To acquire a cassette printer for the mortuary. • For post mortem histology to have equal status to other histological specimens processing.
100	Wound Care Assessment and Documentation	• To feedback individual ward results to band 7 ward managers. • Wards where compliance was less than 90%, Band 7 to work with ward ANT to ensure that all patients have a care plan for each wound present. • On wards with less than 90% compliant, band 7 to work with ANT to remind staff to ensure all dressings are changed as per plan. • For all wards that did not comply, Band 7 and ANT to ensure staff document reason if not following wound formulary.
101	Carbon Monoxide (CO) monitoring in pregnancy	• Women will need to decline an automatic referral to Quitters. • We will hold a specialist study day around difficult and motivational conversations specifically for smoking. • To set up meetings with Commissioners to support good working relationships and communication /referral pathways. • The stillbirth review group will feed directly back to Community Manager if a lady who suffered stillbirth was not monitored or referred. • To work with partners quit 4life for Hampshire patients and Healthy Living for Southampton patients.
102	Colorectal Patient Triggered Follow-Up (PTFU) Audit	• Colorectal PTFU Nurse Practitioner to meet monthly with PTFU Teams to discuss audit results and redesign of the audit protocol. • To find out if PTFU Teams can have succinct audit tool to ensure similar working strategies and promote collaborative working. • Meet with My Medical Record and IT to discuss possible improvements to the system with the aim being to make it easier for data collection. • This Meeting is to occur either separately with involvement of colorectal Band 4 support worker (due to their insight into the system) or within monthly at the joint PTFU meetings. • Changes to documentation to ensure audit compliance and compliance with protocol meet current expectations with patients receiving preparation for PTFU and for support. • Support worker to record information on My Medical Record to state patient has received. • Band 4 Support Worker is to record information on My Medical Record to state patient has received preparation for PTFU.
103	An audit of compliance with national guidelines for external and internal examination at coronial autopsy	• To discuss the audit findings at consultant meeting. • To share findings with the Health Technology Assessment (HTA) lead.
104	Assessment of knowledge of local anaesthetic toxicity in Emergency Department (ED)	• Introduce a local anaesthetic toxicity 'Rescue Box' in the ED department (containing Intralipid, giving set and AABGI guidelines on LAT). • Department teaching on local anaesthetic toxicity, at SHO and Registrar teaching, to increased knowledge and awareness in the department. • An ED email bulletin to all staff in the department highlighting the signs & symptoms of local anaesthetic toxicity and how to treat.

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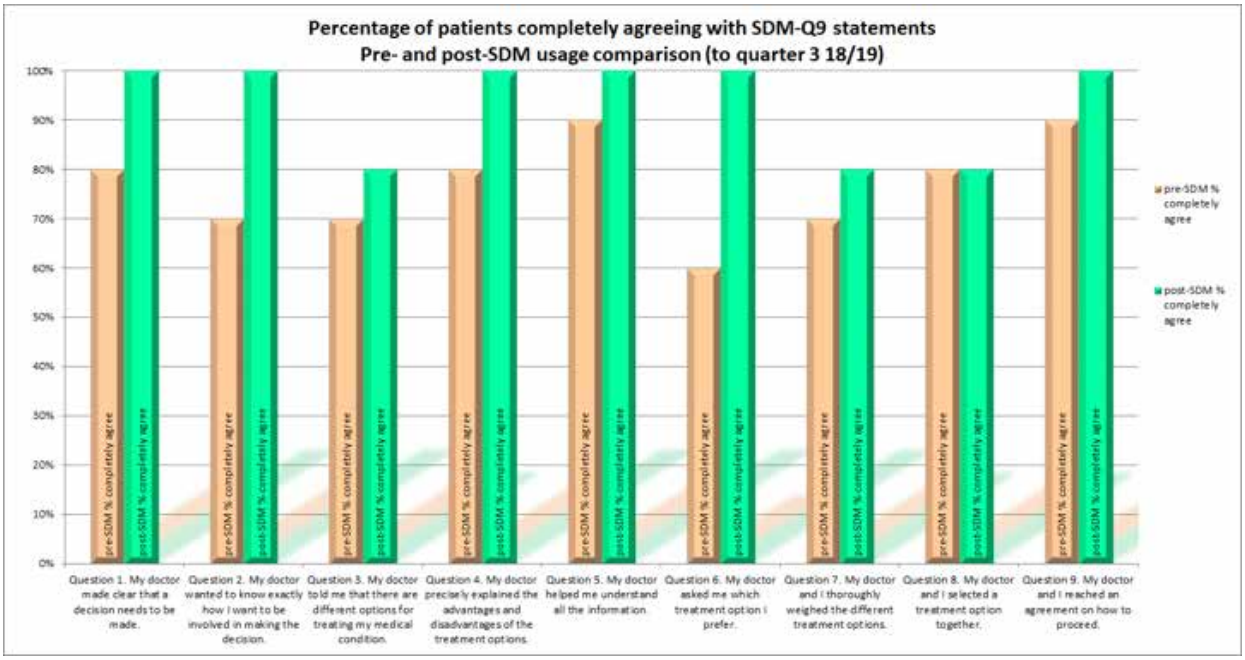
105	An audit of the compliance for the NICE Quality Standard 158 within the General Intensive Care Unit (GICU) Therapy Team	• The GICU Therapy team to complete the Therapy Handover section or to document on Metavision that handover to the ward therapists has occurred. • To implement the dissemination of information to patients with regards to their rehabilitation goals.
106	An audit of compliance with RCPath cancer resection reporting dataset criteria	• An action for Cutaneous Squamous cell carcinoma is to discuss with the skin lead and to remind staff to include all required dataset criteria. • Paediatric renal tumours potential actions will be discussed at consultant meeting. All staff to be reminded to include all dataset criteria. • Lymphoma actions to be discussed at consultant meeting. Staff reminded to include all dataset criteria.
107	Infection, Prevention and Control (IPC) - Miscellaneous audits: isolation	• Care group managers/care group clinical leads to provide support to 12 areas that scored between 94% and 85% and to re-audit within 3 months.
108	IPC - Saving Lives HII 2 Peripheral Intravenous Cannula Care.	• Peripheral Intravenous Cannula Insertion o 2 Areas scoring between 85% and 94% required to complete an action plan. o 6 Areas scored below 85% required to complete an action plan and re-audit in 1 month. • Peripheral Intravenous Cannula Ongoing - o 1 Area scoring between 85% and 94% required to will complete an action plan. o 6 areas scored below 85% required to will complete an action plan and re-audit in 1 month.
109	Management of Supracondylar Fractures in the Paediatric Population	• To present findings at Orthopaedic Mortality & Morbidity (M&M) meeting 13/04/19, to raise awareness and educate Senior House Officer (SHO)'s / Specialist Registrar (SpR)s on importance of accurate documentation. • To implement the pro-forma and then to re-audit.
110	Audit of compliance with BSR and local guidelines for Giant Cell Arteritis	• To request an additional tab on the Hospital Integrated Clinical Support Systems (HICSS) database.
111	Audit of Post-Operative Urinary Catheter Removal in a Surgical High Dependency Unit (SHDU) Environment	• Staff education to take place on the SHDU. This will be a discussion with the doctors and staff on the unit to highlight the benefits of Trial With-Out Catheter (TWOC) at the recommended time to reduce patient complications and to highlight the recommendations in the Enhanced Recovery After Surgery (ERAS) guidelines. • To create an informative poster which highlights the importance of considering the TWOC during a clinical review of a patient. • To illustrate the results of the first cycle of the audit.
112	Post take ward rounds in Trauma and Orthopaedics - are we documenting appropriately?	• To further adapt the proforma based on user response and feedback and to encourage juniors to raise key questions during Post Take Ward Round (PTWR).
113	UHS Trust wide Audit of Hand Hygiene Practice February 2019	• To introduce a new improvement framework specifically for hand hygiene in place of the current audit assurance framework (RAG) system with the aim of driving improvements in practice. Areas will be measured against a performance improvement target, e.g. the trust median score for key moments. • Divisions, Care Groups and Clinical Teams to review their individual reports and identify areas and actions for improvement. • Report to be reviewed and discussed at Infection Prevention Committee, with Divisional representatives, and improvement actions agreed. • Proposal for introduction of new improvement framework to be discussed at Trust Infection Prevention Committee.
114	UHS Personal Protective Equipment Audit February 2019	• 10 areas scoring between 85% and 94% to complete a re-audit within 3 months.
115	UHS Trust Wide Audit of Cleanliness and Decontamination of Clinical Equipment February 2019	• 35 areas failed to submit the audit. Care group managers / care group clinical leads are required to ensure that all areas submit audits as per the infection prevention annual audit programme. • 14 areas scored below 85%. These areas are to: • Produce an action plan to address issues and send to Infection Prevention for monitoring. • Re- Audit within 1 month ensuring compliance addressed through action plans. • 1 area scored between 85% and 94% to complete a re-audit within 3 months.

Audit title		Actions
116	Lying and Standing Blood Pressure Completion	• To share results with Trust Falls Steering Group (TFSG); to share with Trust via OWL. • To complete educational / awareness sessions for staff as part of Falls Focus February. This will include ward visits, OWL, core brief information and staff briefing updates. • To work with Safetrack systems team to change the override options for non-completion of Lying & Standing Blood Pressure (L/S BP) and require staff to input clinical reasoning into the override. • To re-audit compliance with L/S BP completion following education and Safetrack changes. This will be done by a re-audit, and will also consider whether continuous audit may be appropriate through inpatient falls AER questionnaire.
117	An audit of fluid chart completion on SafeTrack for enterally fed patients on the medical wards	• A fluid audit to be carried out on Neurology wards.
118	An audit of calorie provision from citrate anticoagulation in continuous renal replacement therapy in a General Intensive Care (GICU)	• To share results with the Intensive Care Unit (ICU) dietitians. • To share results with GICU MDT.

APPENDIX
8

Shared decision making



APPENDIX 9

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
- Hampshire and Isle of Wight Air Ambulance (HIOWAA)

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.

ANNUAL ACCOUNTS

Statement from the chief financial officer and deputy chief executive

Like all hospital trusts, UHS operates within the context of national NHS finances and across the country, all my colleagues in other hospitals report how challenging NHS finances have been this year. Whilst in comparison to other public spending priorities the NHS has done relatively well, the reality we face is that demand for NHS services, driven by the increasing number of patients and their increased collective severity of illness, is rising faster than the available funding. In this context, despite the NHS being one of the most efficient healthcare systems in the world, many trusts are now spending more than the money allocated to them, resulting in financial deficits, which in turn constrain the cash available for investment in new equipment, buildings and services.

Whilst UHS is not immune to these financial pressures, I am pleased to report that UHS achieved its financial target of a small financial surplus (£4m) for 2018/19. Trusts achieving their financial targets are currently eligible for additional national cash funding which, for UHS, was an additional £22m. Since many trusts failed to achieve their financial targets, a sizeable value of unallocated national funding was redistributed to those trusts which did achieve their targets and for UHS, this resulted in a further £14m of cash funding.

Having delivered its financial targets for the last three years, UHS has benefited hugely from this national funding scheme (known as PSF) with total surpluses of £20m, £40m and £40m for the three years respectively. This funding has enabled UHS to commit to the most ambitious programme of capital investment it has ever seen. Capital expenditure in 2018/19 was £36m, £14m higher than the previous year and construction has now begun on the five-floor building extension which will house an expanded and refurbished General Intensive Care Unit, plus eight new surgical theatres to provide the additional capacity, and quality of patient environment, these areas of the hospital desperately need.

But as the era of PSF additional funding draws to an end, it must be noted that excluding this PSF financial 'bonus', UHS made only a small financial surplus for the year. Indeed, if favourable one-offs such as the release of balance sheet reserves are excluded, the Trust's underlying performance for 2018/19 was a financial deficit, below our expectations for the year and, were this to continue, certainly insufficient to fund our future investment plans for the hospital.

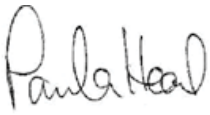
The reasons for this deficit situation include the additional costs of agency staff, because we were unable to recruit enough permanent registered nurses. Also, disappointingly, all the hard work undertaken to increase ward bed capacity by, for example, reducing the number of patients whose discharge was delayed, could not be translated into more chargeable activity due to capacity constraints elsewhere, such as the lack of theatre availability preventing those beds being used for more elective surgery. Nevertheless, efficiency savings of more than £30m were made over the year and this resulted in UHS' financial performance, relative to the rest of the NHS sector, being strong.

Looking forward to the next financial year, the underlying deficit for 2018/19 does mean that our financial target for 2019/20 (£17m surplus) will be more challenging than ever. It means we have to make efficiency savings of £40m over the year, nearly £10m more than we achieved in 2018/19. We have stepped up the capacity of the cost improvement project team and, together with the tenacity and ingenuity of all our brilliant staff, we are determined to achieve our financial targets so we can afford to continue our ambitious investment programme for the benefit of our patients and staff.

David French
Chief financial officer and deputy chief executive

Foreword to the accounts

These accounts for the period to 31 March 2019, 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.



Paula Head
Chief executive officer

28 May 2019

Independent auditor's report

to the Council of Governors of University Hospital Southampton NHS Foundation Trust

. 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 2019 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements 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 2019 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 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

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 and Trust 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	£15.6m (2017/18:£15.2m) 2% (2017/18: 2%) of total income from operations	
Coverage	2% (2017/18: 2%) of total group income from operations	
Risks of material misstatement		**vs 2017/18**
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of NHS and non-NHS income	◀▶
	New: Fraudulent expenditure recognition	▲

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 matters in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (includes expenditure recognition as a new risk in the current year):

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

	The risk	Our response
Land and buildings (£345.0 million; 2017/18: £323.1 million) *Refer to page 35(Audit and Risk Committee Report), page 194 (accounting policy) and page 212 (financial disclosures)*	**Valuation of land and buildings** 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. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. For 2018/19 an interim "desktop" 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 considered the scope, qualifications and experience of University Hospital Southampton NHS Foundation Trust's valuer was appropriately experienced and qualified to undertake the valuation. **Comparing valuations:** — We critically assessed the assumptions to determine whether they were indicative of local market conditions; **Methodology choice:** — We considered the overall methodology of the external valuation performed to identify whether the approach was in line with industry practise; **Benchmarking assumptions:** — We critically assessed the assumptions used by management to assess the carrying value of assets against BCIS All-in TPI and industry norms; **Tests of details:** — We considered the carrying value of the land and buildings, including any material movements from the previous revaluations; — We compared the accuracy of the base data used for the carrying value assessment to ensure it agreed to the Trust estate; — We assessed whether the accounting for valuation changes had been completed correctly in line with the requirements of the Group Accounting Manual; and — 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 and accounting treatment of land and buildings to be balanced (2017-18: balanced).

	The risk	Our response
NHS and non-NHS income (£882.3 million; 2017/18: £811.1 million) *Refer to page 35 (Audit and Risk Committee Report), page 191 (accounting policy) and page 205 (financial disclosures)*	**Accounting treatment:** Of the Group's reported total income, £688.1 million (2017/18: £659.7 million) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). Two CCGs and NHS England make up 78.0% 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 £164.0 million (2017/18: £130.0 million) 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. In 2018/19 the Trust received Provider Sustainability Funding (PSF) 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: **Control observation:** — We critically assessed the design and operation of process level controls over revenue recognition; — 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 assessed the Trust's billing to the amounts stated in the contracts; **Tests of details:** — We inspected invoices for material income in the month prior to and following 31 March 2019 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 tested material non-NHS income balances by agreeing a sample of income transactions through to supporting documentation and/or cash receipts; — We re-performed the Trust's calculation of performance against the financial and operational targets used in determining receipt of Provider Sustainability Funding to determine the amount the Trust was qualified to receive. We agreed the amounts recorded in the accounts to our calculation; and — We inspected a sample of credit notes raised after the year end to verified that they were correctly accounted for by the Trust. **Our findings** We found the resulting recognition of NHS and non-NHS income to be balanced (2017-18: balanced).

	The risk	Our response
Expenditure recognition (£836.3 million; 20117/18: £761.3 million) *Refer to page 35 (Audit and Risk Committee Report), page 193 (accounting policy) and page 207 (financial disclosures)*	**Effect of irregularities** In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As the Foundation Trust fulfils some of the characteristics of a governmental body there is as much focus on the expenditure being incurred as the generation of revenue. The risk of material misstatement due to fraud related to expenditure recognition may therefore be as significant as the risk of material misstatements due to fraud related to revenue recognition and so the auditor has regard to this when planning and performing audit procedures. We consider this risk to relate to the completeness of the expenditure recorded as there may be an incentive to seek to defer expenditure in order to achieve financial targets. The Group and Trust agreed a target for its financial performance with NHS Improvement for 2018-19, achievement of which entitled it to Provider Sustainability Funding. There may therefore be an incentive to defer expenditure or recognise commitments at a reduced value in order to achieve the control total agreed with NHS Improvement.	Our procedures included: **Historical comparison:** — We considered the trend in accruals compared to prior periods to assess the accuracy of accruals made in previous years. Where accruals had not been included we critically assessed the reason for an accrual not being made at 31 March 2019. **Tests of details:** — We inspected invoices for material expenses in the month prior to and following 31 March 2019 to determine whether income was recognised in the correct accounting period and in accordance with the amounts billed; — We tested a sample of expenditure transactions through to supporting documentation and/or cash receipts; — 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 expenses they were entitled to and the payments that could be collected; and — We critically assessed whether senior members are remunerated based upon the financial results. We also critically assessed whether there were funding made available to the Trust based upon the results presented in the financial statements. **Our findings** We found the resulting expenditure recognition to be balanced.

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 £15.6 million (2017/18: £15.2 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

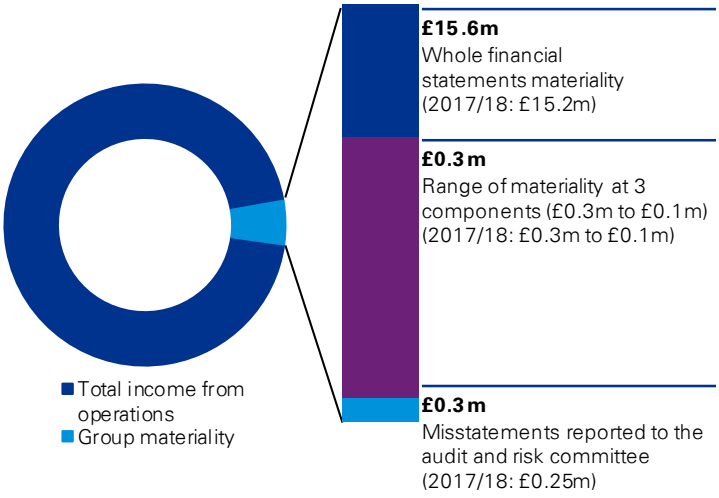
Materiality for the parent Trust's financial statements as a whole was set at £15.6 million (2017/18: £15.2 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%).

We agreed to report to the Audit and Risk Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2018: £0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's 3 reporting components, we subjected 3 to full scope audits for group purposes.

Total income from operation
£882.3m (2017/18: £811.1m)

Group Materiality
£15.6m (2017/18: £15.2m)



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group or the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group or the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Group's and Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1.1 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Group and Trust's 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, and we did not identify going concern as a key audit matter.

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 2018/19, 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 69, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are 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; 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 their 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.org.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 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in 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

28 May 2019

KPMG

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	Group Year ended 31 March 2019 £000	Group Year ended 31 March 2018 £000	Trust Year ended 31 March 2019 £000	Trust Year ended 31 March 2018 £000
Operating income from patient care activities	2.1	718,332	681,070	718,332	681,070
Other operating income	2.1	163,994	130,017	160,334	124,870
Operating income from continuing operations		882,326	811,087	878,666	805,940
Operating expenses of continuing operations	3	(836,277)	(761,284)	(832,844)	(758,912)
OPERATING SURPLUS		46,049	49,803	45,822	47,028
Finance income	7	1,097	217	1,274	146
Finance expenses	8	(495)	(2,834)	(495)	(2,834)
PDC dividends payable		(7,363)	(6,959)	(7,363)	(6,959)
NET FINANCE COSTS		(6,761)	(9,576)	(6,584)	(9,647)
Other gains / (losses)		111	3,647	113	3,685
Gain from transfer by absorption**		1,421	0	1,421	0
SURPLUS FOR THE YEAR *		40,820	43,874	40,772	41,066
Revaluations	10	8,354	544	8,354	544
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		49,174	44,418	49,126	41,610

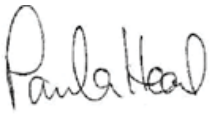
* Adjusting for items such as charitable income and costs, losses on disposal and donated assets, the surplus for NHS performance reporting purposes amounted to £40.470m (2017/18: £41.153m). Excluding monies related to the Provider Sustainability Fund (PSF), the surplus for the Group excluding the Southampton Hospital Charity was £4.424m (2017/18 £13.845m).
** The transfer by absorption relates to an asset transfer from Public Health England of the Microbiology service.

The notes on pages 190 to 220 form part of these accounts.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AT 31 MARCH 2019

		Group		Trust	
		31 March 2019	31 March 2018	31 March 2019	31 March 2018
	NOTE	£000	£000	£000	£000
Non-current assets					
Intangible assets	11	18,320	12,948	18,320	12,948
Property, plant and equipment	12	344,976	323,149	338,241	319,080
Investment Property	13.1	123	125	0	0
Investments in joint ventures and associates	14	1	1	1	1
Other Investments	13.2	2,997	2,997	5,541	3,441
Trade and other receivables	16	3,532	3,492	13,034	8,877
Total non-current assets		369,949	342,712	375,137	344,347
Current assets					
Inventories	15	16,504	16,219	15,688	15,624
Trade and other receivables	16	106,111	81,379	106,428	80,720
Cash and cash equivalents	18.1	65,524	56,600	60,199	51,202
Total current assets		188,139	154,198	182,315	147,546
Current liabilities					
Trade and other payables	19	(100,996)	(83,231)	(101,910)	(79,997)
Borrowings	20	(10,302)	(9,848)	(10,302)	(9,848)
Provisions	23.1	(656)	(626)	(656)	(626)
Other liabilities	22	(9,371)	(15,527)	(9,371)	(15,527)
Total current liabilities		(121,325)	(109,232)	(122,239)	(105,998)
Total assets less current liabilities		436,763	387,678	435,213	385,895
Non-current liabilities					
Trade and other payables	19	(908)	(751)	(6,956)	(6,518)
Borrowings	20	(47,603)	(54,422)	(47,603)	(54,422)
Provisions	23.1	(2,748)	(2,885)	(2,748)	(2,885)
Other liabilities	22	(14,582)	(14,924)	(14,582)	(14,924)
Total non-current liabilities		(65,841)	(72,982)	(71,889)	(78,749)
Total assets employed		370,922	314,696	363,324	307,146
Financed by					
Taxpayers' equity					
Public Dividend Capital		210,981	203,929	210,981	203,929
Revaluation reserve		33,832	25,478	33,832	25,478
Income and expenditure reserve		119,435	78,176	118,511	77,739
Charitable fund reserves		6,674	7,113	0	0
Total taxpayers' equity		370,922	314,696	363,324	307,146

The financial statements on pages 186 to 220 were approved by the Board on 23 May 2019 and signed on its behalf by:



Paula Head, chief executive officer
23 May 2019

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

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 2018	**7,113**	**203,929**	**25,478**	**78,176**	**314,696**
Surplus / (deficit) for the year	**(439)**	**0**	**0**	**41,259**	**40,820**
Revaluations - property, plant and equipment	**0**	**0**	**8,354**	**0**	**8,354**
Public Dividend Capital received	**0**	**7,052**	**0**	**0**	**7,052**
Taxpayers' and Others' Equity at 31 March 2019	**6,674**	**210,981**	**33,832**	**119,435**	**370,922**
Taxpayers' and Others' Equity at 1 April 2017	4,775	195,423	24,872	36,702	261,772
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	(62)	0
Taxpayers' Equity at 31 March 2018	7,113	203,929	25,478	78,176	314,696

Trust	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2018	**203,929**	**25,478**	**77,739**	**307,146**
Surplus / (deficit) for the year	**0**	**0**	**40,772**	**40,772**
Revaluations - property, plant and equipment	**0**	**8,354**	**0**	**8,354**
Public Dividend Capital received	**7,052**	**0**	**0**	**7,052**
Taxpayers' and Others' Equity at 31 March 2019	**210,981**	**33,832**	**118,511**	**363,324**
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

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

		Group		Trust	
		Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	NOTE	**£000**	£000	**£000**	£000
Operating surplus		**46,049**	49,803	**45,822**	47,028
Depreciation and amortisation	**11/12.1**	**22,496**	21,296	**22,181**	21,243
Impairments	**10**	**2,593**	(484)	**2,593**	(484)
Non-cash donations/grants credited to income		**(3,459)**	(1,236)	**(3,459)**	(1,236)
(Increase) in Trade and Other Receivables	**16**	**(24,319)**	(17,900)	**(29,504)**	(22,857)
(Increase) in Inventories	**15**	**(285)**	(1,021)	**(64)**	(907)
Increase/(decrease) in Trade and Other Payables	**19**	**19,345**	6,471	**23,549**	4,015
Increase/ (decrease) in Other Liabilities	**22**	**(6,498)**	3,247	**(6,498)**	3,247
Increase / (decrease) in Provisions	**23**	**(110)**	(1,559)	**(110)**	(1,559)
Movements in charitable fund working capital		**(19)**	351	**0**	0
Net cash generated from operations		**55,793**	58,968	**54,510**	48,490
Interest received	**7**	**1,097**	99	**1,274**	146
Purchase of financial assets		**0**	0	(2,100)	(1)
Purchase of intangible assets	**11**	**(7,840)**	(7,270)	**(7,840)**	(7,270)
Purchase of Property, Plant and Equipment	**12**	**(29,122)**	(24,488)	**(25,843)**	(16,569)
Sales of Property, Plant and Equipment	**9**	**129**	47	129	47
Receipt of cash donations to purchase capital assets		**3,459**	1,240	**3,459**	1,240
Cash from disposals of business units and subsidiaries *	**9**	**0**	3,700	**0**	3,700
NHS Charitable funds - net cash flows from investing activities		**0**	118	**0**	0
Net cash (used in) investing activities		**(32,277)**	(26,554)	**(30,921)**	(18,707)
Public dividend capital received		**7,052**	8,506	**7,052**	8,506
Loans repaid to the Department of Health	**20**	**(3,489)**	(4,922)	**(3,489)**	(4,922)
Other loans repaid	**20**	**(134)**	(171)	**(134)**	(171)
Capital element of finance lease rental payments		**(9,132)**	(5,641)	**(9,132)**	(5,641)
Capital element of Private Finance Initiative Obligations		**(371)**	(353)	**(371)**	(353)
Interest on loans	**8**	**(414)**	(553)	**(414)**	(553)
Interest element of finance lease	**8**	**0**	(2,181)	**0**	(2,181)
Interest element of Private Finance Initiative obligations	**8**	**(87)**	(107)	**(87)**	(107)
PDC Dividend paid		**(8,017)**	(6,355)	**(8,017)**	(6,355)
Net cash (used in) financing activities		**(14,592)**	(11,777)	**(14,592)**	(11,777)
Increase in cash and cash equivalents		**8,924**	20,637	**8,997**	18,006
Cash and Cash equivalents at 1 April		**56,600**	35,963	**51,202**	33,196
Cash and Cash equivalents at 31 March		**65,524**	56,600	**60,199**	51,202

The notes on pages 190 to 220 form part of these accounts.

*Cash from disposals of business units in 2017/18 related to the sale of Complete Fertility

Notes to the accounts

1. 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 2018-19, 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 2019 was £4.256m (unrestricted) and £2.418m (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 2019 was £14.534m and its gross assets at 31 March 2019 totalled £1.328m. UHS Estates Ltd provides building management services to the Trust for buildings that the company develops. Completed developments include Minerva House and Compton House and it is now undertaking the Children's Hospital development. Its turnover for the period ended 31st March 2019 was £1.34m and its gross assets at 31 March 2019 totalled £5.132m.

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 at its financial year end which is 31st December. The joint venture made a small profit (less than £1k) in the year to 31st December 2018.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DH 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 resulting gain or loss 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 transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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 (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. 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. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is based upon the completion of obligations as per the contracts, generally in the Research & Development area.

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, has completed the NHS2 form and confirmed there are no discrepancies with the treatment, 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 in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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.

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.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles, generally 14 days.

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants.
Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of leave 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 scheme 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 the consideration payable. Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Trust recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

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. UPL incurred £34k of corporation tax in 2018/19. UEL did not incur any corporation tax.

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 2019. The last full revaluation was undertaken at 31 March 2015, the next full revaluation being required in the next financial year.

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.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 12.1.

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 radiology 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 cost 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 asset;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its 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 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 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018/19 percentages are expressed in nominal terms with 2017/18 being the last financial year that HM Treasury provided real general provision discount rates.

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 as and when they became due.

1.20 Financial assets and liabilities

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument 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 when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at amortised cost
Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

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.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income
Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Financial assets at fair value through profit and loss
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Impairment
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

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.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. the Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Public Dividend Capital (PDC) and PDC dividend
Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care'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.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash
- any PDC dividend balance receivable or payable.
- Provider Sustainability Fund incentive receivable balances in 2017/18 and 2018/19.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, 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 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.

1.21 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.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation.

This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

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 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.

1.24 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.

1.25 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.

1.26 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.

1.27 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.

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.

	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 2019 was £5.780m (see note 17).

1.28 Other accounting judgements and sources of estimation uncertainty

Provisions

The Trust regularly monitors the position regarding provisions, including legal claims and restructuring, to ensure that it accurately reflects at each balance sheet date the current position in providing for potential future costs from past events, including board resolutions. The total provision for liabilities and charges at 31st March 2019 was £3.404m (see note 23.2).

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 2019 is £5.618m (see note 6.2), and for finance leases £42.226m (see note 27).

Sources of estimation uncertainty

There are no 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.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 12.

1.29 Accounting Standards that have been issued but not adopted.

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

Change published	Financial year for which the change first applies / comment
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 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.

2.1 Operating income by activity

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Income from patient care activities				
Elective income	**136,407**	129,813	**136,407**	129,813
Non elective income	**195,968**	186,662	**195,968**	186,662
Outpatient income	**31,583**	23,036	**31,583**	23,036
Follow up outpatient income	**42,670**	46,350	**42,670**	46,350
A & E income	**18,459**	17,383	**18,459**	17,383
High cost drugs income from commissioners	**108,605**	0	**108,605**	0
Other NHS clinical income	**167,485**	267,870	**167,485**	267,870
Private patient income	**5,619**	5,825	**5,619**	5,825
AfC pay award central funding	**6,546**	0	**6,546**	0
Other clinical income	**4,990**	4,131	**4,990**	4,131
Total income from patient care activities	**718,332**	681,070	**718,332**	681,070
Other operating income				
Research and development (IFRS15)	**1,996**	21,606	**1,996**	21,606
Education and training	**36,370**	35,449	**36,370**	35,449
Cash donations for the purchase of capital assets - received from other bodies	**3,459**	1,236	**3,459**	1,236
Charitable and other contributions to expenditure - received from other bodies	**697**	566	**697**	566
Non-patient care services to other bodies	**16,128**	12,615	**16,519**	12,285
Provider Sustainability Fund income	**36,046**	27,308	**36,046**	27,308
Other (recognised in accordance with standards other than IFRS 15)	**27,790**	0	**27,790**	0
Rental revenue from operating leases	**34**	37	**34**	37
NHS Charitable Funds: Incoming Resources excluding investment income	**3,986**	4,779	**0**	0
Other Operating Income:				
Car parking	**4,416**	3,659	**4,416**	3,659
Staff accommodation rentals	**42**	47	**42**	47
Crèche services	**1,543**	1,468	**1,543**	1,468
Clinical excellence awards	**3,922**	4,055	**3,922**	4,055
Other	**27,565**	17,192	**27,500**	17,154
Total other operating income	**163,994**	130,017	**160,334**	124,870
TOTAL OPERATING INCOME	**882,326**	811,087	**878,666**	805,940

Of total Operating Income of £882.324m, £688.139m was for commissioner requested services (2017/18: £657.011m), and £194.185m was for non-commissioner requested services (2017/18: £154.076m). 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 £35.18m (2017/18: £30.201m). The figure of £27.565m above for Other income includes £10.1m CCG non-clinical income, £6.4m DH income and £3.5m Cancer Drugs Fund income.

2.2 Operating lease income

	Group		Trust	
	Year ended 31 March 2019 Total £000	Year ended 31 March 2018 Total £000	**Year ended 31 March 2019 Total £000**	Year ended 31 March 2018 Total £000
Rental revenue from operating leases - minimum lease receipts	**34**	37	**34**	37
Future minimum lease payments due on leases of buildings and equipment expiring				
- later than five years:	**1,178**	1,216	**1,178**	1,216

2.3 Analysis of income from activities by source

	Group		Trust	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
NHS Foundation Trusts	**410**	435	**410**	435
NHS Trusts	**194**	160	**194**	160
NHS England	**348,784**	335,339	**348,784**	335,339
Clinical Commissioning Groups	**339,355**	324,407	**339,355**	324,407
Local Authorities	**722**	1,020	**722**	1,020
Department of Health and Social Care	**6,546**	0	**6,546**	0
Non NHS: Private patients	**5,619**	5,825	**5,619**	5,825
Non-NHS: Overseas patients (non-reciprocal)	**1,022**	570	**1,022**	570
NHS injury scheme (was RTA)	**3,246**	2,541	**3,246**	2,541
Devolved administrations and Channel Islands	**12,434**	10,773	**12,434**	10,773
Total income from patient care activities	**718,332**	681,070	**718,332**	681,070

2.4 Overseas Visitors

	Group		Trust	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Income recognised this year	**1,022**	570	**1,022**	570
Cash payments received in-year (relating to invoices raised in current and previous years)	**1,304**	644	**1,304**	644
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**69**	158	**69**	158
Amounts written off in-year (relating to invoices raised in current and previous years)	**387**	18	**387**	18

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

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Group and Trust		
Income	**5,281**	5,127
Full cost	**(4,499)**	(4,368)

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

2.6 Additional information on contract revenue (IFRS 15) recognised in the period (Group and Trust)

	Year ended 31 March 2019
	£000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)	**2,000**

2.7 Transaction price allocated to remaining performance obligations (i.e. revenue not recognised this year) (Group and Trust)

IFRS 15 requires the Trust to disclose the remaining transaction price of partially completed contracts that will be recognised when performance obligations are met in future periods, subject to the following exclusions for materiality: (i) contracts with a duration of one year or less and (ii) contracts where the provider recognises revenue from the right to consideration corresponding to work done to date (para B16). The Trust has no such contracts where these exclusions do not apply.

3 Operating expenditure

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**12,964**	15,067	**12,964**	15,067
Purchase of healthcare from non-NHS and non-DHSC bodies	**18,341**	13,866	**18,341**	13,866
Staff and executive directors costs	**481,417**	452,581	**480,772**	451,343
Non-executive directors	**152**	143	**152**	143
Supplies and services – clinical (excluding drugs costs)	**92,460**	84,248	**92,460**	84,248
Supplies and services - general	**19,637**	18,403	**19,381**	18,187
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**108,991**	95,012	**110,002**	96,017
Inventories written down (net including drugs)	**12**	0	**0**	0
Consultancy	**166**	53	**164**	53
Establishment	**3,635**	3,354	**3,615**	3,336
Premises - business rates collected by local authorities	**3,173**	3,039	**3,154**	3,018
Premises - other	**23,315**	19,886	**24,486**	19,805
Transport (business travel only)	**309**	325	**309**	325
Transport - other (including patient travel)	**1,945**	2,099	**1,945**	2,095
Depreciation	**20,580**	19,022	**20,265**	18,969
Amortisation	**1,916**	2,274	**1,916**	2,274
Impairments net of (reversals)	**2,593**	(484)	**2,593**	(484)
Movement in credit loss allowance: contract receivables/assets	**1,998**	0	**1,998**	0
Movement in credit loss allowance: all other receivables & investments	**0**	1,571	**0**	1,571
Change in provisions discount rate	**(51)**	40	**(51)**	40
Audit fees payable to the external auditor:				
Audit services - statutory audit	**36**	66	**59**	58
Other auditor remuneration (payable to external auditor only)	**9**	33	**9**	33
Charitable fund audit	**9**	8	**0**	0
Internal audit - non-staff	**114**	105	**114**	105
Clinical negligence - amounts payable to NHS Resolution (premium)	**18,031**	14,033	**18,031**	14,033
Legal fees	**579**	899	**562**	899
Insurance	**746**	629	**746**	629
Research and development - non-staff	**10,995**	6,847	**10,995**	6,847
Education and training - non-staff	**1,778**	1,447	**1,778**	1,447
Operating lease expenditure (net)	**898**	1,419	**891**	1,403
Redundancy costs - non-staff	**150**	416	**150**	416
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	**1,095**	1,095	**1,095**	1,095
Car parking and security	**798**	713	**798**	713
Other losses and special payments - non-staff	**23**	7	**23**	7
Other services (e.g. external payroll)	**888**	804	**888**	804
Other NHS charitable fund resources expended	**4,256**	1,631	**0**	0
Other	**2,319**	633	**2,239**	550
TOTAL	**836,277**	761,284	**832,844**	758,912

3.1 Group Other Audit remuneration

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	£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;	**0**	10	**0**	10
All other non-audit services	**0**	14	**0**	14
Total	**9**	33	**9**	33

3.2 Group and Trust Losses and Special Payments

	Year ended 31 March 2019		Year ended 31 March 2018	
	Cases by number and value			
Losses and special payments paid out in the year were as follows:	**Number**	**£000's**	Number	£000's
Bad debts and claims abandoned	**283**	**441**	185	41
Damage to buildings, property etc. (including stores losses) due to:	**1**	**12**	0	0
Total Losses	**284**	**453**	185	41
Ex gratia payments	**27**	**21**	32	13
Total Special Payments	**27**	**21**	32	13
Total Losses and Special Payments	**311**	**474**	217	54

4.1 Employee Expenses

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	Total £000	Total £000	**Total £000**	Total £000
Salaries and wages	**373,982**	350,852	**373,625**	350,534
Social security costs	**38,409**	36,190	**38,402**	36,165
Apprenticeship levy	**1,856**	1,740	**1,856**	1,737
Pension cost - Employers contributions to NHS Pensions	**45,109**	42,293	**45,109**	42,287
Pension cost - other contributions	**39**	18	**39**	18
Temporary staff - external bank	**23,791**	19,394	**23,791**	19,394
Temporary staff - agency/contract staff	**12,950**	11,610	**12,827**	11,606
NHS Charitable funds staff	**158**	882	**0**	0
Recoveries from Other bodies in respect of staff cost netted off expenditure	**(12,760)**	(9,253)	**(12,760)**	(9,253)
Total Net Staff Costs	**483,534**	453,726	**482,889**	452,488
Employee Expenses - Staff	**481,259**	451,699	**480,772**	451,343
NHS Charitable funds: Employee expenses	**158**	882	**0**	0
Total Employee benefits excluding capitalised costs	**481,417**	452,581	**480,772**	451,343

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 2019 (in their capacity as directors) totalled £1,047k (2017/18 £1,031k). 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 2019 totalled £129k (2017/18 £152k). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was 6 (2017/18 6).

4.2 Average number of employees (WTE basis)

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	Total Number	Total Number	**Total Number**	Total Number
Medical and dental	**1,511**	1,398	**1,511**	1,398
Administration and estates	**2,064**	1,955	**2,064**	1,955
Healthcare assistants and other support staff	**1,896**	1,827	**1,896**	1,827
Nursing, midwifery and health visiting staff	**3,534**	3,435	**3,534**	3,435
Scientific, therapeutic and technical staff	**985**	944	**974**	944
Healthcare science staff	**510**	448	**510**	448
Other	**107**	132	**107**	132
Total	**10,607**	10,139	**10,596**	10,139
Number of Employees (WTE) engaged on capital projects	**55**	29	**55**	29

4.3 Early retirements due to ill health

From April 2018 to March 2019 there were 6 (Apr 2017- Mar 2018:5) early retirements from the organisation agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements is £342k (Apr 2017- Mar 2018: £264k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority-Pensions Division.:

4.4 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 2019		Year ended 31 March 2018	
£10,001 - £25,000	**4**	**61**	1	21
£25,001 - £50,000	**1**	**35**	1	48
£50,001 - £100,000	**0**	**0**	1	80
£100,001 - £200,000	**0**	**0**	1	150
Total	**5**	**96**	4	299

4.5 Exit packages: other (non-compulsory) departure payments

	Number of other departures Number	**Value of other departures £000**	Number of other departures Number	Value of other departures £000
	Year ended 31 March 2019		Year ended 31 March 2018	
<£10,000	**2**	**12**	0	0
£10,000 - £25,000	**2**	**29**	3	61
£25,001 - £50,000	**0**	**0**	1	28
£50,001 - £100,000	**1**	**63**	0	0
Total	**5**	**104**	4	89

5. 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 2019, is based on valuation data as 31 March 2016, updated to 31 March 2019 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 rose to 2.6% in 2018/19 and will increase to 4% in April 2019. At 31st March 2019 the Trust had 91 members in NEST (31st March 2018: 91) and had made total contributions for 2018/19 of £12k (2017/18: £12k).

6.1 Operating leases

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	£000	£000	**£000**	£000
Minimum lease payments	**898**	1,419	**891**	1,403

6.2 Arrangements containing an operating lease

	Year ended 31 March 2019			Year ended 31 March 2018		
	£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;	**195**	**289**	**484**	248	252	500
- later than one year and not later than five years;	**659**	**190**	**849**	687	318	1,005
- later than five years.	**4,285**	**0**	**4,285**	4,450	0	4,450
Total	**5,139**	**479**	**5,618**	5,385	570	5,955
Trust						
Future minimum lease payments due:						
- not later than one year;	**195**	**289**	**484**	248	252	500
- later than one year and not later than five years;	**659**	**190**	**849**	687	318	1,005
- later than five years.	**4,285**	**0**	**4,285**	4,450	0	4,450
Total	**5,139**	**479**	**5,618**	5,385	570	5,955

6.3 Interest on late payments

There was no interest incurred on late payments in 2017/18 or 2018/19.

7 Finance revenue

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	£000	£000	**£000**	£000
Interest on bank accounts	**396**	99	**396**	99
Interest income on finance leases	**701**	0	**701**	0
Interest on other investments / financial assets	**0**	0	**177**	0
NHS charitable fund investment income	**0**	118	**0**	0
Other	**0**	0	**0**	47
Total	**1,097**	217	**1,274**	146

8 Finance expenses

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	£000	£000	**£000**	£000
Capital loans	**369**	493	**369**	493
Interest on other loans	**36**	47	**36**	47
Interest on finance lease obligations	**0**	2,181	**0**	2,181
PFI finance costs	**87**	106	**87**	106
Total interest expense	**492**	2,827	**492**	2,827
Unwinding of discount on provisions	**3**	7	**3**	7
Total Finance expenses	**495**	2,834	**495**	2,834

The nil value in year on finance lease interest relates to a retrospective adjustment in respect of the Integrated Imaging Support Service (IISS) discount rate applied

9 Other gains and losses

	Group		Trust	
	Year ended 31 March 2019	Year ended 31 March 2018	**Year ended 31 March 2019**	Year ended 31 March 2018
	£000	£000	**£000**	£000
Gains on disposal of property, plant and equipment	**113**	47	**113**	47
Gains on disposal of intangible assets	**0**	3,700	**0**	3,700
Losses on disposal of property, plant and equipment	**0**	(62)	**0**	(62)
Total gains/(losses) on disposal of assets	**113**	3,685	**113**	3,685
Fair value gains/(losses) on charitable fund investments & investment properties	**(2)**	(38)	**0**	0
Total other gains/(losses)	**111**	3,647	**113**	3,685

The gain on disposal of intangible assets in 2017/18 related to the sale of Complete Fertility

10 Impairments and revaluations Group and Trust

Group and Trust	**Year ended 31 March 2019**			Year ended 31 March 2018		
	Net impairment	Impairments	Reversals	Net impairment	Impairments	Reversals
	£000	**£000**	**£000**	£000	£000	£000
Changes in market price	**2,593**	**2,593**	**0**	(484)	0	(484)
Total Impairments	**2,593**	**2,593**	**0**	(484)	0	(484)

All of the amount above was debited to the Statement of Comprehensive Income. There was no impairment charged to the Revaluation reserve, however there was a revaluation of £8.354m (2017/18: £0.544m) credited to the Revaluation reserve.

11 Intangible assets

	Movements for year ended 31 March 2019		Movements for year ended 31 March 2018	
	Software licences (purchased)	**Total**	Software licences (purchased)	Total
Group and Trust	**£000**	**£000**	£000	£000
Valuation/Gross Cost at 1 April	**24,311**	**24,311**	17,603	17,603
Transfers by absorption	**9**	**9**	0	0
Additions - purchased / internally generated	**7,279**	**7,279**	7,519	7,519
Additions - assets purchased from cash donations / grants	**0**	**0**	18	18
Disposals	**(760)**	**(760)**	(829)	(829)
Valuation/Gross cost at 31 March	**30,839**	**30,839**	24,311	24,311
Amortisation at 1 April	**11,363**	**11,363**	9,918	9,918
Provided during the year	**1,916**	**1,916**	2,274	2,274
Disposals	**(760)**	**(760)**	(829)	(829)
Amortisation at 31 March	**12,519**	**12,519**	11,363	11,363
Net Book Value at 31 March	**18,320**	**18,320**	12,948	12,948

The transfer by absorption relates to an asset transfer relating to the Public Health England Microbiology service.

12.1 Property, plant and equipment 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2018	31,031	269,440	1,358	5,076	108,007	792	8,102	22	423,828
Transfers by absorption	0	1,044	0	0	368	0	0	0	1,412
Additions - purchased	62	14,194	9	6,034	3,712	0	1,079	0	25,090
Additions - leased	0	0	0	369	6,333	0	0	0	6,702
Additions - grants / donations of cash to purchase assets	0	3,095	0	0	358	0	6	0	3,459
Reclassifications	0	2,660	0	(4,265)	1,605	0	0	0	0
Revaluations	7,398	905	51	0	0	0	0	0	8,354
Disposals	0	0	0	0	(5,031)	0	(70)	0	(5,101)
Valuation/Gross cost at 31 March 2019	38,491	291,338	1,418	7,214	115,352	792	9,117	22	463,744
Accumulated depreciation at 1 April 2018	0	31,500	81	0	64,287	498	4,295	18	100,679
Provided during the year	0	9,184	28	0	10,095	95	1,177	1	20,580
Impairments charged to operating expenses	0	2,593	0	0	0	0	0	0	2,593
Disposals	0	0	0	0	(5,014)	0	(70)	0	(5,084)
Accumulated depreciation at 31 March 2019	0	43,277	109	0	69,368	593	5,402	19	118,768

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

12.2 Property, plant and equipment 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£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 - government granted	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

12.3 Property, plant and equipment- other entities in Group

	Movements for year ended 31 March 2019			Movements for year ended 31 March 2018		
	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	101	216	115	86	201
Additions - purchased	0	37	37	0	15	15
Valuation/Gross cost at 31 March	115	138	253	115	101	216
Accumulated depreciation at 1 April	54	79	133	38	62	100
Depreciation provided during the year	16	18	34	16	17	33
Accumulated depreciation at 31 March	70	97	167	54	79	133

	Movements for year ended 31 March 2019			Movements for year ended 31 March 2018		
	Assets Under Construction and Payments on Account	Plant & machinery	Total	Assets Under Construction and Payments on Account	Plant & machinery	Total
Of the movements above, the following relate to UHS Estates Ltd:	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	1,605	2,401	4,006	2,281	0	2,281
Additions - purchased	2,940	0	2,940	1,725	0	1,725
Reclassifications	(1,606)	1,606	0	(2,401)	2,401	0
Valuation/Gross cost at 31 March	2,939	4,007	6,946	1,605	2,401	4,006
Accumulated depreciation at 1 April	0	20	20	0	0	0
Depreciation provided during the year	0	281	281	0	20	20
Accumulated depreciation at 31 March	0	301	301	0	20	20

These additions relate to Radiotherapy equipment.

12.4 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 2019	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Group									
Owned	**38,491**	**207,746**	**1,309**	**7,214**	**18,934**	**13**	**3,694**	**3**	**277,404**
Finance Lease	**0**	**8,297**	**0**	**0**	**24,875**	**49**	**0**	**0**	**33,221**
On-balance-sheet PFI contracts	**0**	**3,627**	**0**	**0**	**0**	**0**	**0**	**0**	**3,627**
Government granted	**0**	**0**	**0**	**0**	**838**	**129**	**0**	**0**	**967**
Donated	**0**	**28,391**	**0**	**0**	**1,337**	**8**	**21**	**0**	**29,757**
NBV Total at 31 March 2019	**38,491**	**248,061**	**1,309**	**7,214**	**45,984**	**199**	**3,715**	**3**	**344,976**
Net book value at 31 March 2018									
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

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

	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 31 March 2019	0	45	0	0	0	0	41	0	86
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 31 March 2018	0	61	0	0	0	0	22	0	83

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

	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 31 March 2019	0	0	0	2,939	3,706	0	0	0	6,645
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 31 March 2018	0	0	0	1,605	0	0	0	0	1,605

None of the balance relates to the Trust charity.

13.1 Investments property

	Group		Trust	
	Movements for year ended 31 March 2019	Movements for year ended 31 March 2018	**Movements for year ended 31 March 2019**	Movements for year ended 31 March 2018
	£000	£000	**£000**	£000
Carrying value at 1 April	**125**	108	**0**	0
Additions	**0**	17	**0**	0
Fair value gains / (losses)	**(2)**	0	**0**	0
Carrying value at 31 March	**123**	125	**0**	0

13.2 Other Investments/financial assets (non-current)

	Group		Trust	
	Movements for year ended 31 March 2019	Movements for year ended 31 March 2018	**Movements for year ended 31 March 2019**	Movements for year ended 31 March 2018
	£000	£000	**£000**	£000
Carrying value at 1 April	**2,997**	3,052	**3,441**	3,441
Additions	**0**	0	**2,100**	0
Fair value losses (for assets held at FV through I&E)	**0**	(55)	**0**	0
Carrying value at 31 March	**2,997**	2,997	**5,541**	3,441

Additions relates to UHS investment in UHS Estates Ltd.

14 Investments in joint ventures and associates

The Trust has a 50% share in Southampton CEDP LLP . Its share of the accumulated surpluses were £0k in year and £1k cumulatively and as these are accounted for using the equity method these are shown as an investment in the Statement of Financial Position.

	Group			Trust		
	Drugs £000	Consumables £000	Total £000	Drugs £000	Consumables £000	Total £000
Current						
Carrying Value at 31 March 2018	3,423	12,796	16,219	2,828	12,796	15,624
Carrying Value at 31 March 2019	**4,516**	**11,988**	**16,504**	**3,700**	**11,988**	**15,688**

16 Trade and other receivables

	Group		Trust	
	Total	Total	Total	Total
	31 March 2019	31 March 2018 (Restated)	31 March 2019	31 March 2018 (Restated)
	£000	£000	£000	£000
Current				
Contract receivables (IFRS 15): invoiced	**60,438**	0	**60,431**	0
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**33,626**	0	**34,441**	0
Trade receivables	**0**	58,759	**0**	58,610
Accrued income	**0**	2,976	**0**	2,974
Allowance for impaired contract receivables / assets	**(4,941)**	(6,137)	**(4,941)**	(6,137)
Prepayments (revenue) (non-PFI)	**14,539**	15,394	**14,535**	15,359
PDC dividend receivable	**361**	0	**361**	0
VAT receivable	**1,955**	2,581	**1,418**	2,149
Other receivables	**0**	7,765	**183**	7,765
NHS charitable funds: trade and other receivables	**133**	41	**0**	0
Total Current	**106,111**	81,379	**106,428**	80,720
Non-Current				
Contract receivables (IFRS 15): invoiced	**4,371**	0	**4,371**	0
Allowance for impaired contract receivables / assets	**(839)**	0	**(839)**	0
Other receivables	**0**	3,492	**9,502**	8,877
Total Non-Current	**3,532**	3,492	**13,034**	8,877
Total Trade and other Receivables	**109,643**	84,871	**119,462**	89,597

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

17 Allowances for credit losses (doubtful debts)

	Group	Trust
	Movements for year ended 31 March 2019	Movements for year ended 31 March 2019
	£000	£000
Allowance for credit losses at 1 April 2018 - restated	**6,137**	6,137
New allowances arising	**1,998**	1,998
Utilisation of allowances (where receivable is written off)	**(2,355)**	(2,355)
Total allowance for credit losses at 31 March 2019	**5,780**	**5,780**

18.1 Cash and cash equivalents

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Cash at commercial banks and in hand	**5,448**	5,441	**123**	43
Cash with the Government Banking Service	**60,076**	51,159	**60,076**	51,159
Cash and cash equivalents as in SoFP	**65,524**	56,600	**60,199**	51,202

18.2 Third party assets held by the NHS Foundation Trust

Group and Trust	31 March 2019	31 March 2018
	£000	£000
Bank balances	**11**	7

19 Trade and other payables

	Group		Trust	
	Total	Total	Total	Total
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Trade payables	**48,715**	39,908	**52,686**	38,644
Capital payables (including capital accruals)	**4,491**	5,782	**4,816**	6,090
Accruals (Revenue costs only)	**13,623**	15,199	**10,800**	13,416
Social Security costs	**5,373**	4,994	**5,373**	4,994
Other taxes payable	**4,791**	4,551	**4,791**	4,551
PDC dividend payable	**0**	293	**0**	293
Accrued interest on DH loans	**0**	69	**0**	69
Other payables	**23,444**	11,949	**23,444**	11,940
NHS Charitable funds: Trade and other payables	**559**	486	**0**	0
Total Current	**100,996**	83,231	**101,910**	79,997
Non-current				
Capital payables (including capital accruals)	**503**	346	**6,551**	6,113
Other payables	**405**	405	**405**	405
Total Non Current	**908**	751	**6,956**	6,518
Total Trade and other payables	**101,904**	83,982	**108,866**	86,515

An amount of £6.434m (2017/18 £5.992m) relating to outstanding pension contributions is included within amounts due to other related parties; this liability was due in April 2019.

20 Borrowings

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Current				
Capital Loans from Department of Health	**3,149**	3,489	**3,149**	3,489
Other Loans	**187**	134	**187**	134
Obligations under finance leases	**6,575**	5,854	**6,575**	5,854
Obligations under Private Finance Initiative contracts	**391**	371	**391**	371
Total Current	**10,302**	9,848	**10,302**	9,848
Non-current				
Capital Loans from Department of Health	**14,042**	17,131	**14,042**	17,131
Other Loans	**559**	746	**559**	746
Obligations under finance leases	**31,715**	34,867	**31,715**	34,867
Obligations under Private Finance Initiative contracts	**1,287**	1,678	**1,287**	1,678
Total Non Current	**47,603**	54,422	**47,603**	54,422
Total Borrowings	**57,905**	64,270	**57,905**	64,270

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

Original Advance Date	Original Loan	Balance outstanding at 31st March 2019	Balance outstanding at 31st March 2018	Interest Rate
	£000	**£000**	**£000**	**%**
September 2008	8,000	0	400	4.85%
September 2010	8,000	3,461	3,995	2.74%
October 2011	10,000	2,500	3,500	1.57%
September 2012	5,000	1,664	2,220	0.76%
June 2013	15,000	9,506	10,505	1.91%
Total balance outstanding		17,131	20,620	
Repaid in year		3,489		

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 £0.746m. £134k was repaid in year.

21 Reconciliation of liabilities arising from financing activities (Group and Trust)

	for year ended 31 March 2019
	£000
Carrying value at 1 April 2018 - brought forward	**64,270**
Impact of applying IFRS 9 as at 1 April 2018	**69**
Financing cash flows - principal	**(13,126)**
Financing cash flows - interest (for liabilities measured at amortised cost)	**200**
Additions	**6,701**
Interest charge arising in year (application of effective interest rate)	**(209)**
Carrying value at 31 March 2019	**57,905**

This disclosure is a new requirement of IAS 7.

22 Other liabilities

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Current				
Deferred income	**6,797**	10,839	**9,371**	10,839
Deferred grants	**2,574**	4,688	**0**	4,688
Total Current	**9,371**	15,527	**9,371**	15,527
Non-current				
Deferred income	**14,582**	14,924	**14,582**	14,924
Total Non-current	**14,582**	14,924	**14,582**	14,924
Total Other liabilities	**23,953**	30,451	**23,953**	30,451

Current

23.1 Provisions for liabilities and charges

Group and Trust	**Current 31 March 2019**	Current 31 March 2018	**Non-current 31 March 2019**	Non-current 31 March 2018
	£'000	£'000	**£'000**	£'000
Pensions- Early departure costs	**61**	60	**582**	603
Pensions - Injury benefits	**155**	156	**2,166**	2,282
Other legal claims	**440**	399	**0**	0
Restructurings	**0**	11	**0**	0
Total	**656**	626	**2,748**	2,885

23.2 Movements in Provisions for liabilities and charges 18/19

	Pensions- Early departure costs	Other legal claims	Re-structurings	Pensions - Injury benefits	Total
Group and Trust	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
At 1 April 2018	663	399	11	2,438	**3,511**
Change in the discount rate	(6)	0	0	(45)	**(51)**
Arising during the year	47	183	0	81	**311**
Utilised during the year - cash	(62)	(59)	0	(155)	**(276)**
Reversed unused	0	(83)	(11)	0	**(94)**
Unwinding of discount	1	0	0	2	**3**
At 31 March 2019	**643**	**440**	**0**	**2,321**	**3,404**
- not later than one year;	61	440	0	155	**656**
- later than one year and not later than five years;	244	0	0	620	**864**
- later than five years.	338	0	0	1,546	**1,884**
Total	**643**	**440**	**0**	**2,321**	**3,404**

23.3 Clinical Negligence liabilities

Group and Trust	**31 March 2019 £'000**	31 March 2018 £'000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Foundation Trust	**301,323**	274,049

24 Contingent liabilities

Group and Trust	**31 March 2019 £'000**	31 March 2018 £'000
Other	**110**	88

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 2019		Year ended 31 March 2018	
Group	**Income £000**	**Expenditure £000**	Income £000	Expenditure £000
Department of Health	**34,336**	**0**	26,349	5
Portsmouth Hospitals NHS Trust	**1,626**	**9,384**	1,535	8,878
NHS Resolution	**0**	**18,465**	0	14,383
NHS Southampton CCG	**155,298**	**0**	139,847	0
NHS West Hampshire CCG	**148,828**	**0**	141,609	0
NHS England	**395,055**	**0**	374,411	0
Health Education England	**36,954**	**0**	37,174	0
Solent NHS Trust	**1,789**	**1,610**	1,396	1,467
Southern Health NHS Foundation Trust	**3,579**	**5,700**	2,858	4,582
Hampshire Hospitals NHS Foundation Trust	**1,829**	**2,893**	1,741	2,434
Other NHS Bodies	**53,691**	**17,794**	49,938	17,590
	832,985	**55,846**	776,858	49,339

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**	**45,109**	0	42,293
National Insurance Fund	**0**	**40,293**	0	37,930
NHS Blood and Transplant	**218**	**7,934**	215	7,227
NHS Professionals	**11**	**29,415**	0	23,017
University of Southampton	**6,243**	**12,732**	1,223	2,302
Other government bodies	**2,737**	**557**	2,012	597
	9,209	**136,040**	3,450	113,366
Total value of transactions with related parties	**842,194**	**191,886**	780,308	162,705

The Group comprises the Trust, UHS Pharmacy Ltd, UHS Estates Ltd and Southampton Hospital Charity. The Trust has £2,063k (£558k at 31st March 2018) receivables with Southampton Hospital Charity. It has share capital of £841k (£841k at 31st March 2018), receivables of £603k (£3k at 31st March 2018) and payables of £0k (£141k at 31st March 2018) with UHS Pharmacy Ltd, and share capital of £4.7m (£2.6m at 31st March 2018), and receivables of £9.866m (£5.826k at 31st March 2018) and payables of £11.074m (£6.075m at 31st March 2018) with UHS Estates Ltd. Transactions with related parties are on a normal commercial basis. UHS Pharmacy Ltd made no donations to Southampton Hospital Charity in 2018/19 (2017/18: £50k).

25.2 Related Party balances

	At 31 March 2019		At 31 March 2018	
Group	**Receivables**	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Department of Health	**0**	**0**	320	0
Other NHS Bodies	**67,535**	**15,397**	31,826	8,455
Other government bodies	**3,762**	**19,924**	4,462	19,727
Total balances with related parties at 31 March	**71,297**	**35,321**	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 Prime Partnering Solutions Ltd. The Trust received £0k (2017/18 £0k) and was charged £0k (2017/18 £0k) from its joint venture for services rendered.

26 Capital Commitments

	Group		**Trust**	
	Total	Total	**Total**	Total
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
Group and Trust	**£000**	£000	**£000**	£000
Property, Plant and Equipment	**5,955**	9,703	**5,955**	9,703
Intangible assets	**0**	401	**0**	401
Imaging Infrastructure Support Service	**20,072**	26,374	**20,072**	26,374
Total	**26,027**	36,478	**26,027**	36,478

The Imaging Infrastructure Support Service commitment relates to the purchase of new radiology equipment over the remaining 4 years of the contract.

27 Finance Lease obligations

	Total	Total
	31 March 2019	31 March 2018
Group and Trust	**£000**	£000
Gross buildings lease liabilities	**6,821**	20,756
of which liabilities are due:	**0**	0
- not later than one year;	**1,048**	1,714
- later than one year and not later than five years;	**3,653**	5,604
- later than five years.	**2,120**	13,438
Finance charges allocated to future periods	**(1,023)**	(5,639)
Net buildings lease liabilities	**5,798**	15,117
- not later than one year;	**908**	1,031
- later than one year and not later than five years;	**3,094**	3,607
- later than five years.	**1,796**	10,479
Gross other lease liabilities	**35,405**	33,260
- not later than one year;	**6,494**	6,364
- later than one year and not later than five years;	**16,731**	18,788
- later than five years.	**12,180**	8,108
Finance charges allocated to future periods	**(2,913)**	(7,656)
Net other lease liabilities	**32,492**	25,604
- not later than one year;	**5,667**	4,823
- later than one year and not later than five years;	**15,284**	15,690
- later than five years.	**11,541**	5,091

28.1 On-SOFP PFI obligations

	Total 31 March 2019	Total 31 March 2018
Group and Trust	**£000**	£000
Gross PFI liabilities	**1,678**	2,293
of which liabilities are due		
- not later than one year;	**391**	459
- later than one year and not later than five years;	**1,287**	1,834
Finance charges allocated to future periods	**0**	(244)
Net PFI obligation	**1,678**	2,049
- not later than one year;	**391**	371
- later than one year and not later than five years;	**1,287**	1,678
	1,678	2,049

28.2 On-SOFP PFI commitments

	Total 31 March 2019	Total 31 March 2018
Group and Trust	**£000**	£000
Commitments in respect of the service element of the PFI		
Within one year	**1,553**	1,553
2nd to 5th years (inclusive)	**4,659**	6,210
Total	**6,212**	7,763

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 2019	Total for 31 March 2018
	£000	£000
Unitary payment payable to service concession operator	**1,553**	1,553
Consisting of:		
- Interest charge	**87**	106
- Repayment of finance lease liability	**371**	352
- Service element	**1,095**	1,095

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 2019			31 March 2018		
	Service and maintenance	**Finance lease interest and repayments**	**Total**	Service and maintenance	Finance lease interest and repayments	Total
	£000	**£000**	**£000**	£000	£000	£000
- not later than one year;	**3,372**	**5,034**	**8,406**	3,284	4,901	8,185
- later than one year and not later than five years;	**13,488**	**20,136**	**33,624**	13,136	19,604	32,740
- later than five years.	**5,058**	**7,551**	**12,609**	8,210	12,253	20,463
Total	**21,918**	**32,721**	**54,639**	24,630	36,758	61,388

29.2 Other Financial Commitments

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£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	**10,432**	9,910	**10,432**	9,910
after 1 year and not later than 5 years	**18,777**	13,127	**18,777**	13,127
paid thereafter	**2,635**	22	**2,635**	22
TOTAL	**31,844**	23,059	**31,844**	23,059

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 2019 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 Carrying value and fair value of financial assets

	Group Total	Trust Total
	31 March 2019	31 March 2019
	£000	£000
Trade and other receivables (excluding non financial assets) - with NHS and DH bodies	67,535	67,443
Trade and other receivables (excluding non financial assets) - with other bodies	25,120	35,774
Cash and cash equivalents at bank and in hand	61,544	60,199
NHS Charitable funds: financial assets	7,110	0
Total	161,309	163,416

31.2 Carrying value and fair value of financial liabilities

	Group Total	Trust Total
	31 March 2019	31 March 2019
	£000	£000
DHSC loans	17,191	17,191
Other borrowings excluding finance lease and PFI liabilities	746	746
Obligations under finance leases	38,290	38,290
Obligations under PFI, LIFT and other service concession contracts	1,678	1,678
Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies	13,435	13,237
Trade and other payables (excluding non financial liabilities) - with other bodies	77,746	85,464
Total	149,086	156,606

31.3 Maturity of Financial liabilities

	Group 31 March 2019 £000	Trust 31 March 2019 £000
In one year or less	100,575	101,996
In more than one year but not more than two years	9,827	15,875
In more than two years but not more than five years	19,778	19,778
In more than five years	18,906	18,906
Total	149,086	156,555

32 Limitation on auditor's liability

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

Published June 2019.