Agenda
Solent NHS Trust In Public Board Meeting

Monday 30th July 2018 09:30am – 13:00pm
Eldred Room, Oasis The Venue, 1A Arundel Street, Portsmouth PO1 1NP

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Well Led Domains
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive** *To receive*	Chairman	-
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chairman	-
2	09:35	20mins	**Patient Story** *To receive*	Chief Nurse	W7
3	09:55	10mins	**Board discussion**	Chairman	W7

**Timings are tentative*

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Well Led Domains
4	10:05	5 mins	***Minutes of Last Meeting and action tracker** *To agree*	Chairman	-
5			**Register of Interests & Declaration of Interests** *To receive*	Chairman	-
6	10:10	5mins	**Matters Arising**	Chairman	-
7	10:15	5mins	**Any Other Business**	Chairman	-
8	10:20	10mins	**Safety and Quality First and Feedback from Board to Floor Visits** *To receive*	Chief Executive / Chief Nurse	W3
Strategy & Vision					
9	10:30	20mins	**Chief Executive's Report** *To receive*	Chief Executive	W1-W8
10	10:50	10mins	**Director of Medical Education (DME) Briefing Paper** *To receive*	Chief Medical Officer	W8

11	11:00	20mins	**Performance Report** - including • Operational Performance • Quality Performance • Financial Performance • Workforce Performance • NHSI Compliance *To receive*	Executive Leads	W5, W6
12	11:20	30mins	**Greater Together: Our strategy for community engagement** *To approve*	Chief Nurse	W7
13	11:50	5 mins	***Chairs report on Members Council** *To receive exception report from 6th July 2018 meeting*	Deputy Chairman	W7
14	11:55	5mins	**Emergency Planning Resilience Update Report** *To receive*	Emergency Planning and Business Continuity Lead	
15	12:00	5mins	**Health and Safety Annual Report** *To receive*	Director of Finance	W5,W6
16	12:05	5mins	**Information Governance Briefing Paper & Information Governance Strategy** *To receive*	Data Protection Officer and Head of Information Governance	W6
17	12:10	5mins	**Safe Nurse Staffing – six monthly report** *To receive*	Chief Nurse	W6
***Reporting Committees and Governance**					
18	12:15	10mins	***Audit & Risk Committee** *To receive exception report from May meeting and approve:* • *Committee Annual Report* • *Terms of Reference (changes tracked)*	Committee Chair	W5
19	12:25	10mins	***Assurance Committee Chair's Update** *To receive exception report from June and July meetings.* *The board is asked to formally receive the following reports/annual reports, acknowledging that each were substantively reviewed and discussed at the June/July Assurance Committee(provided as Supplementary Papers) :* • *Speciality Doctors and Associate Specialists (SAS) Annual Report – presented to the June 2018 meeting*	Committee Chair	W4, W5, W6, W8

			• *Exception and Recommendation report Learning from Deaths April 2018* • *Safeguarding Children and Adults Annual Report 1st April 2017-31st March 2018* • *Infection Prevention and Control Annual Report*		
20	12:35	5mins	***People and OD Committee** *To receive verbal update from 21st June 2018*	Committee Chair	-
21	12:40	5 mins	***Extra Ordinary Charitable Funds Committee Minutes & Chairs update** *To receive verbal update*	Committee Chair	W4
22	----	----	**Complaints Review Panel** *No meeting held to report*	Committee Chair	-
23	----	----	*** Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update** *No meeting held to report*	Committee Chair	W5, W6, W8
24	12:45	5mins	***Governance and Nominations Committee** *Verbal update from meeting held 19th July 2018* • *Committee Terms of Reference* • *Committee Annual Report*	Committee Chair	-
Any other business					
25	14:50	5 mins	**Governor comments and questions**	Chairman	
16	12:55	5 mins	**Any other business & future agenda items**	Chairman	
27	13:00	------	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chairman	

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Supplementary papers are available on request from the Assistant Company Secretary

The well-led framework is structured around eight key lines of enquiry (KLOEs):

Date of next meeting: 24th September 2018

Item 4.1

Minutes

Board In Public

Tuesday 29th May 2018 09:00-12:35

Kestrel 1 & 2, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Chair: **Mick Tutt,** Deputy Chairman (MT)	
Members: **Sue Harriman,** Chief Executive (SH) **Andrew Strevens,** Director of Finance (AS) **Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Dan Meron,** Chief Medical Officer (DM) **Jackie Ardley**, Chief Nurse (JA) **Helen Ives,** Chief People Officer (HI) **Jon Pittam,** Non-Executive Director (JPi) **Mike Watts,** Non-Executive Director (MW) **Stephanie Elsy,** Non-Executive Director (SE)	**Attendees:** **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **Sam Stirling,** Corporate Affairs Administrator **Apologies:** **Alistair Stokes,** Chairman (AMS) **Francis Davis,** Non-Executive Director (FD) **Jayne Jenney,** Corporate Support Manager and Assistant Company Secretary (JJ) **Observers:** **Teresa Power**, Risk Manager (TP)

1	**Chairman's Welcome & Update**
1.1	Apologies were received as noted above. MT welcomed the Board and TP in attendance as an observer.
2	**Register of Interests & Declaration of Interests**
2.1	There were no further updates to report.
3	**Confirmation that meeting is Quorate**
3.1	The meeting was confirmed as quorate.
4	**Minutes of Last Meeting and action tracker**
4.1	The minutes of the last meeting held on 26th March were agreed as an accurate record.
4.2	The following actions were confirmed as complete: 598, 601, 605, 609, 610, 611, 612
5	**Matters Arising**
5.1	No matters arising were discussed.
6	**Any Other Business**
6.1	There were no items of any other business.

7	**Audit Results Report**
7.1	AS reminded the Board that the report was discussed, extensively, at the Audit & Risk Committee on Thursday 24th May and he provided an overview of results. It was confirmed that External Auditors, Ernst & Young, were assured of financial statements and judgements made. **The Board approved the Audit Results Report.**
8	**Letter of Representation**
8.1	AS briefed the Board on the uncorrected misstatements, as agreed with Auditors and SH queried the benefits and risks of this judgement. AS explained adjustments made for lack of recovery and intention to credit this. Again, the narrative had been considered by the Audit & Risk committee; so the Board confirmed their agreement that JPi as Chair of the Audit & Risk Committee and AS as Director of Finance sign the letter. **The Board approved the Letter of Representation.**
9	**Audit Opinion**
9.1	AS highlighted positivity of clean opinion and confirmed that there was nothing further to report by exception, to that discussed at the Audit & Risk committee. AS informed the Board of the letter, written to the Secretary of State, regarding the failed breakeven duty and JPi confirmed full review at the Audit and Risk Committee. The Board noted the breech position and the accumulative deficit.
9.2	SH queried the sanctions that could be imposed in line with the guidance of remaining in deficit position. JPi explained uncertainty of legal penalties and the need to rely on Secretary of State recommendations and decisions.
9.3	SE highlighted positivity of improved position despite the breech position without putting quality and safety at risk and queried CQC position. MT confirmed review by CQC into value for money as part of Well-Led inspections. **The Board approved the Audit Opinion.**
10	**Annual Accounts**
10.1	AS confirmed extensive review at the Audit and Risk Committee and highlighted discussions regarding the surplus reflected within the Annual Accounts Report. AS informed of minor amendments being made to the report by the Finance team and auditors which would not impact the report content. **The Board approved the Annual Accounts and noted the Internal and External Auditor opinions.**
11	**Annual Report – including the Annual Governance Statement**

11.1	SH thanked the team for producing this report and commented on the improved content and format. RC confirmed that all comments raised at the Audit and Risk Committee had been included within the report, including ensuring photographs demonstrating a diverse workforce were used. **The Board approved the Annual Report and Annual Governance Statement.**
12	**Quality Account**
12.1	MT confirmed extensive consideration at the Assurance Committee and JA formally thanked teams across the Trust for their contributions. **There were no further comments to highlight and the Board approved the Quality Account.**
	*****15 min break for signing*****
13	**Safety and Quality First**
13.1	SA briefed the Board on monitoring of challenges for residential mental health wards in Portsmouth following incident on Maples ward, including staffing and estates. SA confirmed receipt of daily reporting and confirmed that there were no safety concerns to report.
13.2	The Board were informed of Ambulance provider contract issue, with regard to conveyance to the s136 suite, and SA provided an overview of previous issues following CQC inspection in 2016. SA confirmed raised concerns regarding oversight of provisions and subletting of contracts. It was confirmed that full monitoring was taking place and potential need for timely escalation being considered.
13.3	MT confirmed expected extensive discussions at the Mental Health Act Scrutiny Committee in August with regard to the s136 suite, and commented on recent positive visits to the units. JPi queried the use of beds on the s136 suite and SA confirmed options to use in extreme exceptional circumstances if required.
13.4	Regarding the incident on Maples ward, MW queried the how the lessons learned were identified. SA provided an overview of initial reflections, including estate materials and Hampshire Constabulary responsiveness, and confirmed full SI investigation to review.
13.5	Board to Floor Visits • Learning Disabilities- JA reflected on the visit and shared positivity of the team and Commissioner involvement. • Vocational Rehabilitation- DM reported escalated estate issues within the service however confirmed staff optimism surrounding potential relocation to the Western Community Hospital. DM praised the team for excellent services provided.
13.6	MT reported feedback provided to DN and SA following visits to Aldershot Services and by the Mental Health Network to the Orchards and the Recovery College. **The Board noted the Safety and Quality First update.**
14	**Board to Floor – Six Monthly Summary Report**

14.1	JPi queried current plans for relocating the Turner Centre. SA confirmed intention to relocate to Brunel at the Civic Centre, and commented on challenges due to CCG led locations. SH confirmed review at informal staff session and highlighted the importance of ensuring confidence in all environments relocated to. It was agreed that executive directors review for assurance. **Action- Executive Directors.**
14.2	JA informed of review into Board to Floor reporting; to ensure appropriate review at the Quality Improvement and Risk (QIR) Group. **The Board noted the update.**
15	**Chief Executive Officers (CEO) Report**
15.1	• SH explained review into streamlining reports and ensuring alignment to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) for full oversight of risk management. JA reiterated the usefulness of including reference to the BAF and CRR for triangulation purposes. • SH formally welcomed JA to the substantive Chief Nurse role. • The Board received an update following the Trust Management Team Meeting (TMTM) including focused session on Freedom to Speak up, new learning framework and parking challenges. SH confirmed that a car parking update would be discussed in Confidential Board.
15.2	JPi queried future operation of a merged Speech and Language service in Adults Portsmouth, and SH commented on decisions made against system working and the importance of supporting staff through challenging processes. SA emphasised ongoing work within the integrated care partnerships, to ensure single models within the community. It was agreed to include an update within a future CEO update when available. **The Board noted the CEO Report.**
16	**Performance Report**
16.1	<u>Performance</u> • AS commented on the positive reflections and improvement from the last year.
16.2	<u>Quality</u> • MT referred to the Mental Capacity Act training compliance and requested update to acknowledge this as a Trust-wide issue. • MT queried the accuracy of the CQC summary and JA confirmed that although risks were evident, awareness and mitigations were in place for these. DM highlighted the importance of ensuring clarity on the adequacy of mitigations and assurance provided. • SH emphasised the need to ensure broader consideration of Quality without full focus on CQC actions plans to ensure scope of vision was not limited.

16.3	SE commented on the need to review the format of reporting; to ensure relevance and provide a full demonstration of significant issues. AS acknowledged the challenge and suggested review at a future Board Seminar or Workshop to review potential options. SA suggested a potential 'hot spot' approach to this report and SH emphasised the need to ensure consideration of effectiveness and responsiveness as opposed to a 'technical fix'. It was agreed that AS review outside of the meeting. **Action- AS.**
16.4	<u>Finance</u> • JPi highlighted an error in the figures of the deficit-in-month reported.
16.5	<u>Workforce</u> • HI informed the Board that although there were improvements on agency spend, the Trust was above the limit set by NHSI. HI confirmed overspend on off-framework agency staff, and plans being established for a sustainable staffing framework. • HI reported an improved target compliance and ongoing work with Ops colleagues to improve messaging. • In response to a query, from MT regarding the positive work being undertaken with veterans, HI commented on the importance of balancing demand against the workforce team; due to the size of the service and capacity. HI highlighted consideration of partnerships with other organisations and SH suggested consideration at STP level.
16.6	<u>NHSI Compliance</u> • MT explained the importance of reviewing reporting of Mix Sex Accommodation, to ensure accuracy of data and full clarity regarding reporting expectations in line with the Mental Health Act Code of Practice. JA agreed with the need to review to understand current Trust processes and agreed to review with SA outside of the meeting. **Action- JA/SA.** **The Board noted the Performance Report.**
17	**PSEH Workstream deep dive – Urgent Care**
17.1	SA provided a presentation regarding the Portsmouth & South East Hampshire (PSEH) Workstream. • SA explained the fundamental differences between Community Health and Care and acute services, and the Local Delivery System (LDS) operating plans contributing to the Workstream. • The Board were informed of alternative provisions being considered for the 111 service and a potential postcode-based 'hub' approach. SA emphasised the importance of redesign for the future of out-of-hospital services. • SA informed the Board of the programme of work regarding high impact actions, and focus on 'why not home why not today' support packages. • The importance of correct planning regarding the reduction of people deemed Medically Fit for Discharge from the acute provider was highlighted. SA explained the differences made within Portsmouth, including reduction in waiting list times. The Board discussed the improved position surrounding internal Portsmouth Hospital Trust (PHT) processes. • SA highlighted further work required, including changes to culture and development of neighbourhood models.

17.2	JA queried expected timescales for roll-out of transformation to the 111 service. SA explained that careful procurement work was required, and she outlined the challenges regarding CCG capacity to lead transformation. SH shared the importance of full recognition of system reform and strategic commissioning in line with this.
17.3	SE asked about support that could be provided by Non-Executive Directors, due to strong relationships with local councils. SA commented on positive relationships in Portsmouth leading to significant investment, and the importance of establishing the same strong relationship following the recent change in administration. SH emphasised the importance of ensuring sensitivity surrounding integration plans, and how learning was shared. It was agreed to discuss further in Confidential Board. **The Board noted the PSEH Workstream deep dive.**
***Reporting Committees and Governance**	
18	***Audit & Risk Committee**
18.1	JPi provided a summary of business transacted at the meeting, other than that consider earlier on the agenda: • The Committee received an update on Counter Fraud Initiatives. • Positive Internal Audit results were reported, and JPi acknowledged positivity of audit work completed in terms of risk and improvement. • The Committee recommended that 'James Creston' were appointed as the Trust Charity Auditors and explained expected savings as a result. **The Board approved the proposal.**
18.2	<u>Freedom to Speak Up Report</u> JA confirmed review to ensure strengthening of governance processes; based on letter/guidance from NHS Improvement (NHSI). MT informed the Board of a quarterly report being submitted to June Assurance Committee to reflect on the impact of this letter.
19	***Assurance Committee Chair's Update**
19.1	MT highlighted key points and explained amendments made to the Committee Terms of Reference (TOR) following Internal Auditor recommendations, including revised membership to include the Head of Compliance. **The Board approved the Committee TOR.**
20	***Chairs report on Members Council**
20.1	**The Board noted the report.**
21	***People and OD Committee**
21.1	There was no meeting held since the last report to Board.
22	***Charitable Funds Committee Minutes & Chairs update**

22.1	DN presented the proposal for Charitable Funds review. MT emphasised the importance of ensuring appropriate recruitment processes for the pro bono Director of Charity post were followed. **The Board approved the proposal presented.**
23	**Complaints Review Panel**
23.1	There was no meeting held since the last report to Board.
24	***Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update**
24.1	MT summarised key points following the meeting and reflected on the annual Mental Health Act update provided by Bevan Brittan, with positive attendance including system partner involvement. It was confirmed that MT and Richard Murphy would be holding a session hosted by PHT. It was agreed that MT share relevant details with the Board. **Action- MT.**
25	***Governance and Nominations Committee update**
25.1	There was no meeting held since the last report to Board.
26	**Governance updates**
26.1	RC provided an overview of requirements and amendments made. **The Board approved the following:** • **Amendments to the Code of Conduct** • **Provider Licence Annual Declaration** • **Declaration of Interest.**
Any other business	
27	**Governor comments and questions**
27.1	There were no governors in attendance.
28	**Any other business & future agenda items**
28.1	TP thanked the Board and provided reflections on the meeting.
28.2	SE queried advertising to the public to encourage attendance. RC confirmed promotion methods and review into alternative venues. SA suggested requesting support from the council to ensure wider publishing network to the public and SE queried potential use of social media. **Action- RC to review outside of the meeting.**
28.3	No other business was discussed and the meeting was closed.
29	**Close and move to confidential meeting**

Board Part 1

Action no.	Date of Meeting	Agenda item ref:	Concerning	Action detail	Exec Lead / Manager	Completion date	Update
613	29/05/2018	14.1	Board to Floor – Six Monthly Summary Report - Turner Centre relocation	JPi queried current plans for relocating the Turner Centre. SA confirmed intention to relocate to Brunel at the Civic Centre and commented on challenges due to CCG led locations. SH confirmed review at informal staff session and highlighted the importance of ensuring confidence in all environments relocated to. It was agreed that executive directors review for assurance. **Action- Executive Directors.**	Exec Directors		**July update:** Session held between the service, Estates, SA and AS to go through the draft plans. Clear actions agreed.
614	29/05/2018	16.3	Performance Report - Report format	SE commented on the need to review the format of reporting to ensure relevance and provide a full demonstration of significant issues. AS acknowledged the challenge and suggested review at a future Board Seminar or Workshop to review potential options. SA suggested potential 'hot spot' approach to this report and SH emphasised the need to ensure consideration of effectiveness and responsiveness as opposed to a technical fix. It was agreed that AS review outside of the meeting. **Action- AS.**	AS		**July update:** Workshop will be planned for a future seminar.
615	29/05/2018	16.6	Performance Report - NHSI Compliance Mixed Sex Accomodation	MT explained the importance of reviewing reporting of Mix Sex Accommodation to ensure accuracy of data and full clarity regarding reporting expectations in line with the Mental Health Act Code of Practice. JA agreed with the need to review to understand current Trust processes and agreed to review with SA outside of the meeting. **Action- JA/SA.**	JA/SA		
616	29/05/2018	24.1	Mental Health Act & Deprivation of Liberty Safeguards Chairs update - PHT hosted MHA session	It was confirmed that MT and Richard Murphy would be holding a session hosted by PHT. It was agreed that MT share relevant details with the Board. **Action- MT.**	MT		**July update:** Scheduled for 7th August details to be confirmed at the meeting
617	29/05/2018	28.2	Any other business & future agenda items - promotion to the public	SE queried advertising to the public to encourage attendance. RC confirmed promotion methods and review into alternative venues. SA suggested requesting support from the council to ensure wider publishing network to the public and SE queried potential use of social media. **Action- RC to review outside of the meeting.**	RC		**July update:** meeting held in June with Comms Team to consider further promotion and linkages with stakeholders. To be implemented for July Board and onwards. Complete.

Item 9

Title of Paper	CEO Report – July 2018							
Author(s)	Sue Harriman, Chief Executive Officer							
Link to strategic Objective(s)	x Improving outcomes		x Working in partnership		x Ensuring sustainability			
Well Led KLoEs	**W1** Leadership Capacity & Capability	x	**W2** Vision & Strategy	x	**W3** Culture	x	**W4** Roles & Responsibilities	x
	W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement	x	**W8** Learning, Improvt & innovation	X
Date of Paper	19th July 2018		**Committees presented**		N/A			
Action requested of the Board	X To receive		☐ For decision					

Where appropriate we have indicated alignment to our key strategic risks as outlined within the Board Assurance Framework (BAF) and / or our corporate risks register. A full list of our BAF risks is included for reference under section 6.

1. Our performance

This is covered in full within the integrated performance report.

2. Strategic update

Celebrating NHS70

Over the last few weeks we have held numerous events to celebrate NHS70 and in recognition of our dedicated and valued workforce. Events included; a Garden Party to celebrate long service, many Big NHS70 Tea Parties attended by employees and volunteers coming together to share a cup of tea and a piece of cake as well as attendance at national events including services at Westminster Cathedral, York Minster Cathedral and Winchester Cathedral.

We have been sharing stories and celebratory moments on Facebook and Twitter; each story demonstrates the passion people in the NHS have and the difference they make.

We are also extremely proud of Rose Bennett a domestic assistant at St James', who was awarded the Lifetime Achievement Award at the NHS70 Parliamentary Awards. Stephen Morgan MP, who nominated Rose, said:" *I'm immensely proud that Rose from our city has won national recognition for her work in the NHS. She is truly an unsung hero at @solentnhs_trust. Her dedication and talent for improving the lives of fellow NHS workers and patients is outstanding. Rose faced stiff competition but she has consistently gone above and beyond the call of duty to help people in Portsmouth and her victory is very much deserved".*

I am incredibly proud of our NHS and of our team here at Solent.

Research & Improvement Conference 2018

On 10th June we hosted our annual conference coproduced with Side by Side. At the event, which had a prominent social media following, we formally launched our Solent Academy of Research and Improvement and heard key note speeches from both Professor Catherine Pope on 'What would real partnership working with patients and families look like?' and Derek Stewart OBE on 'The Patient Advocate perspective on partnership working'. It was a truly inspiring and motivating event where our teams had the opportunity to proudly showcase their amazing work.

We were delighted to find out this week that we are again at the top of the 'National Institute for Health Research (NIHR) Research Activity League Table' in the category of Care Trusts, for the volume of research studies undertaken during 2017-18. This fantastic news comes at a time when we are also aware that we continue to see ongoing improvements in key areas of our services.

CQC

We have received a Provider Information Request (PIR) for a Care Quality Commission (CQC) inspection, which will include a well led inspection. We believe that we can expect an inspection sometime between now and mid-September. Whilst we know to expect an inspection soon, the CQC could still review any of our services, at any time, as part of their specific targeted service visits.
We know that every single person in Solent makes a huge difference and as such we are openly encouraging people to:

- Be proud
- Be passionate
- Be honest
- Be yourself

We look forward to welcoming the CQC and firmly believe this is an opportunity for us to show the wonderful feedback we receive from our patients and families, and the great care they tell us we give.

CQC Local System Review Hampshire

The Hampshire local system has been subject to a System Wide CQC Review over last 4 months and we have been actively involved and engaged in the process. On June 20th a CQC Review Summit was held where the CQC and multiple stakeholders considered the findings of the report and coproduced a Local System Review Action Plan in response to the recommendations. We are working with partners to progress the plan, the themes of which align and support those already identified within our Sustainability and Transformation Partnership (STP) Plan.

Sustainability and Transformation Partnerships (STP) (Ref to BAF# 58)

The System Reform Programme continues to progress and the work of the designated Task & Finish Groups presented their recommendations at the Hampshire & Isle of Wight (HIOW) STP Transformation Leadership Event on 19th July. This was an opportunity for partners from across the health and care system of HIOW to consider the work to date around the System Reform agenda and to support further work to develop and mature thinking.
The focus of the work of the STP continues to be around ensuring the quality and sustainability of the health and care services for HIOW but most importantly ensuring that the offer we make to the citizens of HIOW meets their needs. There will be some continued work within newly established Task & Finish Groups that will lead to a suite of papers that will be considered through Boards and Governing Bodies over the late Summer period.

Southampton and County Services

Primary Care / MPP service line

- GP and Associate Nurse Practitioners (ANPs) staffing availability within our Primary Care Services over the summer remains a concern. However, we are actively reconfiguring staffing during July and August to mitigate the risk and we continue to work to contingency plans in order to sustain service delivery within safe staffing levels. (Ref to BAF# 55)

Children and Families (West)

- We are experiencing estates challenges within the Eastleigh and Southern Parishes geography having recently needing to vacate a temporary premise. As an interim solution we are currently providing services at Kings Community Church at Hedge End (for group work only as there are no clinical rooms at this location). Our estates team are urgently progressing alternatives including Mitchell House, the preferred site, which will also provide opportunities for us to provide Sexual Health and Special Dentistry services from this location. (Ref to BAF# 27)
- We continue to seek sustainable solutions to enable us to achieve the required health assessments and checks for Looked After Children and have developed an options paper for consideration by Southampton's Designated Nurse for Safeguarding Children, Adults and Looked After Children. (Link to Corporate risk Clinical Capacity)
- There continues to be a significant issue with demand outstripping capacity in our Child and Adolescent Mental Health Services (CAMHS) West, and performance has deteriorated against the 18 week target for first assessment over the last month. Demand and capacity remodelling is underway and HR colleagues are supporting a number of Organisational Development initiatives. (Link to Corporate risk Clinical Capacity)
- Innovative options, in close collaboration with University Hospitals Southampton NHS Foundation Trust, have been developed for a future admission avoidance/early discharge out of hospital service for children in the

city. We are currently in discussions with Commissioners regarding this potential service as a replacement for the former Child Outreach Assessment Support Team (COAST) service. (Ref to BAF# 55/ Corporate risk Clinical Capacity)

Special Care Dental Services

- Waiting times remain a concern with the number of patients waiting for treatment outstripping our current capacity, including those for General Anaesthesia (GA). We continue to consider options to address this including alternative locations for theatre space including the possibility of procuring a mobile theatre. (Link to Corporate risk Clinical Capacity)

Portsmouth System

General exceptions:

- Following investigation into reasons for short-notice booking of agency staff in Adults Portsmouth; we have introduced a new senior oversight and sign off process for all agency requests – effective from 16th July. Additionally, any off-framework agency requests will require COO authorisation. (Ref to BAF# 55/ Corporate risk Clinical Capacity)
- Although there is intent from Portsmouth Clinical Commissioning Group (CCG) to fund the growth into community and mental health budgets for 2018/19, the CCG have requested further information about longer term financial planning. Currently there is a risk of cost pressure if the growth does not materialise, and we currently have insufficient Cost Improvement Plans (CIPs) to mitigate. (Ref to BAF# 53)

Mental Health Services

- Six Psychiatric Intensive Care Unit (PICU) beds remain closed on Maples, following the serious incident in May 2018. There have been some delays in the refurbishment plan, due to availability issues with specialist fixtures. This has delayed the reopening date until mid-late August. The impact on local people requiring a PICU is that over 100 days, during May and June have been required in out of county specialist mental health provision – the first out of area beds purchased for over 5 years. This has affected 5 patients from Portsmouth who have been placed in PICUs as far away as Bradford. The readiness of each patient to return to local acute care is reviewed formally twice weekly by the senior clinical and management team.
- Work continues in our Older People's Mental Health (OPMH) services to develop the model of care and ensure best practice standards are embedded.

Adults Services

- There is concern over maintaining and enhancing the current out of hospital capacity for the adults urgent care pathway to ensure there is flow in the urgent care pathway out of Portsmouth Hospitals NHS Trust (PHT). The analysis by PWC has been responded to with proposals for further out of hospital capacity to contribute to the achievement of a 92% bed occupancy at PHT leading into the winter. (Link to Corporate risk Clinical Capacity)

Finance

The year to date position is an adjusted deficit of £634k against a plan of £689k. We are currently on track to deliver our financial plan which is a deficit of £1.0m. However, this plan requires significant savings in the second half of the year and the mitigations of any cost pressures.

Estates

Although the St James phase 2 work was approved as part of the NHS wave 3 capital allocations, additional formal paperwork has been required. This is now with the Department of Health and Social Care (DHSC) for formal sign-off prior to accessing the necessary funds.

The formal lease for Adelaide Health Centre has now been signed.

ICT

There has been no reoccurrence since the end of May 2018 of the Microsoft Outlook Exchange issue that had a significant impact on Trust email users over the preceding two month period. Associated investigations and reports related to this issue are on-going and will complete by the end of August 2018.

The mobile phone project that updated the Trust's mobile phones and migrated the management of these phones to a new system has successfully completed with approximately 1500 new smart phones rolled out to users.

3. Current news

Current Trust news is available on the trust website www.solent.nhs.uk

4. Complaints

Formal Complaints

This report has been written following an extraction undertaken by the Solent PALs and Complaints Service on 06 July 2018 of complaints data received during June 2018.

During June 2018, the PALs and Complaints Service received a total of

- 17 formal complaints, MP Queries, or Professional Feedback
- 34 service level concerns.
- 63 advice and signposting requests and
- 81 plaudits

The complaints per Service Line can be broken down as follows:

Service Line	Formal Complaint	MP Query	Professional Feedback	Total
Adults Portsmouth	1		1	2
Adults Southampton	1			1
Children's Services	2			2
Mental Health Services	4			4
Primary Care	5	1		6
Sexual Health Service			2	2
Total	**13**	**1**	**3**	**17**

There were 25 themes recorded amongst these complaints, and they are detailed in the table below;

Appointments	3
Attitude	4
Clinical	10
Communication	6
Confidentiality	1
General Procedures	1

During May 2018 there was an overall increase in the number of Formal Complaints received (27). The rise in complaints was specific to Primary Care (9) and Child and Family Services (6). Both Services have looked into the details of the individual complaints and have confirmed that there are no specific trends or themes identified.

We have also seen a rise in complaints and service concerns during Q1 2018/19 in comparison to last year (67 complaints during 2018/19 compared with 50 in 2017/18, and 110 service concerns compared with 82 in 2017/18 for the same period). At present we are unable to determine if there is a long term trend, however the situation continues to be closely monitored and analysed. Regular discussions are held with the service leads to ensure that any areas of concern are addressed immediately.

At the end of June 2018 there were

- 28 open complaints.
- 25 complaints were closed in the month.
- 11 complaints were closed as not upheld,
- 4 were closed as partially upheld.

- 9 complaints were found to be upheld,
- 1 complaint was closed as withdrawn.

Learning from June's closed complaints includes the following:

- Following a review of the E referral system it was identified that there was possible room for an error to occur when making a referral resulting in the referral going to the wrong team. The clinicians meet with the patient systems team and designed a new referral pathway to ensure that it was not possible to send a referral to the incorrect team.

- Having been discharged form UHS into a rehabilitation bed at the Royal South Hants Hospital (RSH) a patient and her family expressed that they were not fully aware of all the resources available to support rehabilitation in her own home. She had also been promised intense physiotherapist by a member of UHS staff. The therapy team developed a leaflet clearly outlining for both patients and their families what they can expect during their rehabilitation at the RSH. This includes a section on: what happens when you arrive, what you can expect from us, your discharge plans and details of the member of the team.

5. Update from the Trust Management Team (TMT) meeting

A summary of the significant business transacted and matters discussed at the TMT meeting held on 23rd May is as follows:

- An update was provided with regards to system developments
- A draft learning framework was shared with TMT members and an interactive session was held where members worked in groups to identify previous issues and apply the learning framework methodology. It was agreed that the framework be considered for implementation at Serious Incident Panels.
- The Chief People Officer briefed the members on key workforce metrics, including mandatory training compliance, turnover, agency spend and sickness data.
- Freedom to Speak Up (FTSU) Guardians joined the meeting and shared videos of staff providing insight into the FTSU process. The need to empower staff to speak out and reinforce the message that there are no repercussions as a consequence of speaking out, was reiterated.
- An update was provided regarding the improving situation concerning IT /Outlook, with a new technical architecture being created and email accounts being migrated.

An update of business discussed at the 18th July meeting will be provided at the meeting.

6. Board Assurance Framework and Corporate Risk Register

Board Assurance Framework – the following table summarises the key strategic risks:

BAF number	Concerning	Lead exec	Raw score	Mitigated score (Current score)	Movement since last reported (and previous score)	Target score
58	Future organisational function	Sue Harriman	20	16	⇔	6
55	Workforce Sustainability	Helen Ives	20	16	⇔	9
57	Quality Governance, Safety and Professional Standards	Jackie Ardley	16	12	⇔	6
13	IT	David Noyes	16	12	⇔	6

KEY: ⇔ = same as previous, ⇧ increase in score ⇩ decrease in score

Risks scoring <12 include: #59 – Business as Usual, #60 –Organisational Development, #62 –Executive Capacity, #53 – Financial Sustainability, #27 - Estates

Significantly a new risk #63 has been included to reference potential Third Party Supplier Risks – the current mitigated score is 9 (amber). The full Board Assurance Framework Report is presented to the Board separately within the confidential meeting.

Corporate Risk Register

The new Risk Management Framework and Risk Management Process have now been launched across the Trust.

New risk management e-learning training went live on 16th July and is compulsory for all staff and new starters. The e-learning is being supplemented with face to face training to key staff groups in Service Lines and being delivered throughout the summer.

All risks scoring 12+ are being reviewed by Service Line Professional Leads during July to improve the quality of entries in the Risk Register and aid accurate risk analysis theme and trend identification in future.

As at 12th July 2018 there were 109 open risks on the Risk Register. Since the last report to the Board, 7 risks have been closed (eliminated) and 24 new risks have been added.

There are 9 risks which score 15+ and these relate to:

- Adult Mental Health: High level of registered nurse vacancies
- Human Resources: Ability to evidence compliance with statutory and mandatory training requirements
- Occupational Health: Service unable to meet increase in demand for services
- Primary Care: Ability of service to deliver performance target and risk of financial penalties
- Primary Care: Patients unable to access complex diagnostic imaging in Portsmouth and Southampton and impact on ability to deliver MSK service
- Primary Care: Risk of loss of contract and subsequent source of income (translation service)
- Sexual Health: Automated system for alerting staff to live safety concerns not viable
- Sexual Health: Availability of premises to deliver services in Winchester
- Sexual Health: Financial risk of delivering above contracted activity

The most prevalent (highest number) of risks on the register are concerning:

- *Workforce staffing* – risks associated with vacancy levels and difficulty recruiting clinical staff
- *Clinical capacity* – risks associated with maintaining quality of care and performance targets due to increasing demand for services
- *Information Technology* - at corporate level risks relate to the provision of data, the effectiveness of the Trust's IT provider and the robustness of IT business continuity and backup arrangements. At service level risks relate to problems with access to essential systems and IT connectivity.
- *Estates and facilities* – risks associated with availability of suitable premises from which to deliver safe services and maintenance of plant and equipment

Sealings

No.	Concerning	Date of Signing/ Sealing
68	South West Hampshire Lift - Underlease for part of Adelaide Health Centre, Millbrook, Southampton (excluding GP Area)	Andrew Strevens and Sue Harriman - Sealed 18/06/2018
69	South West Hampshire Lift - Underlease for part of Adelaide Health Centre GP Practice, Millbrook, Southampton	Andrew Strevens and Sue Harriman - Sealed 18/06/2018

Signings as reported to Finance Committee since last Board meeting

Solent as Provider (Service Line)	Commissioner	Description of service
Various	Portsmouth CCG, Fareham & Gosport CCG, South Eastern Hampshire CCG, North Hampshire CCG, North East Hampshire & Farnham CCG, Isle of Wight CCG	Main CCG Contract – Variation to revise Finance Schedules to reflect 18/19 changes
Various	NHS Southampton City CCG, West Hampshire CCG	Main CCG Contract – Variation to revise Finance Schedules to reflect 18/19 changes
Sexual Health	NHS England	Specialist Public Health Services Contract - Variation to update the contract for 2018/19
Various	University Hospital Southampton NHS Foundation Trust	Clinical Support Services & Clinical and Non-Clinical Services – Provider to Provider contract – Extension for one year
Trustwide	TFS Healthcare	Provision of Agency Staffing
Adult Mental Health	Southern Health NHS Foundation Trust	Provision of Hampshire Liaison and Diversion (covering Portsmouth and Southampton). Extension for 1 year and additional Basingstoke settings added to the specification

Sue Harriman

Chief Executive

REPORT

Item 10

Presentation to	**Public Board**		
Title of Paper	Director of Medical Education (DME) Briefing Paper		
Author(s)	Dr Suyog Dhakras, Consultant Child & Adolescent Psychiatrist & Director of Medical Education (DME)	**Executive Sponsor**	Dan Meron, Chief Medical Officer
Date of Paper	30th July 2018	**Committees presented**	N/A

Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	
	W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	

Executive Summary

Mental Health Services in the Trust engaged with 3 Quality Assurance visits Oct 2017 – April 2018:

Wessex HEE (Wessex Deanery, School of Psychiatry) visit to review training at The Orchards (AMH inpatient unit) - October 2017

Overall rating – 'Green 1': "Meets all national standards for education and provides an appropriate and quality assured training experience. Clear action plans for any challenges which arise, with the impact of difficult to resolve issues minimised."

Things going well:

1. Good support for training and education from Service Line
2. Combination of substantive and long term locum medical workforce though not ideal, no adverse impact currently on training
3. Trainees reported generally supportive atmosphere; training valued in service (Clinical Director (CD) & Clinical Tutor emphasised that the service did its best to ensure trainees considered as 'supernumerary' – thanks to Matthew Hall who was CD at the time); very good weekly educational programme run jointly with Southern Health; good access to Psychotherapy experience. Additionally good rest facilities
4. Trainers – Educational Supervisors (Consultants) reported good support from Service Line in discharging supervision and educational + training duties

Challenges:

5. Prompt IT access when starting placement with the Trust
6. Difficulties in night shifts and covering a large area on-call (includes 5 inpatient units) – rota jointly run with Southern Health and agreement from both Trusts that current area covered is difficult for 1 trainee on shift / on call
7. Concerns regarding new contract – and difference in pay (partially due to lack of clarity in understanding difference in 'on-call' pattern and 'shift-rota' pattern)
8. Sustainability of training placements in the face of lack of enough substantive consultants
9. Trainees would benefit from having taster sessions of other specialties whilst on placement (e.g. Child &

Adolescent Psychiatry, Liaison Psychiatry at QAH) – was agreed to immediately as already on offer to trainees (following discussion with Supervisors)

Plan:

- Discussion re no. 5 with HR, CD & IT
- No. 6 – discussion ongoing with Southern Health to check feasibility of a 2 track shift rota – however lack of trainees in Psychiatry would make this difficult. Tutors, CDs and DMEs to discuss initiatives such as ANPs (Advanced Nurse Practitioners) – i.e. evidence when this programme goes live in Dorset. Undoubtedly difficulties in rota make Trusts & services less attractive to trainees.
- No. 7 – regular HR surgeries being offered, also Junior Doctor Forum (as per T&Cs of new contract)
- No. 8 – new CD appointed – recruitment initiatives to be decided with Service line
- No. 9 – already on offer to trainees

Southampton University School of Medicine Quality Assurance Visit to Portsmouth Hub for Psychiatry Year 4 UME Teaching – Nov 2017 (3 yearly visits)

Previous QA Visit was in 2014.

All recommendations from previous visit in 2014 achieved – especially:

- Clarity and transparency in funding delivered to Service Line – highlighting specific funding for Tutors & Undergraduate Lead (Solent in vanguard of Trusts working with Southampton Uni Med School, in getting clarity regarding funding streams)
- Appointment of Undergraduate Lead and clarity re time commitment, ensuring all tutors and supervisors have time allocated in job plans
- Appointment of Administrator (in post for 2 years already)
- Appointment of Learning Facilitator – successful
- Recommendations from Nov 2017 visit already achieved
- Excellent feedback from medical students regarding the supervision and quality of teaching
- Feedback for all the supervisors and Tutors is well structured and detailed

GMC visit to review all UME (Undergraduate Medical Education) & PGME (Post Graduate Medical Education) in Child & Adolescent Psychiatry in Solent – March 2018 (formal feedback report expected September 2018) –

One area for improvement – significant issue*:*

CAMHS out-of-hours on call (rota staffed by trainees predominantly from Solent, and a few from Sussex FPT-Hants CAMHS; and CAMHS consultants from Solent, UHS & Southern) – covering Soton and P'mth cities, UHS & QAH and Leigh House Adolescent Unit – 5 different Trusts involved

- *Difficulties in access to patient records (of the Trusts involved) for trainees and consultants needs to be resolved as quickly as possible as potential impact on patient safety & quality (though no SIRI has happened so far)*
- *lack of formal commissioning of the rota*

They were appreciative of the fact that DME had secured a rota administrator – and of Jonathan Prosser's on going

work re the out-of-hours CAMHS rota extranet web-page as a means to share information. They were also appreciative that Jonathan and I both had raised this as a significant issue in the very first meeting of the morning.

I understand that this is under the aegis of the Children's STP – would need action as GMC likely to highlight as patient safety issue.

Eight areas they highlighted as positives:

- *Governance structures as presented in my initial introduction in the morning for Education & Training in the Trust – good governance processes*
- *Good UME induction*
- *Specific teaching especially at UME level to address equality & diversity issues*
- *That the UME team had adopted a bespoke appraisal system for faculty members*
- *Good evidence of access to multi-professional learning at both UME & PGME levels – highlighted by students and trainees*
- *PGME Trainees especially complimentary re excellent quality of supervision & protected supervision from Ed & Clinical Supervisors*
- *PGME Trainers felt supported by Service (also through formal job-planning) in carrying out supervision and having PG trainees in the service*
- *Special mention for the QI project re CAMHS-Acute Paeds-ED interface by Katya Certic (QI Fellow – Paeds) under supervision and delivery of training by Drs Suyog Dhakras & Julie Waine – as an 'excellent example' of working between organisations and specialties for the benefit of patients (especially emphasising the joint CAMHS-Paeds de-briefs happening every 3 months between CAMHS trainees and QAH & UHS Paeds MDT members- as a now integral part of the Child Psychiatry Academic Programme)*

The lead reviewer mentioned that this was the 'most positive' visit they had done (over a 7 year visit cycle reviewing all the Trust in the country) – though not sure this will be part of the formal feedback.

Other issues:

- PGME - GMC National Trainees' Survey – results out – we are awaiting details.
  1. Excellent feedback re training for CPMS (Community Paediatrics) – very good feedback overall from trainees
  2. Concern about 'induction' across all specialties – predominantly again due to IT issues – with likely adverse impact on Trust training reputation
  3. for CAMHS out-of-hours rota, on call concerns and handover issues highlighted as concerns (significant barriers to access to clinical records across Trusts – highlighted in GMC Visit section above)
- UME - Reduction in annual income from Southampton University Medical School – due to a reduction in student numbers – will affect CPMS mainly - by £54,000.

Other positive developments:

- Faculty Development – as a first step in the development of a virtual undergraduate and postgraduate education centre; DME has started Trust based faculty development - one day each annually to develop the faculty for UME & PGME; very good participation from clinicians involved – 1st UME Faculty Development Day held successfully on 02 July 2018; PGME Day on 31 Oct 2018

Aspiration: To advocate that Training and Education becomes a crucial part of Trust business and 'Solent Story' – and a key part of Trust identity along with great patient care, and especially being the partner of choice for service provision and education & training provision – especially in the context of changing contexts of providing healthcare.
Risks identified in relation to this report (and include date of when included on the Risk Register)
N/A
Key Decisions/ Action(s) requested
The Board is asked to note the report.

Item 11

NHS Solent NHS Trust

Presentation to	Public Board Meeting							
Title of Paper	Trust Board Performance Report Part I – June 2018							
Author(s)	Alasdair Snell		**Executive Sponsor**		Andrew Strevens			
Date of Paper	20/7/18		**Committees presented**		Trust Management Team			
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy	x	**W3** Culture		**W4** Roles & Responsibilities	
	W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement		**W8** Learning, Improv't & innovation	

Executive Summary

A monthly overview of performance against the NHS Improvement Single Oversight Framework, key contractual requirements and operational indicators of quality, our workforce, finance and service hotspots.

Risks identified in relation to this report (and include date of when included on the Risk Register)

Key Decisions/ Action(s) requested

To receive.

Table of Contents

1.1 Solent NHS Trust Performance Report - Operations June 2018/19

Activity

			Same Period 2017/18
14,904	New Referrals in month*		15,238
60,819	Attended Contacts in month*		55,606
3,371	DNA'd Appointments in month*	4.3%	4.0%
34	Delayed Patients in month (DTOCs)		25
615	Delayed Days in month		402
14,456	Discharges in month*		13,842

Key Performance Indicators

275	KPIs due in month
202	KPIs achieved in-month

CQUIN Schemes

15	CQUIN schemes
0	Milestones due YTD
0	Milestone Achieved YTD

1	Contract Performance Notices (CPN) open

* Data reported for Community and Mental Health Services only. IAPT, Substance Misuse and Specialised Services data not included.

Hotspots

- CAHMs & Paediatric Continence services vacancies
- CAMHs Waiting List Growth
- Children's Dental GA - increasing waiting list and capacity concerns
- MH OOA Placement Days
- COAST Closure
- Wheelchair Delays
- MCA Training Compliance
- Potential future MSA Breaches
- DTOC Admissions
- Cardiometabolic assessment improvements
- NHS 70 Awards**
- NO. 1 for Research**

**Reported on in the CEO Report

1.2 Chief Operating Officer Commentaries – June 2018/19

Portsmouth System

- The new service to provide integrated 24/7 primary care to Portsmouth City has gone live on 29 June 2018 with the PPCA taking on the provision of GP out of hours service for the City.
- The MSK triage service is being rolled out to remaining GP practices. This innovative service directs patients with MSK related illness to the most appropriate care, reducing demand on GPs. The roll-out to the remaining practices in the City will be complete by March 19.
- The MCP Programme Board agreed that the MCP Partnership Agreement between the Portsmouth Primary Care Alliance (PPCA), Solent NHS Trust, NHS Portsmouth CCG and Portsmouth City Council (PCC) be extended for a further year from 1/7/18 to 30/6/19.
- A new process to improve the provision of dressings to patients at home will commence in July. It is hoped that this will reduce the time taken for the correct dressings to be prescribed and supplied, saving GP and community nurse time.

Portsmouth Care Group Hotspots

- Mental Health PICU capacity continues to be severely diminished by the closure of six beds at Maples. The situation continues to be managed by twice weekly SITREP meetings and judicious use of ECR placement. There has been a four-week slip in the re-opening date – to the end of August, due to investigative works revealing more complex damage than originally anticipated.
- "Red to Green" productivity mapping exercise on Jubilee House has revealed that delays caused by waiting for Nursing Home placement and in the funding process accounted for 45% of the bed days used on the unit. An improvement plan aims to reduce wasted bed days by 15% in the period June - September 2018.
- CAMHS East vacancies have reduced and we now anticipate secondary waits within the service to improve over the coming months. At present the greatest effect of capacity challenges is on completing Autism assessments. The service is producing a plan to ensure that the waiting list prioritisation process includes ongoing risk assessment of waiters.
- Clarification has been received from CQC and NHSI about the definitions of "Mixed Sex" accommodation. The implication is that 2 of the 10 Maples Ward bedrooms will automatically breach, because they open into a communal ward area. This has been added to the risk register. Options are being explored with SHFT to create single-sex units.

Southampton System

In Southampton we have concluded a review of the Better Care programme governance structure, and from April 18 are governing the programme using:

- Better Care Southampton Steering Board
- Better Care Southampton Working Group

We have successfully appointed a full time programme manager to help the system drive progress towards making the operating model a reality on the ground. The successful candidate started work for the system from the end of May 18.

At the Jul 18 Steering Board, the outline future out of hospital operating model was endorsed; the working group will now work on further refinements to the model and start to draw together implementation plans.

Southampton & County Wide Care Groups Hotspots

- As stated in the Single Oversight Framework commentary, the Trust had 5 breaches out of 195 diagnostic procedures of the national 6 week diagnostic target. There were all due to a sub-contractor for MRIs from our Specialist MSK service. We are working with our partner to reduce them as soon and safely as possible.

- The demand on our Children's specialised Dental services that require a general anaesthetic, remains. Demand continues to outstrip theatre capacity and the Trust are actively pursuing all possible opportunities to acquire additional theatre space.
- The Southampton COAST service continues to remain temporarily closed to new referrals. This service is commissioned to deliver via a very small team of less than 3 WTE making it vulnerable to staffing pressures. The service continues to work with commissioners regarding future provision options.
- Solent continues to work under the Contract Performance Notice for the Behaviour Change service, but performance has improved markedly during 2018, yet still not meeting most contractual targets.
- Solent has a number of vacancies in Southampton CAHMs and Paediatric Continence services. There is a risk that service quality will not be maintained, especially waiting times, without significant impact to staff morale.
- Although the Operations Dashboard in section 2.1 states that 73 KPIs are not meeting their targets YTD, there are no specific concerns. There are a significant number of new KPIs recently varied into the contract for services such as CAMHS and Health Visitors that the Trust has not had time to build bespoke reports against and a large proportion of the red KPIs for our Sexual Health Services are already under review with commissioners as no longer relevant to the service model delivered. KPI performance for all services continue to be monitored closely monthly within our performance governance structure and also in contract review meetings with our commissioners.

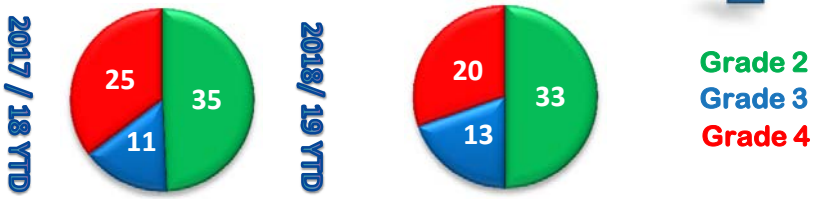
2.1 - Quality Performance June 2018/19

Serious Incidents

5	Serious incidents occurred in month
10	more year to date than 17/18
0	Healthcare Infections / Cdiff / MRSA
0	Safety compliance breaches

Pressure Ulcers in Solent Care

19	Occurred in month
3	More than same month 17/18



Friends and Family Test

2136	Responses received
1162	More than same month 17/18
96%	Positive ratings %
1%	Negative ratings %

Formal Complaints

20	Complaints received in month
32	Required response in month
7	Breaches in month

Care Quality Commission

2016 CQC inspection made 179 recommendations

MUST DO 86	SHOULD DO 93

Of these:

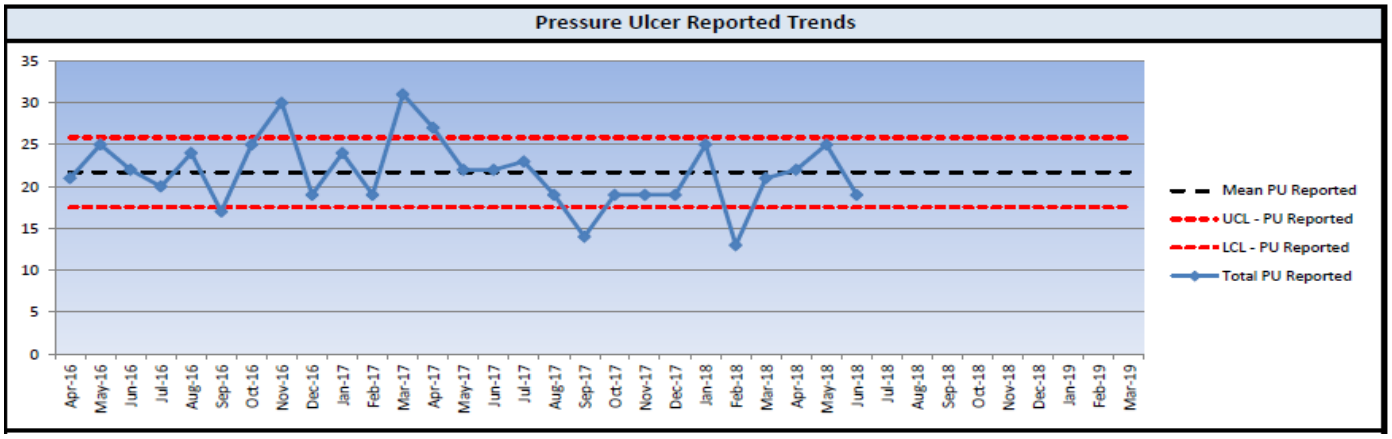
134	Have been completed
32	On target for delivery
13	At risk but mitigation in place
0	At risk requiring further mitigations

2.2 Chief Nurse Commentary - 2018/19 Month 03

Staffing

Staffing remains an issue within Mental Health services, however a number of actions have been taken, including a skills-based training package being developed for Band 2 and 3 practitioners to enable development outside a formal academic route. The two Advanced Nurse Practitioners (ANPs) working alongside medical staff on the Orchards Unit are proving to be capable of undertaking a range of duties, which would traditionally be performed by non-Consultant Grade medical staff (Staff and Associate Specialist – SAS – doctors).

Pressure Ulcers Acquired in our Care



Pressure Ulcers acquired in our care have reduced this month with a reduction in both Grade 2 and Grade 4 Pressure Ulcers.

PICU accommodation and out of area placement

Six PICU beds remain closed on Maples, following the serious incident in May 2018. There have been some delays in the refurbishment plan, due to availability issues with specialist fixtures. This has delayed the reopening date until the end of August. The impact on local people requiring a PICU is that over 100 days, during May and June have been required in out-of-county specialist mental health provision – the first out-of-area beds purchased for over 5 years. This has affected 5 patients from Portsmouth who have been placed in PICUs as far away as Bradford. The readiness of each patient to return to local acute care is reviewed formally twice weekly by the senior clinical and management team.

Portsmouth Mental Health – Mixed Sex Compliance

We have received further informal guidance from NHS Improvement about the CQC interpretation of mixed sex accommodation compliance. Further clarification is currently being sought through the Provider Information Request process with CQC with regard to Mental Health Psychiatric Intensive Care Units being exempt from this process.

Information Governance (IG) Breaches

Thirty four IG breaches were reported in June, which is above the expected average. The average number of IG breaches reported in 2017/18 was 27. However upon review, it has been identified that six of these breaches reported, due to mitigating factors in place have been downgraded to no breach subsequently and will be retrospectively removed from reporting e.g. lost laptop which is encrypted. The reporting of these potential breaches is important as they allow us to track and ensure that we have the appropriate mitigating factors in place. This type of reporting is positive and a result of training, awareness and an open reporting culture.

If these incidents were to be removed, as per above, this would bring the number of incidents down to 28, which is back within expected perimeters.

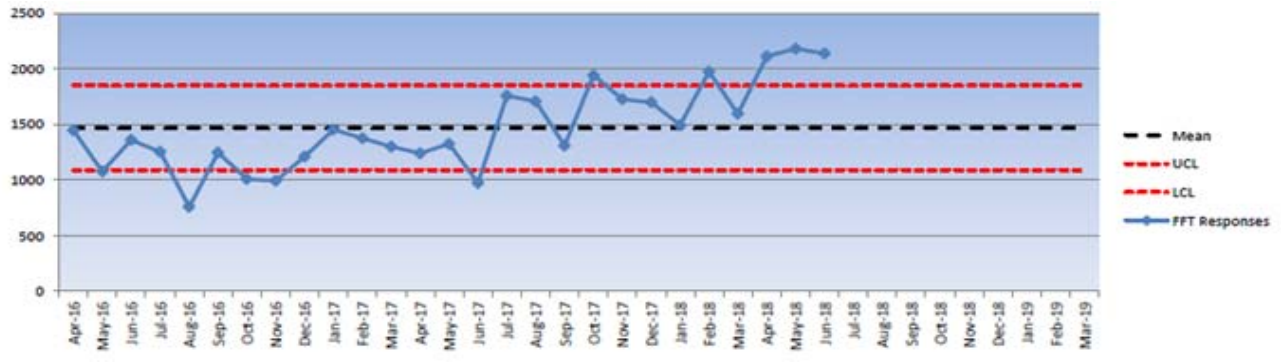
The number of IG breaches in month is the highest it has been twelve, with a significant number in Primary Care Service Line accounting for the steep increase. The Service Line has completed a deep dive review on the incidents and believes it demonstrates good reporting and as a service line, they are continuing to work with the teams to improve their processes.

Insulin Dependent Patients

We have recently seen an increase in the volume of patients requiring insulin administration by Community Nursing arising from a change in practice towards injection rather than oral administration (representing safer clinical practice). In Adults Services Southampton this has risen form 16 in April 2017 to 60 in April 2018, we are also seeing a rise in Portsmouth but not of the same magnitude. The impact on service ability to deliver in a timely way has been raised with commissioners.

Patient Experience

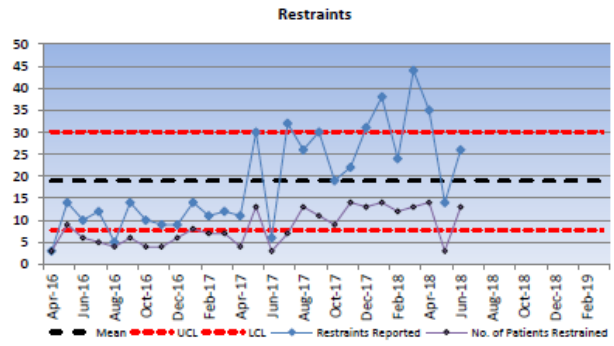
Out FFT response rate has now exceeded the upper control limit for the third month in a row.

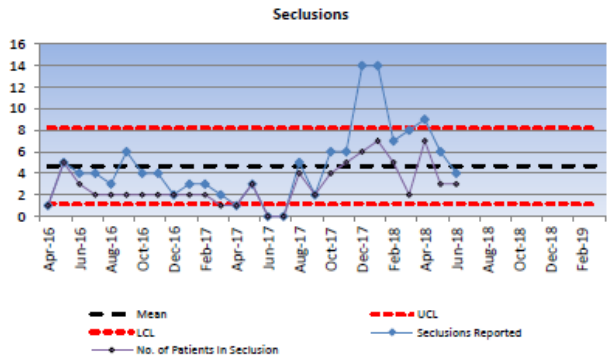


In June, there were 32 complaints that were due for closure and the Trust breached 7 of these. The main cause for the delays in closure is the complexity of cases, ensuring the response provides the answer and response in full to an excellent standard.

Restraint and Seclusion

The rates for both restraint and seclusion continue to be affected as a result of the closure of beds on Maples, it is likely that this will continue for a number of months making the comparison of trend and historic data reporting difficult.





Gosport War Memorial Hospital

We have convened a small working party to review the recommendations, which will report back via QIR/Assurance Committee and Trust Board in September.

CQC Update

The identified actions from the 2016 CQC inspection have now been successfully embedded in business as usual practice. The Chief Operating Officers have reviewed and signed off each action's completion through the monthly Performance governance structure.

As a result, the CQC Infographic on the Quality Dashboard will be removed by the September Trust Board and replaced with another key Quality metric.

During July, Solent NHS Trust received formal notification from the CQC that they will be reviewing the Trust within the next 3 months and we are in the process of completing a comprehensive provider information request (PIR). This was due to for completion by July 24.

The Trust are looking forward to showcasing our excellent services, staff and patient care.

Positive Action

- The quarterly MRSA Screening compliance was 100%.
- A text messaging service introduced in the GP Surgery has improved the DNA rate as patients are able to cancel their appointment by text rather than phoning the surgery. Positively the system also supports patients to respond to the FFT and this has significantly increased our responses.
- A new format of Board report based on 'Outstanding' Trusts' is being discussed by QIR and Assurance Committee.
- Participation in the annual national audit of physical healthcare for patients with psychosis (NCAP) is mandated requirement for all NHS mental health providers. The results for the 2017 audit showed a

continued improvement on the previous 2 years results. NCAP noted that Solent "*was generally above average. In particular, monitoring of physical health factors, and intervention if these were abnormal, was very good*". Improved process control on inpatient wards and bespoke local training for clinical staff have been instrumental in achieving these outcomes.

3.1 - Financial Performance June 2018/19

Performance

£239k Deficit in Month
£26k Adverse to plan

£634k Deficit YTD
£55k Favourable to plan

£971k Deficit Year End Forecast
£0k Achieving control target

Purchase Orders and Debts

Eligible invoices raised in month **965**

960 Purchase orders raised in month

Purchase orders raised in month against eligible invoices **99%**

£7,322,382 Total debt month end

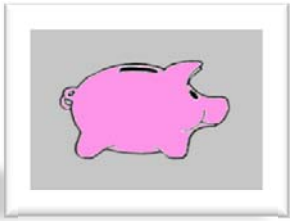
£1,899,554 Total debt over 90 days month end **26%**

Savings

£1,398,000 Savings Target YTD

£1,461,000 Savings Delivered YTD

£428,000 QIA Savings Delivered YTD

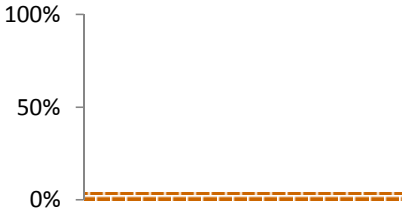


105% Savings Achieved

Capital Finance Summary

£511,000 YTD Spend

£12,713,000 Year end plan



4.0% Spend against year end plan

3.2 Finance Commentary

Month 3 Results

The Trust is performing marginally better than plan and has qualified for the quarter 1 Provider Support Funding (PSF) of £82k.

CIPs

The CIP plan is performing slightly better than expected due to headcount controls in Children's West and Primary Care.

Capital and Cash

Month 3 capital expenditure spend is £250k. Projects totalling £4.1m have been approved and in most cases are in progress.

The cash balance at 30 June 2018 was £7.4m.

Aged debt

Debt over 90 days overdue has increased by £445k month on month, at 30 June is £1.9m and at 31 May was £1.5m. Total debt overall has decreased month on month from £7.7m to £7.3m.

Invoices processed via PO

The Trust continues to promote the use of purchase orders when ordering goods and services. In month 3 the percentage of eligible invoices processed via a PO (rather than via Non-PO) was 99%.

4.1 - Workforce Performance June 2018/19

There were **2,911.4** FTE in post this month, which equates to **3,528** staff in post.

A decrease of **7.1** since last month

85% YTD mandatory training compliance

60% YTD information governance training completed

36% YTD appraisals completed

Bank and Agency

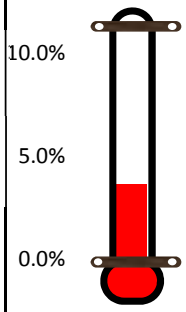
27,500 Hours requested in month

17,935 Hours filled by bank in month **£403,519**

7,857 Hours filled by agency in month **£320,379**

1,708 Hours requested not filled

In month, Solent are above agency ceiling by **£45,379**



3.6%

Sickness & absence in month

Last month, the rate was **3.7%**

94.8% *budgeted establishment (FTE) worked in month*

5.2% *vacancy factor*

FTE Posts **160.9**

12 month rolling turnover is **13.9%**

40 (34.3 FTE) new starters in month

49 (40.1 FTE) leavers in month

4.2 - Workforce Commentary

Sustainable Workforce

Our vacancy factor for June as a Trust is 5.2% with an average annual staff turnover of 13.9% which is a slight increase on the previous month, mainly due to there being more leavers than starters in month.

Temporary agency costs for June reduced by £75,172 which reflects the decrease in hours filled by agency workers. An increase in temporary agency costs is expected next month however, due to a slight drop in the Bank service fill rate. Services continue to review rosters, bank staffing, recruitment and education pathway solutions to address job vacancy related agency spend with strategic oversight from the Trust's Workforce Planning Sub-committee.

There is a continued decline in the monthly sickness absence rate falling to 3.6% in June as part of a sustained focus on attendance management. We are encouraged to see this improvement, which is an essential part of our safe and sustainable staffing strategy.

Having commenced a digital advertising campaign to recruit Band 4 and 5 mental health nursing staff, our selected platforms are performing above the industry benchmarks. The recruitment team are following up on expressions of interest to encourage people to apply and attend a recruitment event scheduled for next month.

Learning & Development

The annual statutory and mandatory training compliance rate is 85% for June. The Information Governance compliance rate has increased from 51.7% to 60% and the performance appraisal completion rate has increased from 22.9% to 36%.

The recent Workforce Focus Forums highlighted the need to "grow our own staff" via the apprenticeship route. There is now a diverse portfolio of apprenticeships allowing progression from level 2 to level 7. So far we have received over 55 applications from Trust staff to access apprenticeships for the current academic year.

Leadership, Culture & Values

The People and OD team continue to run local development programmes to strengthen leadership capability. A senior leadership team away day was held in June focussing on the Solent Story as a communication and engagement strategy to deliver our vision of *"keeping more people safe and well at home"*.

Communication & Engagement

As part of our work to encourage a culture of pride and celebration, preparations are in place to celebrate our people and the NHS during the week of NHS70. We are also preparing to launch a new Solent Awards scheme to replace WOW. The scheme will give employees and services users the chance to nominate and vote for people who do exceptional things and really make a difference.

Services continue to work through their staff survey results to identify areas for action as part of local operational and business plans.

5.1 NHS Improvement Single Oversight Framework

The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework was introduced on 1 October 2016, at which point the Monitor 'Risk Assessment Framework ' and the TDA's 'Accountability Framework ' no longer apply. The Framework uses five themes: 'Quality of care'; 'Finance and use of resources'; 'Operational performance'; 'Strategic change'; and 'Leadership and improvement capability'. The 'Quality of care', 'Finance and use of resources' and 'Operational performance' themes contain a list of metrics, however not all of these have nationally measured thresholds. Where internal, aspirational thresholds exist, these have been included below, highlighted in grey. The 'Operational performance' metrics do not provide a performance assessment, however NHS Improvement state that they will consider whether support is required to providers where performance against the 'Operational Performance' metrics:

- for a provider with one or more agreed Sustainability and Transformation Fund trajectories against any of the metrics: it fails to meet any trajectory for at least two consecutive months
- for a provider with no agreed Sustainability and Transformation Fund trajectory against any metrics: it fails to meet a relevant target or standard for at least two consecutive months
- where other factors (e.g.. a significant deterioration in a single month, or multiple support needs across other standards) indicate we need to get involved before two months have elapsed.

Providers will be placed in a segment based on NHS Improvement's assessment of the seriousness and complexity of any issues identified as per the table below:

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
4	Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

Please note that Solent does not have any Sustainability and Transformation Fund trajectory metrics.
For some indicators, no definition has been confirmed by NHS Improvement. Our interpretation has been applied in the below.

Performance Exceptions

The Trust has continued to achieve a level 2 on the NHS Improvement scale, where level 1 is the best and level 4 the most challenged. This is a good position for the Trust. The Organisational Health Domain has remained consistent with staff sickness meeting the Trust target. The Use of resources score has remained at level 3. mainly due to agency spend, I & E margin and capital services capacity.

Operationally, against the framework, the Trust has only not met 4 indicators in the Quality and operational metrics – including maximum 6-week wait for diagnostic procedures - this is the first time we have breached this indicator in over 2 years. In 2018/19, we are including a sub-contractor's performance for MRIs under our Physiotherapy service. There were 5 breaches of 6 weeks out of 195 diagnostic procedures trust-wide. The sub-contractor is being challenged to performance and we will expect an improvement over the coming months.

As a consequence of the events on Maples in May, bed availability has reduced by 6 with a total of 71 days in June being out of area placements. The overall performance against the Single Oversight Framework is positive however the only concern is the use of resources score against the framework currently.

Quality of Care Indicators

Organisational Health

Internal aspirational thresholds are highlighted in grey

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Staff sickness (in month)	4%	4.1%	4.3%	4.8%	4.6%	4.9%	5.2%	5.1%	5.2%	4.3%	4.2%	4.2%	3.7%
Staff turnover (rolling 12 months)	12%	15.1%	14.8%	14.8%	14.5%	14.2%	14.3%	14.4%	14.1%	14.4%	14.2%	14.2%	13.6%
NHS Staff FFT	40%	64.4%	-	-	64.1%	-	-	-	-	-	69.0%	-	-
Proportion of Temporary Staff (in month)	6%	6.1%	6.1%	6.4%	5.8%	5.7%	6.0%	6.1%	6.0%	5.9%	6.0%	5.6%	4.9%

Caring

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Written Complaints		22	14	16	17	11	19	16	18	22	20	19	32
Staff Friends and Family Test Percentage Recommended - Care	80%	83.0%	-	-	82.3%	-	-	-	-	-	84.0%	-	-
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Scores from Friends and Family Test - % positive	95%	95.1%	97.8%	95.2%	95.0%	96.0%	97.0%	96.6%	96.2%	96.2%	95.9%	95.4%	96.4%
Mental Health Scores from Friends and Family Test - % positive	95%	87.1%	100.0%	90.5%	83.3%	85.4%	91.3%	83.3%	95.6%	84.3%	80.5%	74.7%	71.2%

Effective

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	100%	100%	92%	100%	98%	100%	100%	100%	100%	100%
% clients in settled accommodation		68%	69%	70%	72%	72%	71%	71%	71%	70%	71%	74%	75%
% clients in employment	5.0%	6.0%	6.0%	5.0%	5.0%	6.0%	6.0%	5.0%	5.0%	5.0%	5.2%	4.4%	5.0%

Safe

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Occurrence of any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
NHS England/ NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95%	97.0%	99.0%	98.0%	97.0%	100.0%	97.0%	97.0%	96.0%	95.0%	92.0%	91.0%	99.0%
Clostridium Difficile - variance from plan	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile - infection rate	0	0	0	0	0	1	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	-	-	-	-	0	0	0	0	0	0	0	0
Escherichia coli (E.coli) bacteraemia bloodstream infection	0	-	-	-	-	0	0	0	0	0	0	0	0
MRSA bacteraemias	0	0	0	0	0	0	1	0	0	0	0	0	0
Admissions to adult facilities of patients who are under 16 yrs old	0	0	0	0	0	0	1	0	0	0	0	0	0

Operational Performance Indicators

Indicator Description	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	100.0%	99.9%	99.8%	99.5%	99.7%	99.6%	99.7%	99.4%	99.4%	99.7%	99.5%	99.8%
Maximum 6-week wait for diagnostic procedures	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
Inappropriate out-of-area placements for adult mental health - services - Number of Bed Days	0	-	-	-	-	0	0	0	0	0	0	0	21
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	50.0%	86.0%	67.0%	83.0%	80.0%	88.0%	50.0%	40.0%	83.0%	100.0%	75.0%	100.0%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%	97.7%	-	-	97.4%	-	-	97.4%	-	-	-	-	-
Improving Access to Psychological Therapies (IAPT) / Talking Therapies		-	-	-	-	-	-	-	-	-	-	-	-
- Proportion of people completing treatment who move to recovery	50%	57.4%	57.3%	56.5%	61.1%	60.4%	57.8%	53.4%	57.8%	57.6%	58.2%	51.1%	56.1%
- Waiting time to begin treatment - within 6 weeks	75%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%
- Waiting time to begin treatment - within 18 weeks	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Finance Score

A few financial metrics will be used to assess financial performance, with a score from 1 (best) to 4 (worst) being assigned to each metric. These scores will be averaged across all metrics to derive a 'Finance Score' score for the organisation. An overall score of 3 or 4 in this theme will identify a potential support need, as will providers scoring a 4 against any individual metric.

Indicator Description		Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Capital service capacity	Financial Sustainability	2	1	2	2	2	2	2	2	2	2	2	1
Score		*3*	*3*	*3*	*3*	*3*	*3*	*2*	*3*	*2*	*2*	*2*	*4*
Liquidity (days)	Financial Sustainability	-12.5	-13.0	-12.9	-13.3	-12.7	-14.4	-15.4	-14.7	-10.7	-6.7	-6.2	-6.7
Score		*3*	*3*	*3*	*3*	*3*	*4*	*4*	*4*	*3*	*2*	*2*	*2*
I&E Margin	Financial Efficiency	1.3%	1.4%	1.1%	0.9%	1.0%	-1.0%	-1.0%	-0.9%	-0.7%	0.4%	-0.9%	-1.3%
Score		*2*	*2*	*2*	*2*	*2*	*4*	*3*	*3*	*3*	*2*	*3*	*4*
Distance from financial plan	Financial Efficiency	0.0%	0.1%	0.2%	0.3%	0.1%	0.0%	0.1%	0.1%	0.2%	1.3%	0.3%	0.2%
Score		*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Agency spend	Financial Controls	24%	25%	47%	40%	38%	38%	42%	42%	43%	38%	24%	37%
Score		*2*	*2*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*2*	*3*
Use of Resources Score		2	2	2	2	2	3	3	3	2	2	2	3
RAG		G	G	G	G	G	R	R	R	G	G	G	R

5.2 NHS Provider Licence - Self Certification 2018/19

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
Condition G6 – Systems for compliance with licence conditions				
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	The Board is not aware of any departures or deviations with Licence conditions requirements. The effectiveness of internal control systems and processes are reviewed on an annual basis and documented within the Annual Governance Statement as presented to the Audit & Risk Committee and incorporated within the Annual Report. In addition, assurance to the Board is supported by opinions from Internal Auditors and External Auditors. Annually the Trust declares compliance against the requirements of the NHS Constitution	
Condition FT4 – Governance Arrangements				
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS..	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate.	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate.	
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation	Confirmed	The Board is not aware of any departures from the requirements of this condition. On an annual basis the Trust has implemented a process of governance reviews (via the Governance and Nominations Committee) including; - Reviewing composition, skill and balance of the Board and its Committees - Reviewing Terms of Reference - The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business conducted in year. A mid-year review of each Committee is also conducted. The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditor (or other external review) – including the outputs of the Audit concerning the effectiveness of the Assurance Committee and Quality Improvement and Risk Group. The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.	

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	For 2017/18 The Trust achieved a £0.7m surplus against an agreed deficit control total of £1.5m. External Auditors issued an unqualified Value for Money opinion and an unqualified opinion concerning the Trust's financial statements for the year 2017/18. For 2018/19 Our agreed control total is £1.0m deficit Internal control processes has been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls. The Board is not aware of any other departures from the requirements of this condition.	Concerning CQC compliance: We continue to address actions and monitor compliance with requirements made following our 2016 comprehensive inspection and subsequent inspections.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. Concerning Board level capability – All positions are substantively filled and qualifications, skills and experience are taken into consideration together with behavioural competencies as part of recruitment exercises for any vacancy. The Executive team will be undertaking a 360 degree team appraisal during Q1 2018/19. Established escalation processes allow staff to raise concerns as appropriate.	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Item 12

Presentation to	☐ In Public Board Meeting		☐ Confidential Board Meeting				
Title of Paper	**Greater Together: Our strategy for community engagement**						
Author(s)	Jackie Ardley, Jon Bashford		**Executive Sponsor**	Jackie Ardley			
Date of Paper	13th July 2018		**Committees presented**	----			
Link to CQC Key Lines of Enquiry (KLoE)	☐ Safe	☐ Effective	☐ Caring	X Responsive	X Well Led		
Well Led KLoEs	**W1** Leadership Capacity & Capability	☐	**W2** Vision & Strategy	☐	**W3** Culture	☐	**W4** Roles & Responsibilities ☐
	W5 Risks and Performance	☐	**W6** Information	☐	**W7** Engagement	☐	**W8** Learning, Improvt & innovation ☐
Action requested of the Board	☐ **To receive**		☐ **For decision**				

Executive Summary

This paper contains a proposal for the development of a community engagement strategy.

Purpose

The purpose of the strategy is to ensure that the Trust has a coherent and robust structure and process by which it can manage and develop the approach to community engagement. This seeks to build on the Trust's existing work on service involvement and participation and increase its confidence and competence for engagement with communities, in particular the community and voluntary sector.

The Aim

The aim is to ensure that community engagement is recognised as being essential to the Trust's shared vision to provide great care, create a great place to work and deliver great value for money and to the fulfilment of its framework for being an organisation that is well led.

In short the Trust believes that we are ***greater together*** and that only by working in partnership and collaboration can the health and wellbeing of everyone be best achieved.

Recommendations

In addition to endorsing the strategy and objectives the Board are being asked to take the decision to disband the Members Council from September 2018 as discussed and agreed with the Council in July 2018. Also, to recognise that the current Council members have a wealth of experience and skills and it is hoped that individuals will choose to continue to lend their support and be involved as the engagement strategy is implemented.

Introduction

The purpose of this paper is to set out a strategy for the Trust's approach to community engagement. The Trust is committed to making community engagement a core part of its functions and practice and it has already developed some expertise in this area. The strategy recognises that the Trust can do more and that community engagement is sufficiently important to require a specific strategy that will enable community engagement to become part of the culture and routine quality and performance management of the organisation.

- The proposed approach is the culmination of previous discussions at board, bringing together the work that is on-going within the organisation and a process by which the Trust has been scoping the potential benefits that formal adoption of an engagement strategy might bring. These benefits include:

- ensuring high awareness of the Trust's services and what it is providing to those who use its services and amongst local communities and diverse population groups;

- having a robust and effective approach to community engagement that places service user and community involvement and participation at the heart of quality improvement and service delivery;

- having a diverse workforce that represents the communities served by the Trust with staff members who feel confident and proud about service user and community engagement and involvement;

- being recognised as an organisation that is taking a lead in community engagement and is able to influence other public sector providers, third sector and commissioners so that service users and local communities are at the heart of wider system changes.

The paper sets out the steps that the Trust needs to take to bring the community engagement strategy to life, including specifying the aims and objectives and providing an outline of the required governance alongside next steps for agreement and action. It is the intention that the strategy is developed over time, though the pace of change is to be determined by the Board.

Some of the objectives are cost neutral, for example aligning some of the existing Trust functions within a coherent structure. However, some will require additional investment and commitment such as agreeing a small number of focused priority programmes that can be achieved in the short to medium term. The aims and objectives should also be viewed in light of longer-term ambitions for the strategy and how it can act as a transformational process that embeds engagement across all of the Trust's objectives and practices. The ultimate aim is for engagement to become part of the culture of the Trust so that is widely and comprehensively practised as 'part of the way we do things'.

Background of work to date and the local context

Over the last few months a number of discussions were held with staff members, the Members Council, Board members and system partners about the ways in which the Trust currently manages engagement and the issues and gaps that people perceived to be important. The key issues identified included:

- the need to take a broad approach to what is meant by the term engagement, for example encompassing equality and diversity, having a representative workforce and leveraging the Trust's procurement and contracting for social value;
- the focus on patients/service users should include families and carers;
- recognising the good work on community engagement that already takes place across the Trust and how this can be better supported at senior levels of the organisation;
- recognising that historically the NHS does not have a good reputation for collaboration with local government and other public bodies and that community engagement would support collaboration and enhance the Trust's reputation as a partner agency;
- identifying and building on areas of best practice from across the local public and community and voluntary sectors;
- the need for a clear strategy that is adequately resourced and demonstrates the benefits.

Recent work has sought to consolidate the learning on engagement so far and to put this into a formal proposal for a strategy on engagement that can be taken forward. In addition to various conversations with staff members, the current thinking on community engagement was also discussed with the Members Council and system partners amongst other organisations and groups.

A presentation for the Members Council on current thinking about community engagement was well received, with the 'Council' showing a lot of interest in being involved with the evolving engagement strategy and lending their expertise and experience in helping to make it a success.

The Trust does have some excellent relationships with local community and voluntary sector organisations and already undertakes a range of community engagement activities.

For example, a recent staff survey on the types of engagement activities that people are undertaking shows:

- nearly half of respondents (47%) feel they are making progress in developing engagement activities
- almost a third (32%) are just getting started; and
- 6% reported that they had well established engagement activities.

However, anecdotally, some staff members have reported that although they are undertaking engagement activities they feel uncertain about the degree to which these are supported by the Trust. Staff members have also asked for more guidance on best practice for community engagement.

A survey undertaken in 2017 by Action Hampshire of 478 not-for-profit organisations across the county found that more than half (53%) found communicating with public sector bodies challenging. Many also reported increasing difficulties coping with reduced budgets as a result of austerity cuts in funding, while the numbers of clients presenting with more complex problems are increasing. Also, local community and voluntary sector organisations report having fewer options for signposting clients despite having more referrals from statutory services and less availability of specialist organisations to meet needs. Respondents also expressed fears that mental health problems are threatening to overwhelm many services[1].

National policy context

The origins of community engagement lie within the principles of democratic participation and involvement. Within health and social care it has been variously associated with consultation, the empowerment of disadvantaged people or groups and as a means by which the health needs of particular communities or groups are identified and addressed:

"Community engagement is built on the principles of equality and social justice. It acknowledges that barriers to public health and social care services exist for many people and that those barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities. It further recognises that within some communities there is a lack of awareness about a range of health and social care issues and services."[2]

Whatever the policy framework or origin, there has been a consistent theme to interpretations of community engagement that encompasses empowerment, active citizenship and involvement in decision-making. Over the last two decades there has been greater commitment to the inclusion and involvement of service users and communities in health and social care policy. For example, last year NHS England published guidance on patient and public participation in commissioning health and care, in which it states:

"Effective participation comes from our mindset and culture. It moves beyond process and embraces people, carers and patients in the design, delivery and assessment of care. It should be a natural part of the way we work."[3]

[1] Action Hampshire (2018) Findings from Hampshire's state of the voluntary sector survey. Winchester: Action Hampshire

[2] Winters, M and Patel K (2003) Community Engagement: Report 1 The process. Preston: University of Central Lancashire

[3] NHS England (2017) Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England. London: NHS England

Community engagement has also come to be increasingly recognised as an essential component of ensuring the quality, safety and effectiveness of health services. For example, in speaking about the learning from the events at Mid-Staffordshire Robin Morrison, Chair of Engaging Communities Staffordshire stated:

"In those tough early days of dealing with the aftermath of the Stafford Hospital tragedy, we learned many things; most importantly to give the public a voice on health and social care issues and, of course, to act upon what they told us."[4]

The NHS Five Year Forward View talks about the need for a 'new relationship' with patients, citizens and communities which directly addresses the deficits in historical approaches across the NHS to patient and community engagement:

"…sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and underdeveloped advocacy and action on the broader influencers of health and wellbeing."[5]

In its series on *Ideas that Change Healthcare* the Kings Fund produced a paper on building collaborative partnerships among professionals, patients, carers and communities that recognises how achieving collaboration will require changes in how the NHS works:

"Achieving a more collaborative dynamic will require a change in the way that all of us work. The ability to adapt, communicate and shift between roles will be important for all who seek to establish a new, collaborative relationship that puts safety and quality at the heart of health and care in our communities."[6]

Establishing these new, collaborative relationships requires NHS organisations and their public sector partners to change their culture and practices and to make evident their organisational strategies and commitment to community engagement. The need for this kind of change in community relationships is in evidence from the local context and is increasingly recognised as a priority amongst public sector partners. Within this national and local context the Trust recognises that new ways of thinking and behaving about community engagement are necessary. In particular, health and social care can no longer be something that is 'done to or for' people; it must become something that is done 'with' people.

The purpose of engaging with individuals who use services and the wider communities in which they live is not to determine what is the matter with them, but what matters to them. That is the context within which community engagement needs to be developed and understood.

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[4] Community engagement: a positive power for change. https://www.england.nhs.uk/blog/community-engagement-a-positive-power-for-change/

[5] NHS England (2014) Five Year Forward View. London: NHS England

[6] Seale, Becky (2016) Patients as Partners: Building collaborative relationships among professionals, patients, carers and communities. London: The Kings Fund

Definition of terms and principles

It is clear from the conversations and feedback to date within the Trust that different people do not always understand the term 'community engagement' in the same way. For example, some see it as being about the way that the Trust engages with and involves service users/patients in feedback about their experience and others are more focused on how engagement can help the Trust fulfil its role as a corporate citizen, for example by supporting the development of civil society groups and organisations and being an active partner with other public bodies.

As noted above many people think that it is important to take a broad approach to engagement, but this should not result in engagement being seen as the panacea for all ills or as the ultimate strategy that can somehow subsume all other programmes of work. There is a need for consensus about the terms and principles that the Trust will use to define engagement and importantly, what it can and cannot achieve. For example, as described by the ladder of participation there is a process by which individuals progress from non-participation to active engagement[7].

These terms and principles should form part of a statement of purpose that can be placed at the front of the strategy, rather like a set of principles are sometimes attached to legislation, so that it is clear to anyone interested in the strategy what its primary functions are and the principles on which it is based. The following draft statement of purpose is included as an example of how this might work.

Draft statement of purpose

Solent NHS Trust believes that high quality, safe and effective services are best designed and delivered through engagement with those people and communities who are the intended users and beneficiaries of those services. By communities the Trust means service users/patients, carers, family members, friends and the full diverse range of population groups who live and work in the areas served by the Trust. By engagement the Trust means meaningful involvement and participation in planning and decision-making within a culture and ethos of mutual respect and shared learning. The Trust believes this is essential to its shared vision to provide great care, create a great place to work and deliver great value for money and to the fulfilment of its framework for being an organisation that is well led.

In short the Trust believes that we are greater together and that only by working in partnership and collaboration can the health and wellbeing of everyone be best achieved.

The principles by which the Trust is seeking to develop its strategy for engagement include:

- *actively reaching out to those service users and communities who face the greatest barriers in accessing services so that no one is considered 'hard to reach';*

[7] Sherry R. Arnstein, 'A ladder of citizen participation', Journal of American Planning Association, Vol. 35, No 4, July 1969, pp. 216 - 224.

- *ensuring that the lived experience of those who use services and those who are carers, family members or friends of service users is respected at all times and that people's lived experience forms the basis of service design and delivery;*
- *developing positive and constructive relationships with local community and voluntary sector organisations and groups so that they feel able to work with the Trust as equal partners in promoting health and wellbeing;*
- *making the protection and promotion of civil, legal and human rights and equality part of its everyday practice as an employer and service provider;*
- *being responsive to local emerging community and population needs by having a diverse membership and active volunteer programme that is reflective of the local population and empowers members and volunteers to make an active contribution to strategy and planning processes for the design and delivery of services;*
- *using the resources of the Trust in the best and most appropriate ways to support the development of the social capital of those who use and depend on its services so that they are able to lead healthy lives as active citizens and to participate fully in the life of the local community;*
- *working with other pubic and independent sector providers and commissioners to ensure that service users and communities feel able to participate in planning and decision making for service changes and developments that will affect their health and wellbeing.*

Aims and objectives

The aims of the strategy for engagement are three-fold:

- ***Firstly*** to increase the capacity, understanding and expertise within the Trust on what constitutes best practice for service user and community engagement and how this can be embedded across the Trust as part of routine culture and practice.
- ***Secondly***, to increase capacity for meaningful engagement with local community groups and organisations which play a role in keeping people healthy and supporting wellbeing.
- ***Thirdly***, to develop the Trust's reputation as a system leader for engagement by which it takes a prominent role with other public bodies to promote greater engagement and involvement of service users, staff and local communities in wider system changes and service developments.

These aims are set our below in more detail including specific objectives for each aim.

P6

Aim 1: To improve our internal capacity, understanding and expertise on engagement

This aim seeks to ensure that the Trust gets its own house in order by attending to the capabilities that are needed and providing the right processes, structures and resources for building a solid foundation on which it can develop and rollout the engagement strategy. This is in recognition of the fact that there are variable levels of understanding and experience about engagement across the Trust and that one of the primary functions of the strategy is to ensure that there is a co-ordinated and robust process and structure behind the delivery of the Trust's ambitions for engagement within the overarching context of being an organisation that is well led. The specific objectives include:

- to review and improve the Trust's current systems for mapping and understanding the composition and needs of local communities in particular for those with protected characteristics[8] and how these link with wellbeing, health, socio-economic status and aspirations.

- understanding the range and variety of engagement activities that already take place across the Trust for example, what works and does not work, where gaps exist within specific service lines, what best practice looks like and how this might be better replicated, who the emerging leaders for engagement are within staff teams and how to better support them to be proud of this work;

- increasing the skills and competencies of the workforce on community engagement through development of resources, policy and training, for example toolkits, specific guidance notes for particular groups of service users and/or local communities, briefings on relevant policy and legislation etc. Managers will be supported and trained to promote community engagement within staff teams and for particular service lines as part of routine performance management and supervision.

- supporting service user/ patient groups and carers, family members and friends to contribute their lived experience as actively involved partners in the delivery of care. This will include a priority focus on those service users and patients who are least seldom heard and/or who face particular barriers to accessing services, for example as a result of mobility or communication needs, cultural barriers and increased risk of experiencing stigma and discrimination.

- increasing the diversity and representativeness of the workforce at all levels by actively promoting employment amongst those groups and communities that are least well represented. This will include targeted activities and projects to raise awareness and

[8] Protected characteristics are defined by the Equality Act 2010. They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

understanding about working for the Trust for these communities and population groups.

The Trust will also seek to use the apprenticeship levy to ensure that individuals from these groups and communities are encouraged to come forward and take advantage of the opportunities that apprenticeships can bring.

- developing the skills and competence of Board members and senior management to ensure that the leaders in the Trust understand community engagement and are supported to take active roles in the development of engagement activities with different community groups.

- alignment of internal resources and personnel so that they form part of a coherent structure for delivery of the engagement strategy and related objectives, for example equality and diversity, patient experience and volunteering.

Aim 2: To develop positive and constructive relationships with local community and voluntary sector organisations so that they can become equal partners in service design and delivery.

This aim seeks to ensure that the Trust takes an active role in building the capacity of local community groups and organisations that support people to stay healthy, to recover from illness and to be able to live their lives as full citizens. Through this aim the Trust will demonstrate that it takes its corporate citizenship role seriously. The Trust will use its resources and expertise to support the growth of local community organisations so that these can be used to ensure that the health and wellbeing of local communities can increase in sustainable ways. The specific objectives will include:

- demonstrating the Trust's commitment to engagement by consulting with the community and voluntary sector on the strategy and inviting local organisations and community groups to contribute to the identification and development of specific projects and programmes;

- based on feedback from the consultation, developing a series of targeted community engagement projects that will build positive relationships between the Trust and local community and voluntary sector organisations. This will involve capacity building and support to develop the ability for these organisations to work as equal partners with the Trust in service design and delivery;

- promoting and developing shared care protocols with local community and voluntary organisations whereby they can work effectively alongside Trust services in ensuring that individual service users can benefit from a shared care approach and improvements in care planning and delivery.

- improving the way in which local community and voluntary sector organisations can communicate with the Trust though a series of Executive and Board community forums

whereby local community groups and organisations can meet with individual Executives and Board members on a regular basis.

These forums will be targeted to particular groups and communities to ensure that their specific needs and issues can be discussed in sufficient depth. The forums will take place on a rolling basis so that over time increasing numbers of local community groups and organisations can participate;

Aim 3: To develop the Trust's reputation as a system leader for engagement

This aim seeks to ensure that the Trust's community engagement strategy has wider impacts in terms of local area system changes and in particular the drive towards integrated care systems. Increasing appreciation and understanding about the central importance of the social determinants of health means working in partnership with local communities. In particular, this aim will ensure that the Trust is recognised as a leader in community engagement and that it can share and use its evolving knowledge and expertise to influence other public and independent bodies that are responsible for the health and wellbeing of the local population. The specific objectives will include:

- the establishment of a specific marketing strategy for engagement that captures the developing experiences of the Trust and promotes learning from the strategy. There will be various communication strands to this including regular staff communications, use of social media networks that reach particular communities and briefings and reports for public sector partners, commissioners and regulators;
- working with local Higher Education Institutes to develop research on engagement that can contribute to the body of best practice knowledge and the evidence base for the impact of engagement programmes on health outcomes;
- supporting the development of place based approaches to health and wellbeing that puts the social determinants of health at the forefront through the active engagement of local communities in enhancing their capacity and ability to take an active role in health promotion and prevention.

Governance

In order for the community engagement strategy to have maximum impact and be as effective as possible it needs to have the right governance structure. This should be viewed as a process by which initially the Trust is able to ensure the strategy is effectively implemented through the right leadership and internal structures. But the ultimate aim should be for community engagement to become fully embedded across the Trust's corporate governance and performance management systems.

In the first instance and for a limited time period, for example no more than 12 months, a new NED led committee should be formed that reports directly to the Board. Membership

of the committee should be small enough to ensure there is a focused agenda with sufficient seniority of members to ensure that there is effective decision making. The membership should be considered across service lines and be fully specified within the Terms of Reference. The Committee should meet monthly and receive reporting lines for each of the strategy's objectives and programmes.

The full Board should receive a bi-monthly update on progress in the first instance. As the aim is for community engagement to be embedded across routine Trust governance and performance systems this should be part of the explicit aims and objective for the Terms of Reference of the committee and progress towards this goal included as part of its regular Board reports.

Once the committee feels confident it will be possible to open up the membership to other relevant stakeholders including service users, carers and local community and voluntary sector partners. At this stage the committee may transform into an alternative governance structure, for example a forum or network meeting that meets less frequently and does not need to report directly to the Trust Board. Rather, the new entity will be a body that receives reports from the Board on key issues and developments that have arisen from the Trust's community engagement strategy. Reaching this level of maturity will depend on the degree to which the Trust has mainstreamed its community engagement strategy so that is truly part of its routine quality and performance governance and management systems.

Board Recommendations

The Board are asked to endorse this strategy and to:

- Agree the statement of purpose and underlying principles for the strategy.
- Endorse the aims and objectives including the commitment to aligning key functions and resources within the Trust.
- Agree to consult on the strategy and its aims and objectives culminating with a formal launch later in the year. This will ensure greater ownership and buy-in amongst staff, service users/patients, carers, family members and friends and also with local community and voluntary sector organisations and associated public service partners.
- Based on feedback from the consultation to identify specific priority programmes that can be implemented in the short to medium term.
- To establish a new committee that reports directly to Board on the strategy including the development of Terms of Reference and nominating a Non-executive lead for the strategy who will also act as the Chairperson for the newly formed community engagement committee.
- To consider the pace of change that Board members think is appropriate and the resources that will be needed to support this. Board members have already expressed their commitment to getting this right and while the strategy is designed to be

implemented over the short to longer term, sufficient resources and appropriate senior management and leadership will be required to ensure the strategy is implemented successfully.

REPORT

Item 13

NHS Solent NHS Trust

Presentation to	**Public Board**							
Title of Paper	**Members Council Meeting**							
Author(s)	Jayne Jenney		**Executive Sponsor**		Mick Tutt, Non-Executive Director and Deputy Chair			
Date of Paper	30th July 2018		**Committees presented**					
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	
	W5 Risks and Performance		**W6** Information		**W7** Engagement	X	**W8** Learning, Improvt & innovation	

Executive Summary

- The Members Council met on 6th July 2018.
- Sharon Collins (SC) briefed the Council on historical and current issues associated with the Wheelchair Service and provided and update on the status in finding a resolution going forward. SC also highlighted the quality of collaboration between Solent and other providers during the process to date. Mick Tutt (MT) thanked SC for her continued contribution and assistance with the matter.
- Andrea Hewitt, Head of Communications provided assurance that Solent membership was General Data Protection Regulation (GDPR) compliant.
- Sue Harriman (SH) provided a CEO update including 70th Birthday celebration activities and expectations for the return of the CQC for a further well led inspection. The Council were also briefed on the Trust's activity and financial performance.
- SH shared the Hampshire and Isle of Wight STP system reform work in progress.
- Jon Bashford was in attendance and explained the next steps planned to develop the Community Engagement strategy. The Council discussed the framework and the implications to governors. It was noted that current governors were to be stood down, should the Board agree this at the July 2018 meeting. However individual members would be given the opportunity to be involved in future engagement work. MT stressed his and the Board's appreciation for their contribution over the years. It was agreed that a message would be sent to those who were not in attendance at the meeting regarding the agreed direction of engagement to promote the new model and encourage continued participation.
- It was agreed that current Council members meet with the Trust Board, for a last time, at the beginning of October; as a celebration and a look forward to new working relationships.

Risks identified in relation to this report (and include date of when included on the Risk Register)

Key Decisions/ Action(s) requested

The Board are asked to note the Members Council Report.

REPORT

Item 14

Presentation to	**Public Board**							
Title of Paper	**Emergency Planning, Resilience and Response**							
Author(s)	Elaine Peachey		**Executive Sponsor**		David Noyes			
Date of Paper	30th July 2018		**Committees presented**					
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	
	W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	

Executive Summary

The NHS England Core Standards for EPRR are the standards which must be met to provide assurance that all NHS organisations are prepared and able to respond and recover from incidents. The aims are clearly set out in the standards expected for each NHS organisation and provider of NHS funded care.

A formal review and assessment of Solent Trust was undertaken by the commissioning Emergency Planning Leads, who supported the assessment of evidence provided to NHS England. Formal feedback from NHS England in 2017-18 stated that Solent NHS Trust was one of the two trusts in Hampshire and the IOW to achieve 'full compliance'.

The EPRR review process commences again in July 2018 with submission of all evidence by October 2018 when a further assessment will be led by NHS England although NHS England will this year work in partnership with NHS Improvement looking at EPRR. This joint working may result in a number of changes in the assessment process.

Over the last few months NHS England Wessex (HIOW and NHS England Thames Valley (TV) have merged to become NHS England HIOW and TV which has included a change in the EPRR management structure. The likelihood is that assessment this year will change not only the key subjects but also the level of evidence required to provide assurance.

The key areas of change and focus are likely to be:

Focus area	**Current actions**
Mass casualty response	Solent NHS Trust are already working alongside NHS England to update local response plans to a mass casualty event.
Cyber attacks	Assurance will be required to show organisational responsiveness to a future attack
HCID (high consequence infectious diseases)	New standards are being issued this year and will need to be incorporated in our infectious disease planning. The EPRR Lead and the Infection Prevention Lead are working together on this.
Pandemic flu planning	The EPRR Lead and the Infection Prevention Lead are working together on this.
Development of standards for evacuation of hospitals due to be	This has not yet been published

published in 2018	
There will be more requirements for engaging EPRR lead in reconfiguration, service redesign and transformation plans to ensure ability to maintain capacity and capability when responding to major incidents	The EPRR lead is working with key services such as contracts, estates and clinical services to improve engagement

Risks identified in relation to this report (and include date of when included on the Risk Register)

Over the last year there have been a number of changes to the NHS England structure and a number of key changes in the way in which assurance for the core standards is both evidenced and assessed. It is still unclear how many changes there will be in the this year's 31 core standards however we have been advised to continue with last year's template for evidence submission. We are however aware that this year there will be a deep dive into 'Command and Control' during an incident particularly the use and management of the incident co-ordination centre (ICC). Therefore the testing and validation of the ICC plans will be evidenced through all exercises and incidents by ensuring that lessons identified in the ICC environment are clearly highlighted and actions completed.

It has also been made apparent that the previous process for assessment is going to become much more rigorous this year which may result in all trusts achieving a less favourable outcome. The EPRR lead will however continue to work closely with services, staff and the CCG to provide the necessary evidence in an effort to retain the 'full compliance' result.

Key Decisions/ Action(s) requested

To note that we are aiming to achieve full compliance again 2018-19 year even though there are many changes in the assessment process.

The self -assessment results in September will form part of the full report present to board for sign off in September 2018.

REPORT

Item 15.1

Presentation to	Solent Trust Board							
Title of Paper	Annual Health & Safety Report							
Author(s)	Dave Keates		**Executive Sponsor**		Andrew Strevens			
Date of Paper	16 July 2018		**Committees presented**		Health & Safety Sub-Committee			
Well Led KLoEs	**W1** Leadership Capacity & Capability	✓	**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	✓
	W5 Risks and Performance		**W6** Information	✓	**W7** Engagement		**W8** Learning, Improvt & innovation	✓

Executive Summary

The purpose of this report is to provide evidence that arrangements are in place for Health and Safety management and sets out some objectives for 2018/2019. The report will provide assurance that there are robust policies, systems and procedures in place for the identification and management of health, safety, welfare and environmental issues across the organisation.

This report also summarises key areas associated with successful health, safety and security management and provides assurance that we are meeting our statutory requirements for Health, Safety and Security. This report covers staff, patients, visitors and contractors for the period from 1 April 2017 to 31 March 2018.

Risks identified in relation to this report (and include date of when included on the Risk Register)

The spike in security incidents from October 2017 is now subject to an incident review led by the Chief Nurse and Chief Medical Officer.

Key Decisions/ Action(s) requested

For the Trust Board to receive and note the contents of the annual report and to formally agree the Health and Safety Policy Statement of Intent

Item 15.2

Solent NHS Trust

Annual Report for Health & Safety
For the year 1 April 2017 to 31 March 2018
Board Version

Section 1: Executive Summary

The purpose of this report is to provide evidence that arrangements are in place for Health and Safety management and sets out some objectives for 2018/2019. The report will provide assurance that there are robust policies, systems and procedures in place for the identification and management of health, safety, welfare and environmental issues across the organisation.

This report also summarises key areas associated with successful health, safety and security management and provides assurance that we are meeting our statutory requirements for Health, Safety and Security. This report covers staff, patients, visitors and contractors for the period from 1 April 2017 to 31 March 2018.

Section 2: Governance and management arrangements

The ultimate responsibility for Health and Safety management throughout Solent NHS Trust is vested in the Board and Chief Executive Officer (CEO) who, on an annual basis, review endorsing Solent's commitment to health and safety with the signing of the health and safety policy statement of intent as compliant with the Health and Safety at Work Act (section 2 (3) ("HSAWA").

A copy of the Health and Safety Statement of Intent can be found in Appendix A.

The CEO had delegated lead responsibility of Health and Safety to the Chair of the Trust Health and Safety Group who has the authority in accordance with the requirements of section 2 (7) of the HSAWA to act upon the decisions reached by the Group. For the year 1 April 2017 to 31 March 2018 the Chair changed from the Associate Director for Quality and Safety to the Associate Director of Estates & Facilities.

The Terms of Reference were changed during 2017/2018 and membership has evolved.

The Health and Safety Group met quarterly on 25 April 2017, 25 July 2017, 24 October 2017 and 23 January 2018 and were quorate at all meetings.

The following are some examples of notable areas of work which have been led by the Health & Safety Group over the last year:

- Review of the Health and Safety Group Terms of Reference
- Changes in Health and Safety legislation as a standing agenda item. Any impacts are reflected within organisational policies and/ or Standard Operating Procedures
- Occupational health control audits of Stress Management, sharps incidents and musculoskeletal disorders
- Support in working with display screen equipment and mapping of incidents related to mobile working (hot desking etc.) and the use of lap tops

- Lone working devices usage, lone working risk assessments and lock down procedures
- Estates compliance report, compliance logs introduced for Trust retained sites
- Conflict resolution or breakaway training

In addition there was a series of specialist subject matter reports presented, these included reports from the Emergency Planning & Resilience lead, Resuscitation Officer, and Tympanic Falls lead.

The Associate Director of Estates & Facilities (Chair) confirmed that any outstanding action's recorded on the action tracker from this year's Health and Group programme will be carried forward to next year.

It is the view of the Health and Safety Manager and the Associate Director of Estates & Facilities that the Health and Safety Group is fulfilling its statutory requirements with the representation of both elected unionised and non-unionised representatives of employees in accordance with the Safety Representatives and Safety Group Regulations, and the Health and Safety (Consultation with Employees). The Group is working effectively with an open culture where attendees are playing an active role in talking through decisions about health and safety to identify joint solutions to issues being raised and we are reasonably assured that the Trust has adequate policies, systems and procedures in place for the identification and management of health and safety issues across the organisation

Solent NHS Trust as an employer is required to appoint one or more competent persons with the necessary skills, knowledge, and experience to assist in helping them to meet their legal duties. Solent NHS Trust meets this obligation: the Trust has a full time Health and Safety Manager; other competent persons are in place in regards to Estates Management, with specialist advisors for fire safety, local security management, and environmental management. The Trust has also nominated a Non-Executive Director to take an overview responsibility for Health & Safety and attends the quarterly meetings. This appointment has been a positive step in raising the importance of Health & Safety.

Section 3: Compliance & Assurance

External Agencies and Reporting of incidents

The Health and Safety Executive (HSE) is the national independent watchdog for work-related health, safety and illness. They are an independent regulator and act in the public interest to reduce work-related death and serious injury across Great Britain's workplaces. HSE will investigate and where appropriate, prosecute breaches of Health and Safety law.

There were no investigative proceedings being undertaken in regards to breaches of health and safety legislative requirements or the Environmental Protection Act by either the HSE or the Environmental Protection Agency.

Solent NHS Trust has not received a visit from any external regulatory agency, either pre-planned or as a result of a specific incident or complaint during the period 1 April 2017 to 31 March 2018

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR regulations are made under the Health and Safety at Work Act 1974; they apply to a set of reporting requirements for work activities in Great Britain. The main purpose is to

provide reports, where appropriate, to the Health and Safety Executive and to Local Authorities; the report alerts enforcing authorities to individual incidents.

There has been a significant reduction of reportable RIDDOR incidents from 13 in the previous year to 4 incidents reported during the period 1 April 2017 to 31 March 2018; all were reported using the online reporting system used by the Health and Safety Executive. The incidents reported were reportable under schedule one and all reported within the stipulated time frame.

Staff or member of Public	Location	Injuries	Incidents
Staff	Solent Property	Bone fracture	2
Staff	Community	Injury preventing the injured person from working for more than 7 days	2

Department of Health Central Alert System (CAS)

Solent NHS Trust receives safety notices and alerts from a number of agencies that require consideration and in many cases action by managers and employees. Methods of receiving alerts and notices is through the Central Alert System (CAS) which is an electronic system developed by the Department of Health to distribute patient safety alerts and other safety critical guidance to the NHS and other health and social care providers.

The table below shows the breakdown of the type of alerts received via the Department of Health through the Central Alerting System (CAS):

Total number of CAS alerts per category for 2017/2018

Year	Medical Devices Alerts	Estates Facilities Notices High Voltage	Estates Facilities Notices Low Voltage	Civil Emergency Messages	Patient Safety Alerts	Drug Alerts	Other
2017/ 2018	45	39	7	5	6	16	8

All 126 alerts received within 2017/2018 above were acknowledged within the stipulated timescales to the Department of Health and all alerts have been disseminated to the appropriate groups, replies received / tracked and all alerts are compliant having been closed off within each alert to the Department of Health.

To ensure accuracy the CAS Alert contact list is circulated each month (started March 2018) to those on the list plus members of the Health & Safety Group requesting any names to be added or removed from the list, this process will continue. During 2017/2018 the CAS website moved to www.cas.mhra.gov.uk. This change has not affected the alerts received.

Section 4: Annual Security Management Report 01 April 2017 – 31 March 2018

The Accredited Local Security Management Specialist ("LSMS") left the Trust in February 2018; as part of the business continuity plan for the compliance team there was another Accredited

LSMS who in the interim has been able to continue to support the security management. Recruitment is currently being undertaken for a full time Accredited LSMS.

The NHS Counter Fraud Authority ("NHSCFA") was set up on the 1 November 2017 to replace NHS Protect; NHSCFA charged with identifying, investigating and preventing fraud within the NHS and the wider health group. NHSCFA standards follow the same principles as the previous NHS Protect which are Inform and Involve, Prevent and Deter and Hold to Account. By adopting these principles through our LSMS role this ensures we put the security of our staff at the forefront of our commitment to maintaining a safe environment.

Below is a summary of the work streams under taken by the LSMS

Inform and involve

The following specific security and the management of violence and aggression related policies were reviewed and agreed at the Policy Steering group during 1st April 2017 to 31st March 2018.

- Policy for Surveillance Camera System
- Physical Security Management Policy

Information and intelligence has taken place with meetings, and close working relationships with local Head of Counter Fraud and Security Management Hampshire and Isle of Wight Fraud and Security Management Service, Police, Safer Neighbourhood and Specialist MH Teams

LSMS has established contacts with LSMS's in the South East and Wessex (this is due to the geographical location of Solent overlapping with both areas).

As part of the organisations property rationalisation programme a number of premises and properties are being refurbished and re-developed. The LSMS has been working with the design and service teams to ensure that appropriate security measures are included at the design stage to avoid the additional and more expensive retrofit option.

The LSMS examines every incident reported through Ulysses to establish reported cases of crime and acts of violence, whether they are physical or non-physical, against the Trust and its staff.

The LSMS supports staff members who have been subjected to assaults, regardless of the cause and has issued warning letters to individuals who, during appointments, home visits or by telephone have threatened or verbally abused Solent NHS Trust staff members.

Prevent and Deter

LSMS in liaison with Solent's Emergency Planning and Business Continuity Lead have created Lockdown procedures and have supported services in completing lockdown assessments and liaised with external landlords ensuring site wide lockdown procedures are appropriate. These were tested successfully at St Mary's Community Hospital and Royal South Hants Hospital.

LSMS created a generic lone working risk assessment form and worked with services to complete the assessment.

Lone workers require additional security measures to ensure their safety and wellbeing. LSMS has, with the support of the compliance administrator; undertaken training of Solent individuals in the use of the Trust approved Lone Working Devices (LWDs) and has provided reports on usage through the Health and Safety Group.

Using information supplied by departments via risk assessments undertaken in their areas of operation and working with the Trust Prevention Management Violence and Aggression ("PMVA") trainer the training needs analysis for Conflict Resolution and Physical Intervention has been updated.

Hold to account

Where appropriate the (LSMS) has supported staff members who have been subjected to assaults or verbally abused and has consulted with staff members prior to any sanctions / letter being sent out to individuals. Guidance on what level of support can be provided is being produced for publication following a recent lessons learnt from a specific incident within Portsmouth.

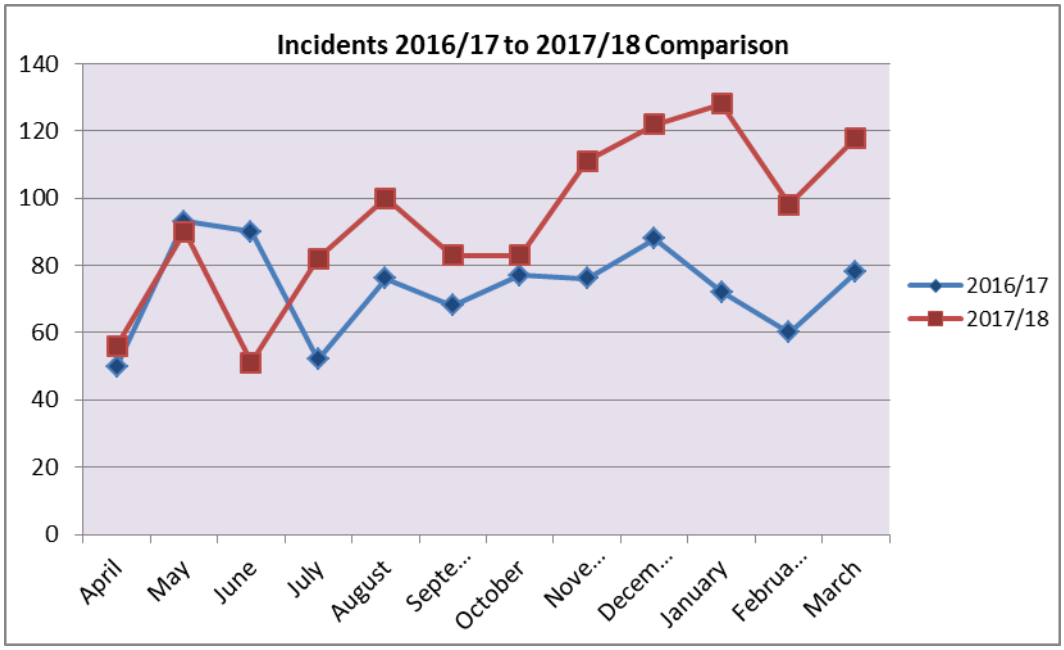
Conclusion

In summary the Trust has over the last year, demonstrated that it has the ability to respond reactively to a security incident and if an event should occur the incident will be formally reviewed to identify lessons learnt and will proactively support designing buildings and creating processes/procedures to reduce security incidents occurring.

The LSMS will work to develop closer working relationships and involvement with Hampshire Police to ensure that where criminal activity takes place, including violence and aggression directed at our staff, that every action is taken to ensure the perpetrator is identified and action taken.

The new appointed full time LSMS will, working in collaboration with our Counter Fraud colleagues, review the self-assessment tool to formulate a work plan to demonstrate continued compliance

Below is a statistical overview of all security incidents reported by members of Solent NHS Trust, it covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons for the periods 2016/2017 to 2017/2018.



Month	2016/17	2017/18
April	**50**	**56**
May	**93**	**90**
June	**90**	**51**
July	**52**	**82**
August	**76**	**100**
September	**68**	**83**
October	**77**	**83**
November	**76**	**111**
December	**88**	**122**
January	**72**	**128**
February	**60**	**98**
March	**78**	**118**
Totals	**880**	**1122**

The chart and table indicates reporting rates across the last two years. This shows an upturn of the total number of incidents reported of 242 (circa 27%). The increase of incidents are largely attributed to a smoking ban being applied across Solent NHS properties impacting on some individuals within AMH resulting in behavioural challenges to that staff and patient group.

Top cause of incidents

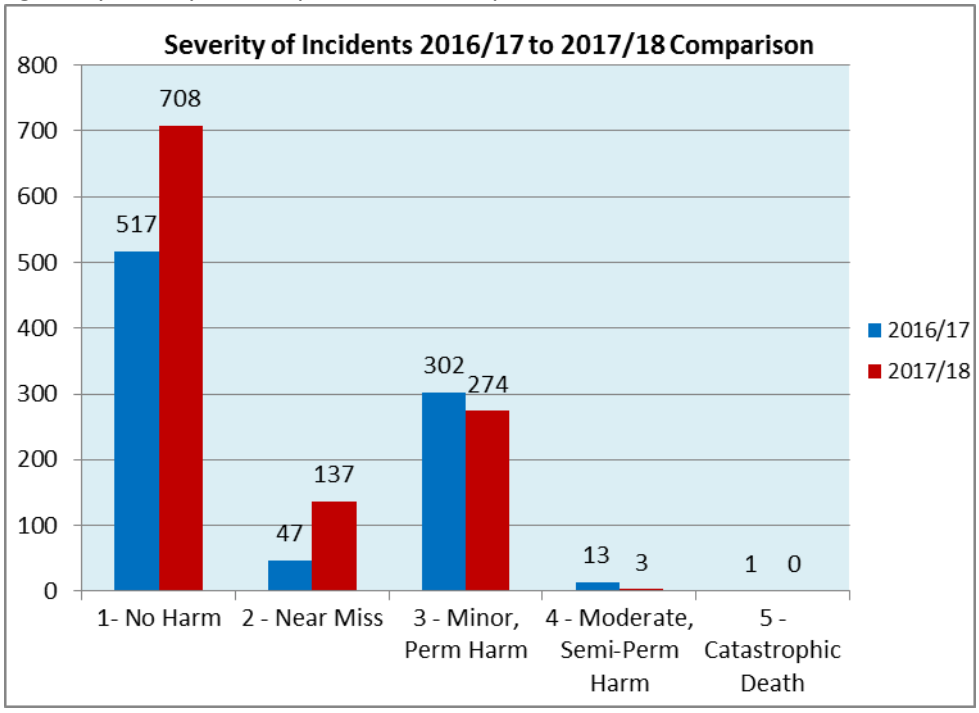
Violence and Aggression "Patient to Staff" remains the highest reported category accounting for some 34% of the total number of incidents reported

Violence and Aggression "Patient to Staff" prevention work undertaken includes:

- Solent's current support is via Solent NHS Trust lead PMVA trainer
- Inpatients, patient to staff incidents reviewed where staff have been assaulted and/or restraining techniques are used
- Variety of collaborative works taking place between the Local Security Management Specialist, PMVA lead and Services

Security Incidents by Actual Impact

Below are the risk ratings of all security incidents reported by members of Solent NHS Trust. It covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons for the periods 2016/2017 to 2017/2018



The table above indicates reporting rates across the last two years. The trends show a decrease in the number of Moderate Semi Permanent Harm reported incidents significantly reduced from the previous year of 13 down to 1 and a decrease in reported Minor Non perm-harm

incidents. There is a significant increase (circa 50%) in Near Miss reported incidents and a reduction of No harm incidents.

The increase in near miss reporting reflects the Trust encouraging staff to report incidents particularly near miss/No Harm and the staff commitment to report providing the Trust with more source data to enable a better understanding of the issues to be established.

Section 5: Annual Fire Management Report 01 April 2017 – 31 March 2018

The past year has seen major events in regards to fire which has had an impact on to the NHS estate. The Grenfell tower block fire led to emergency inspections of healthcare buildings and a report for NHSI. This report identified some areas to be considered but the fire advisor indicated that Solent NHS Trust properties did not fall within the criteria identified. Inspections were also undertaken by the local Fire Service of cladding materials and fire risk assessments (FRA) were received. The Fire Service certified Solent's properties as compliant.

There has been a marked increase in false alarm activations within our secure mental health unit, which gave a number of unwanted and unnecessary calls to the Fire Service; to date the Fire Service has been understanding of the situation, but they do have a mandate to control unwanted calls giving the possibility of them taking action against the Trust. After recommendation it has been agreed to control the situation by fitting staff key operated fire call points in the ward areas.

Throughout the year, the ability to achieve rectification of identified fire risks within buildings owned or controlled by third party landlords has been difficult. A number of mitigation controls are in place, which have been formally identified within Solent's fire risk assessments (site wide mobile radios, emergency lift training etc.). Additional work is required to ensure that procedures and mitigations are centrally recorded (as well as kept on site) and that relevant staff are aware of the procedures; this is a priority for 2018/19.

To satisfy compliance with The Regulatory Reform (Fire Safety) Order 2005 and the Fire Safety (Employees Capabilities) Regulations 2010, all Fire Risk Assessments (FRA) are subject to an FRA review on a periodic basis. Below are the recommended time periods between reviews as per Trust Fire Safety Policy:

- High risk premises, (e.g. inpatient sleeping risks) within each calendar year period a fire risk assessment
- Medium risk, (e.g. client areas, health centres) annual FRA review form, with a full FRA document every 3 years
- Low risk (e.g. non-client area, offices, low risk stores) periodic FRA review form, with a full fire risk assessment document produced at least every 5 years

Further operational checks are carried out inclusive of but not limited to weekly fire alarm testing, monthly emergency light testing, annual portable fire equipment checks and annual fire evacuation drills. Evidence of these checks is held at each site and is being updated onto the MICAD system. Risk ratings have been allocated against each site and Quarterly assurance reports are generated and sent to the Health and Safety Group who oversee specific issues and actions.

The FRA's provides Estates with monitoring and feedback for remediation and assurance. Evidence of these assessments is held on the Trust MICAD system. Quarterly assurance reports are generated and sent to the Trust Health and Safety Sub-committee who oversee specific issues and actions.

Section 6: Annual Estates Management Report 01 April 2017 – 31 March 2018

Background Since October 2014 Estates Services have been provided by Kier Workplace Services. Their principal responsibility is to provide Mechanical, Electrical and Fabric, Reactive and Planned Preventative Maintenance to relevant Mandatory and Statutory requirements. They also provide a useful labour source for our Minor Works procedure with pre-determine hourly rates.

Kier Workplace Services are monitored through Key Performance Indicators, (KPI's) and stringent Service Level Agreements ("SLAs") with monthly reporting. After some initial issues Kier has consistently achieved the expected standards and targets set out under their contract terms. Site visits are undertaken with departmental and/ or building managers to assess building condition, identify any apparent shortfall and praise good works/practice. At these visits the Building Manager or departmental lead completes a "customer satisfaction survey" which is scored and discussed at the monthly contract review meeting.

Statutory and mandatory maintenance is carried out to comply with Good Industry Practice and NHS Requirements and guidelines.

The Solent Estates Team, have the responsibility for maintenance of all compliance documentation. To ensure these records are kept up to date and are accurately stored, they are held on a property database software system, MICAD.

In addition to the Trusts Freehold Properties, Solent occupies a number of premises as Leasehold or Licenced Tenants. Work is underway as a continuing exercise to contact landlords to ensure they are adequately meeting their obligations in accommodating Trust staff.

Current

Work is on-going to ensure that information regarding compliance evidence from all parties is uploaded onto the MICAD system. This will highlight any omissions and areas where action may be required.

Estates Backlog Maintenance and Strategy

The Trust has identified, in collaboration with its maintenance service provider, a robust backlog programme and is now working to enhance the current 5 year plan to establishment a strategy for the next 15 years. The Trust Board has adopted the current programme and is supporting the programme through financial investment.

The backlog programme is risk assessed using the 5x5 risk matrix and in consultation with Trust key-stakeholders in order to prioritise works to be authorised.

The backlog programme of works forms part of a larger programme of works, including client minor works request and reactive work repairs that are regularly reviewed, monitored and reported on.

Legionella management and risk assessments

To comply with our legal duties, employers and those with responsibilities for the control of premises should identify and assess sources of risk, this includes checking whether conditions are present which encourage bacteria growth e.g. adverse water temperatures outside recommended standards and infrequently used outlets.

Legionella control and measures are being carried out at grass root level with on-going performance monitoring as part of the Water Assurance Management. Over the last year full Legionella Risk Assessments for properties have been undertaken by the Trust appointed FM Provider, and specifically TWC Services Ltd as their named subcontractor. Response processes, action plans and remedial works have been implemented in accordance with TWC Services Ltd recommendations. Evidence of these assessments is held on the MICAD system.

A number of more frequent tests are carried out to ensure that premises are being maintained to reduce the risk from either contaminated water or water temperature. These testing regimes are required to be carried out monthly and form part of the Planned Preventative Maintenance (PPM) schedules as compliant with the due diligence testing as recommended by HTM 04-01 part B and H&S Doc L8. Microbiological testing is on-going at identified outlets and has indicated an overall reduction in the number of recorded positive outcomes from the previous review period.

Part of the Water Management System written within the newly implemented 'Control of Legionella Bacteria in Water Systems and Pseudomonas Aeruginosa Assurance Policy' includes a defined process of immediate notification, action and supervision by selected Trust Personnel in the event of a suspected 'high count' or confirmed case of Legionella or similar. Those personnel will be informed to ensure a suitably weighted and proportionate response include the Head of Infection Prevention and Control, the Trust Health & Safety Manager, Compliance Officer, Responsible Person(s) Legionella, Head of Estates and Director of Estates & Facilities. The remodelling of the HTM 04-01 during 2016 placed a greater emphasis on the efficacy of the Water Safety Group and the requirement for members to be kept informed and collaborate to achieve identified responses to any high count or outbreak.

Quarterly update meetings are also held with Infection Control representatives. A potential weakness that has been identified is the flushing of low use outlets. Flushing of low use outlets is our primary and most effective water management control measure used in our Legionella strategy. The flushing is currently being carried out by several different Facilities organisations; i.e. Interserve, Southern Health and our own Domestics with no central reporting database and no central management. The team are currently preparing a costed, managed process and strategy to facilitate this process. A greater level of awareness around the importance of flushing is being provided by the Estate Maintenance Department utilising the opportunity to educate IPT Link Advisors and service users alike with a series of presentations.

Asbestos Management
The control of asbestos is covered under a number of items of legislation; every non domestic building is required to have an asbestos register, containing an asbestos risk assessment. The Property Team have asbestos registers for those buildings transferred to Trust ownership. As part of the Trusts on-going Backlog Maintenance Programme, the Estates Team are committed to undertake a full Management re-inspection of known asbestos locations and provide status reports on the presence and condition of any asbestos and any actions required to reduce the risk of contamination. Any Capital Works are subject to a full Refurbishment and Demolition Survey, and Contractors are directed to the asbestos registers and surveys before carrying out any works.

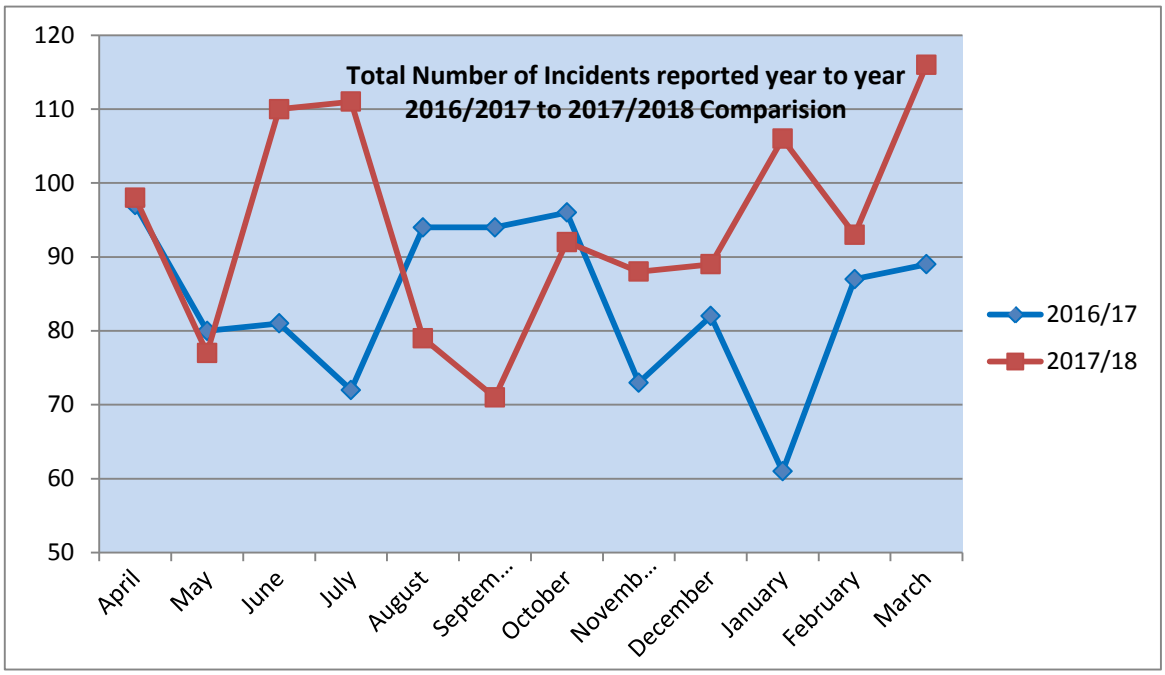
Other associated Estates H&S Issues
In addition to the work programmes for fire, water and asbestos management noted above, a full programme of other compliance procedures is also undertaken. This includes, but is not limited to gas, electrical installations, lifts and display energy certificates, details of which are held on the MICAD system.

An external assessment of our property portfolio using the NHS Premise Assurance Model (PAM) is being scheduled for September.

Section 7 Health and Safety Risks & Issues

Below is a statistical health and safety overview of all health and safety incidents reported by members of Solent NHS Trust. This comparison covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons. This also sets out the current position in relation to an overview of reported incidents during 2017-2018, inclusive of the most reported cause one incidents.

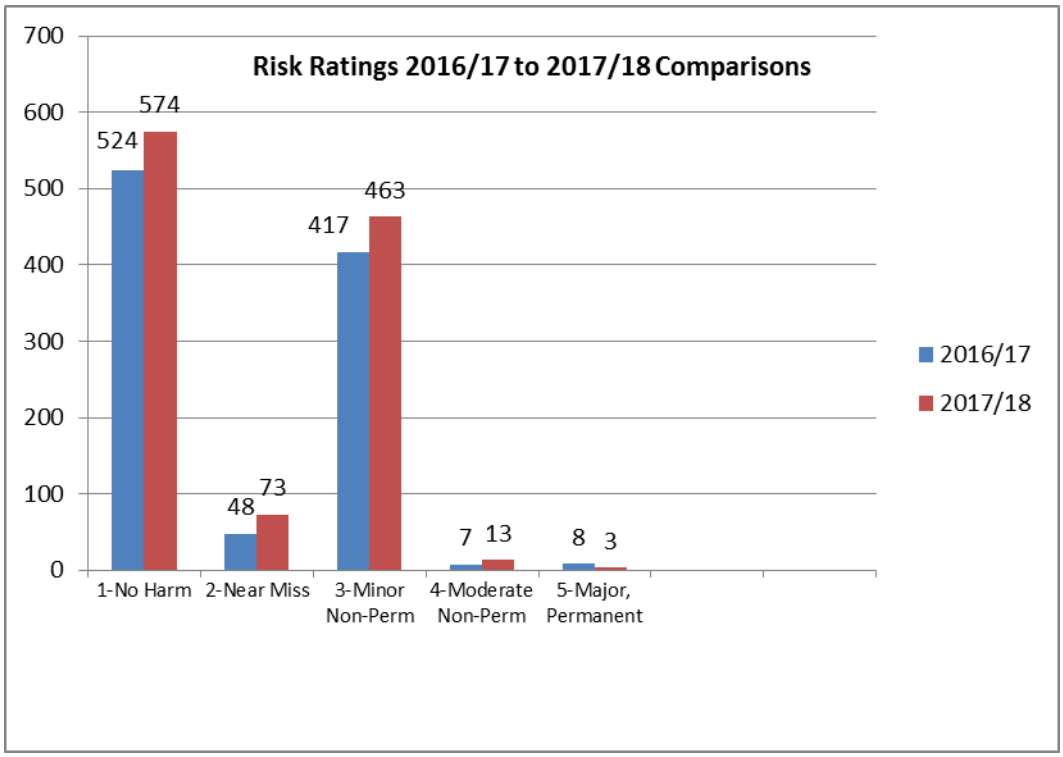
Year to Year comparisons Total Health and Safety incidents for 2016 to 2018



Risk Ratings

Below are the risk ratings of all health and safety incidents reported by members of Solent NHS Trust.

It covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons 2016/2017 to 2017/2018.



The chart and table above indicates reporting rates across the last two years. This shows an upturn of the total number of incidents reported of 122 (circa 11%) this trend of % increase of reported incidents has remained consistent over the last three years; greater reporting of incidents is encouraged.

A breakdown of the major causes of health and safety incidents is shown below:

Top 8 Cause One Health and Safety Incident Groups

The table below shows year to year comparisons for the Top 8 Health and Safety Reportable Cause Group One Categories ONLY

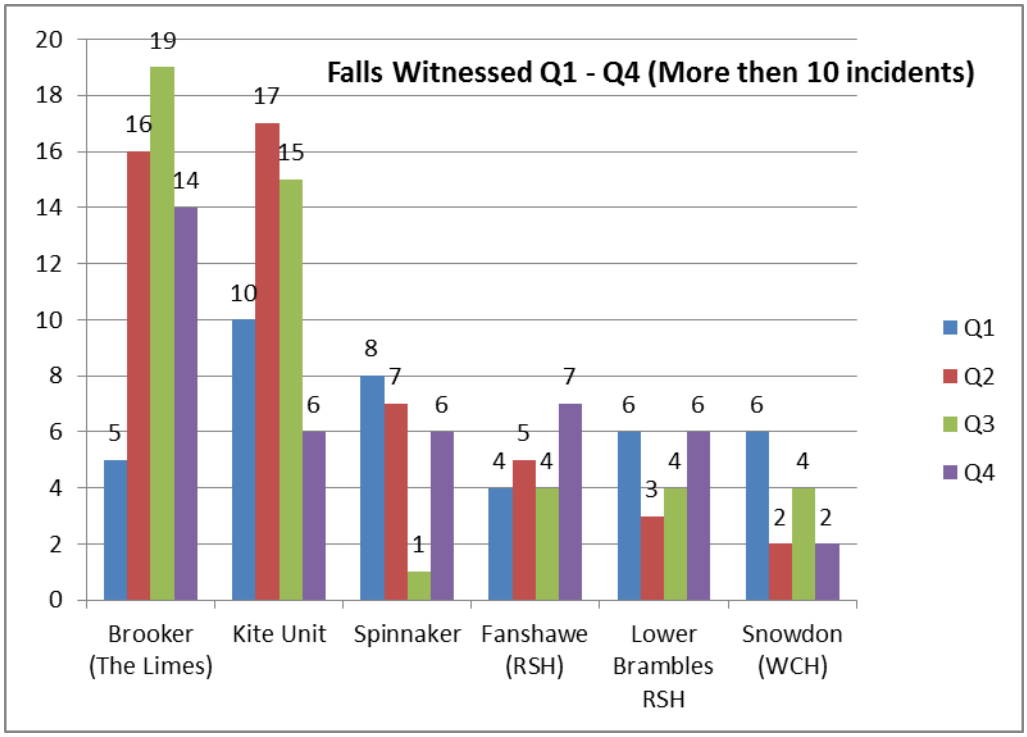
2016/2017 Top 8 Health and Safety Reportable Cause Group One Categories	Total	2017/2018 Top 8 Health and Safety Reportable Cause Group One Categories	Total
Fall Not Witnessed/ Falls Witnessed	**536**	Fall Not Witnessed/ Falls Witnessed	**614**
Maintenance of Property	**45**	Injury Sustained During Procedure	**46**
Manual Handling Patient	**43**	Manual Handling Patient	**46**
Injury Sustained During Procedure	**34**	Walking/Running Sustained Injury	**45**
Slip/Trip/Fall Staff	**31**	Collision / Contact With Stationary Object	**34**
Collision / Contact With Stationary Object	**28**	Service Failure (Utilities)	**32**
Equipment/ Device Service Delay	**17**	Slip/Trip/Fall Staff	**29**

Further analysis of falls witnessed and not witnessed is provided below.

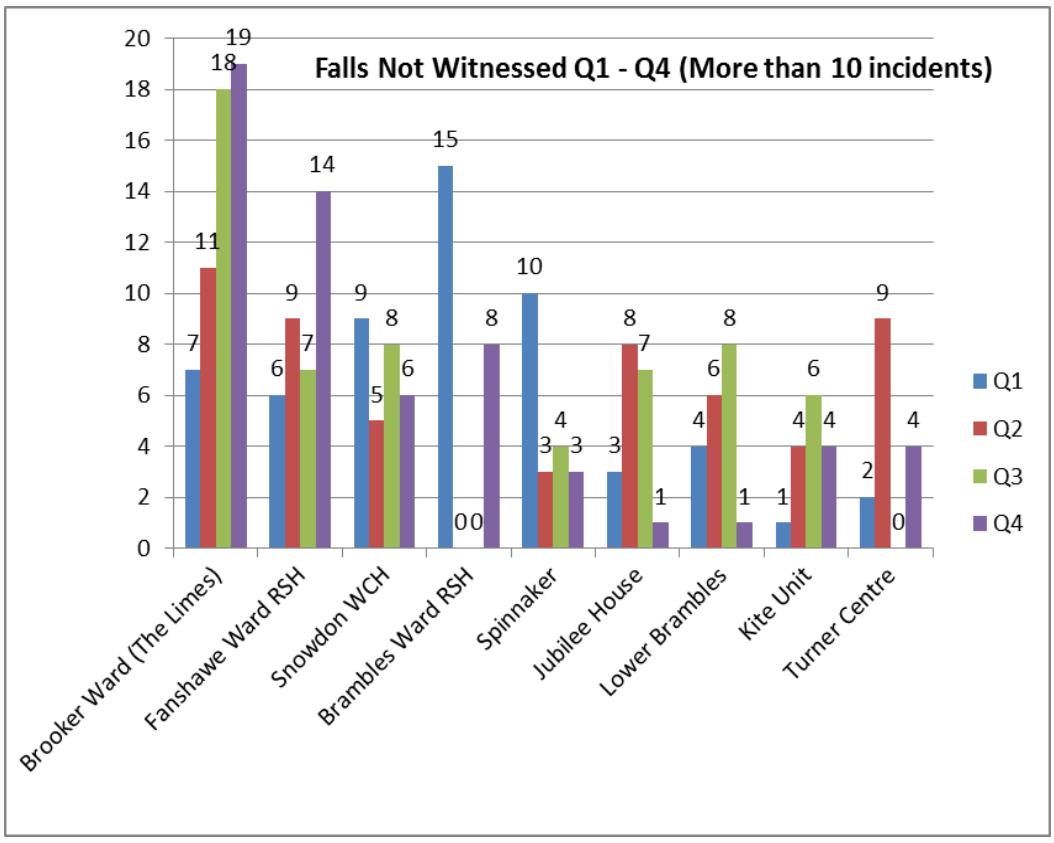
Top Cause One incident

As with the previous year's falls not witnessed and fall witnessed again is the highest reported cause one incident, circa 49% of the total number of reported incidents

Falls Witnessed Quarter 1/Quarter 4 2017/2018 Comparison



Falls Not Witnessed Quarter 1/Quarter 4 More than 10 Incidents



Falls Prevention Work undertaken includes:

- The Policy for the Prevention and Management of Patient Slips, Trips and fall with supportive falls protocol flow charts etc. is now in use
- Falls Champions have been created for all in patient areas
- Inpatient falls meetings being held with the In patients falls Champions to discuss falls reviews, looking at any trends / patterns
- Moderate incidents or above are being provided to Falls Clinical Lead Physiotherapist (Southampton) & Falls Thematic Lead (Solent) to support investigations
- Installation of Hover Jack in high fall area
- Bed Safety Rails – Risk of entrapment assessment review undertaken
- Evaluation of bed exit alarms

Section 8: Looking Ahead

H&S Manager will be focusing on the following areas of activity during the next 12 months:

- Support the AMH/OPMH ligature reduction programme and provide anti-ligature assessment and ligature point training.

- Maintain appropriate arrangements to address counter-fraud issues and security management issues, with a review of the Solent security self-review tool, identify any gaps or room for improvement and develop an action plan to maintain compliance.

  Encourage managers to facilitate staff release for training, particularly in areas with limited vacancies and the travel time required due to the geographical location of our sites is not always easy. The compliance team will continue undertaking more 'Pop up' training sessions requested by service for staff to achieve the required competency

  Support the gathering of appropriate information on estates building compliance evidence held on the MICAD system. Work in collaboration with the estates team in the review of the NHS Premises Assurance Model (PAM) assessment.

- Annual inspection programme - Map a schedule of workplace health, safety and security inspections for properties working closely with services to aid the completion of the inspections. Create an action tracker of any recommendations and feed them into the Estates Backlog Maintenance tracker and report findings through the health and safety sub-committee.

- Combine the compliance team expertise with the Emergency Planning and Business Continuity Lead through the appointment of a LSMS and Deputy Emergency Planning Officer role.

- Support services in lone working assessments and management and use of lone working devices. Undertake a cost analysis and option appraisal in regards to other lone working devices on the market that could be adopted

- The health and safety manager will continue to work closely with E&F Management Team as a key stakeholder in all new build, refurbishment projects or acquisitions of new buildings. Providing expert advice and support and authorised compliant sign off to issues that are identified within sites that relate to statutory compliance with appropriate legislation and Health Technical Memorandums

- Development of further user friendly guidance for workstations and hand held devices. Work with Occupational Health and Wellbeing to initiate various campaigns and posters. Support Occupational Health and Wellbeing in regards to assessment of staff presenting with musculoskeletal disorders. Create next round of health and safety training programme tor Occupational Health and Wellbeing

We have engaged and formally consulted with our employees and staff side representatives in regards to health and safety management ensuring we remain compliant with the requirements of health and safety legislation.

Author: David Keates
Job Title: Health and Safety Manager Solent NHS Trust
Date July 2018

APPENDIX A

HEALTH AND SAFETY POLICY

STATEMENT OF INTENT

This Health and Safety Policy Statement of Intent identifies the commitment of Solent NHS Trust to provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, patients, visitors and other persons affected by the Trust 's undertaking or omissions.

Health, safety and welfare are the responsibility of all staff and are an integral important part of their duties. The Trust's commitment to health and safety therefore ranks equally with all other aims, objectives and activities.

The Health and Safety Policy establishes both general and specific arrangements relating to the Trust's undertaking and extends to all premises, buildings, areas and activities throughout the Trust.

A copy of the Health and Safety Policy is made available to all employees at induction and subsequent training. It is also available on the Trust intranet SolNet. The Trust ensures that all employees are fully aware of their legal obligations to take reasonable care for their own health and safety and that of any persons who may be affected by their acts or omissions at work. All employees are legally required to co-operate with their employer in health and safety matters.

Where employees do not have access to SolNet, line managers are to make such arrangements as may be necessary to ensure employees have access to this policy.

To enable the effective implementation of the health and safety policy and the performance of all tasks safely and without risk to employees, patients or visitors, staff will be provided with suitable and sufficient information, instruction and training.

To encourage and promote effective consultation, communication and co-operation between management and employees, all departments shall develop appropriate systems by which the contributions and concerns of employees can be raised at departmental management meetings, and the Health and Safety Subcommittee

This Health and Safety Policy Statement of Intent shall be reviewed and amended periodically, or as dictated by changes to legislation, working procedures, policies or conditions, whichever is the sooner.

Sue Harriman
Chief Executive Officer
Solent NHS Trust

July 2018

Item 16

Board Report – In Public Meeting

Presentation to	*Board In Public*							
Title of Paper	**Information Governance Briefing Paper & Information Governance Strategy**							
Author(s)	Sadie Bell, Data Protection Officer and Head of Information Governance & Security		**Executive Sponsor**		Report issued by Data Protection Officer David Noyes - SIRO			
Date of Paper	19th July 2018		**Committees presented**		N/A			
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	
	W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	

Please Note: It is a requirement of the General Data Protection Regulations (2016) that the Board have oversight of and take accountability for Information Governance (IG).

This report should be considered as "read" prior to the meeting and will not be discussed in detail at the meeting. The Trust's Data Protection Officer will attend to address queries and any challenges or concerns raised by the Board Members.

The purpose of this report is to provide the Trust with a summary of the last financial year's Information Governance Compliance, as well as a detailed report of the Trust's current Information Governance compliance, with both Law and National Requirements.

Information Governance Compliance Report

Solent NHS Trust has made a significant improvement in its Information Governance compliance and awareness within the last financial year and this has continued into the first quarter of this financial year. Examples of increased compliance are;

- Ranking 2nd out of 55 Mental Health Trust's on the IG Toolkit
- Outstanding GDPR Compliance Audit Report
- Vast improvements with its compliance percentage for legal requests for information, above mandated Information Commissioner's requirements.

The Trust's objectives for 2018/19 are to continue with this compliance, as well as;

- Continue to achieve outstanding IG compliance
- Navigate new challenges introduced by the new Data Protection and Security Toolkit
- Strive for a level of assurance above average compliance for GDPR, by providing greater transparency
- Help our partners and the public understand GDPR, and assist in providing expert advice, where perspective of the law may be misunderstood.
- Support our working partners with the wider Health and Social Care integration, whilst maintaining IG compliance.

Areas of concern around IG incidents are to continue to be monitored, awareness raised through training and changes to practices made where applicable. One particular area to be focused on is Unintentional / Deliberate staff breaches, which, although are a rarity, are an area the Trust will continue to mitigate.

1. Purpose

1.1 The purpose of this report is to provide the Trust with a summary of the last financial year's Information Governance Compliance, as well as a detailed report of the Trust's current Information Governance compliance, with both Law and National Requirements.

1.2 Solent NHS Trust believes that it is essential to the delivery of the highest quality of health care for all relevant information to be accurate, complete, timely and secure. As such, it is the responsibility of all staff and contractors working on our behalf to ensure and promote a high quality of reliable information to underpin decision making.

1.3 Information Governance promotes good practice requirements and guidance to ensure information is handled by organisations and staff legally, securely, efficiently and effectively to deliver the highest care standards. Information Governance also plays a key role as the foundation for all governance areas, supporting integrated governance within Solent NHS Trust.

1.4 This reports covers Solent NHS Trust's Information Governance's Activity;

- Information Governance Toolkit Submission, V14.1, 2017/18
- Introduction of the Data Protection and Security Toolkit, V1, 2018/19
- Compliance with legal requests for information
- Information Governance Incidents
- Implementation of the General Data Protection Regulations (2016)

2. Information Governance Toolkit Submission 2017/18

In order to be compliant within the Information Governance Toolkit, Solent NHS Trust must achieve Level 2 or above in all 45 requirements. The Information Governance Team and the Trust set the target of achieving Level 3 compliance in 42 out of 45 of the IG Toolkit requirements in 2017/18. The reasons behind this were;

- Allow the Trust to demonstrate a high level of compliance with IG Toolkit Standards and Records Management Standards, which will allow for GDPR compliance
- Demonstrate a higher level of compliance, which will provide patients with greater trust that Solent NHS Trust ensures their information, is kept secure and appropriately used.
- Provide assurance to our commissioners that we have outstanding Information Governance measures in place and these are regularly measured.
- Allow the Trust to become compliant with GDPR Regulations and sustain compliance thereafter

At the end of the financial year 2017/18, Solent NHS Trust declared that it had met its target compliance of Level 3 in 42 requirements and Level 2 in 3 requirements.

A full breakdown of the Trust's compliance can be found in Appendix A.

2.1 Overall Compliance Statement

Solent NHS Trust's overall Information Governance (IG) Toolkit compliancy score for 2017/18 was 97% and was graded as Green – Satisfactory.

When compared to other Mental Health Trust's, Solent NHS Trust ranked 2nd out of 55 Trusts, compared to 2016/17 scores, where the Trust ranked 48th out of 55 Trusts.

A comparison of the Trust's compliance, compared to other Mental Health Trust's can be found in Appendix B.

2.2 ***Next Steps – Data Protection and Security Toolkit, V1, 2018/19***

The Information Governance (IG) Toolkit in the format used for the previous 15 years has ceased to exist. This has now been replaced by the Data Security and Protection Toolkit (DSPT).

The DSPT remains an online self-assessment tool, mandated by NHS Digital, which enables Health and Social Care organisations to measure their performance against Data Security and Information Governance legislation. The DSPT was developed following the National Data Guardian's (NDG) review which was instated in July 2016 and as a result has taken a shift in focus when compared to previous version of the IG Toolkit and has become more Security focused; therefore although previous compliance levels have assisted with currency compliance status of the DSPT, it cannot be compared like for like.

The ten Data Security Standards were a result of the NDG review and therefore the focus of the new Toolkit, which is then split into three categories:

- **Leadership Obligation 1 – People:** *Ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles*.
- **Leadership Obligation 2 – Process:** *Ensure the organisation proactively prevent data security breaches and responds appropriately to incidents or near misses*
- **Leadership Obligation 3 – Technology:** *Ensure technology is secure and up to date*

Compliance Matrix

The predecessor self-assessment the "Information Governance Toolkit" consisted of a three tiered structure in which compliancy was measured:

- Non-Compliant
- Level 2 Compliant – is **working towards** the implementation of Caldicott 2 standards
- Level 3 Compliant – has **fully implemented and abides by** a Caldicott 2 standard

The Data Security and Protection Toolkit for 2018/19, however, does not have differing levels of compliance, instead it features ***forty assertions*** that have been identified for Mental Health Trust's, Community Trust's and General Practitioner's to provide evidence of compliancy against. Within the forty assertions there are ***thirty-two mandatory assertions*** which, if not met, the Trust will be deemed as non-compliant for the entire toolkit.

The Toolkit's assertions are categorised into the following ten data security standards as per the National Data Guardian Review:

- Personal Confidential Data: eight assertions
- Staff Responsibilities: three assertions
- Training: five assertions
- Managing Data Access: three assertions
- Process Reviews: three assertions
- Responding to Incidents: four assertions
- Continuity Planning: two assertions
- Unsupported Systems: three assertions
- IT Protection: four assertions
- Accountable Suppliers: five assertions

Within each assertion are multiple requirements, with an overall total of ***one hundred and forty-nine requirements***.

NHS Digital has confirmed that the Data Security & Protection Toolkit is a 'rolling' system for which they will continuously provide updates and guidance for throughout 2018 as to "what constitutes a 'good' self-assessment".

A full breakdown of the Trust's current compliance can be found in Appendix C.

3. Summary of Information Governance's Legal Requirements Compliance

3.1 Subject Access Requests / Request for Personal Information Compliance Overview:

In 2016/17 the Trust's compliance with Subject Access Requests (SARs) was approximately 85% and Freedom of Information Requests were 87.5%. These two types of requests are legal statutory requirements, with strict deadlines and the ICO have stated that organisations' levels of compliance should not fall below 90% compliance.

In 2017/18 the Trust implemented a dedicated resource (from Q3) to process, manage, action and monitor such requests. As a result of this the Trust's compliance increased to;

- Subject Access Requests 2017/18; 86% (compliance increased to over 90% in Q3 & Q4)
- Freedom of Information Requests 2017/18; 89.7% (compliance increased to over 90% in Q3 & Q4)

In Q1 of 2018/19 compliance has continued to remain high and within the ICO mandate of a minimum of 90%, even with the reduced change in timescales with SAR's from 40 days to 30 days (1 calendar month);

Subject Access Request, Q1, 2018/19; 95% compliance

	Q1 2018/19 *
Number of requests received	235
Number of requests responded to within 21 days (best practice)	140 (71%)
Number of requests responded to within DPA (40 days)	40 (20%)
Number of requests responded to within GDPR (30 days)	8 (4%)
Number of breaches within DPA (in excess of 40 days)	7 (3.5%)
Number of breaches within GDPR (in excess of 30 days)	3 (1.5%)
Not Due	37

*figures are total number of requests, minus those requests who are currently not due, to show current level of compliance. Final figures are subject to change once outstanding requests are closed.

Freedom of Information Requests; 96%

Quarter	**Q1**		
Month	**April**	**May**	**June***
No. Requests	30	29	16
No. Breaches	2	1	0
No. Not Due	0	0	5
% Compliance	96%	96%	100%

* Final figures are subject to change, as some requests are currently not due to date

A full breakdown of the Trust's current compliance can be found in Appendix D.

Summary:

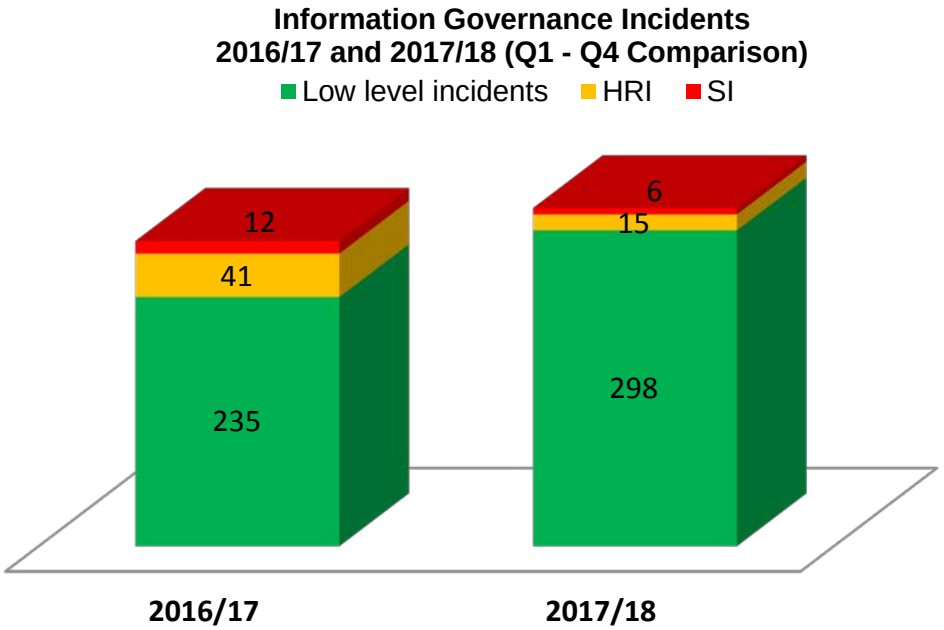
The number of SAR Requests received within in a financial year has increased by 17.6%, when compared to 2016/17 and positive compliance during 2017/18 has also increased from 83% to 86% compliance, with the last two quarters being above 90% compliance.

The number of FOI Requests received within a financial year has remained the same, when compared to 2016/17 and, positive compliance during 2017/18 has also increased from 87% to 90% compliance, with the last two quarters being above 90% compliance.

The centralising of these of two processes within the IG Team and the implementation of a dedicated resource has led to an increase in compliance to within and above mandated guidelines.

4. Information Governance Incidents

4.1 *IG Incident 2017/18*



*The above incidents exclude IG categories associated with low risk (lost smart card, system error and out of our control)

The IG Team have compared Q1 – Q4 2016/17 to Q1 – Q4 2017/18 incidents in order to highlight good IG practices and IG awareness of staff. Overall there has been a slight increase in the number of incidents reported in 2017/18 compared to 2016/17; although this is only an extra thirty incidents. However, there has been a dramatic reduction in the number of High Risk Incidents (HRI) and Serious Incidents (SI being reported; from fifty-three to twenty-one.

- The number of Serious Incidents Requiring Investigation (SI) incidents has decreased by half, from twelve incidents to seven.
- There were fifteen High Risk Incident (HRI) reported in 2017/18, which has decreased by nearly two-thirds when compared to 2016/17.

Where an IG incident HRI or SI is reported, the approach and response taken by services, means that actions are immediately put in place, learning can quickly be cascaded throughout the Trust and we can provide a full summary report to the Information Commissioner's Office (ICO), which is resulting in positive feedback from them and the closing of their investigation in under two weeks.

The IG Team would also like to point out that, even if an IG incident meets a HRI or SI threshold, this should not be seen as a negative thing and we do not blame individuals, but instead look at the process as a whole and how we can improve. Remember if it happened to you it could happen to anyone. There are lots of different reasons an IG incident could be investigated as a HRI or SI;

- The type of data
- The impact it has had on the individual
- The processes followed
- Media Interest
- ICO involvement

Trends 2017/18:

IG Incidents – Main Issues					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Stolen Notes/PID	0	0	0	0	0
Lost Notes/PID	3	9	2	6	20
PID sent to wrong address / person	26	24	20	14	84
PID in wrong record	17	21	15	24	77
Records Error	8	12	5	3	28
PID Saved / Stored Insecurely	9	5	5	10	29
NHSMail not used for PID	1	4	9	5	19
Post Issues (way in sent/received)	3	2	1	1	7
PID found in public place	1	3	3	0	7
Breach by staff - Deliberate	3	0	0	2	5
Breach by staff - Unintentional	4	1	1	7	13
Printing Issues (left on printer / wrong printer)	4	4	0	2	10
Cyber Security	1	0	0	0	1
Other	7	5	5	2	19
Sub Total	**87**	**90**	**66**	**76**	**319**

An additional 196 incidents with a 'minimal impact' result or 'out of Solent NHS Trust's control' result were also reported in 2017/18. Although these incidents are considered to be out of Solent NHS Trust's control they are still reported and monitored, as they could impact upon our data, patients and care provided.

IG Incident – Low Risk Incidents					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Lost Smart Card / ID Badge	15	7	5	7	34
System Error	22	19	7	14	62
Out of our control	27	31	23	19	100
Total	**64**	**57**	**35**	**40**	**196**

4.2 *IG Incidents, Q1, 2018/19*

IG Incidents – Main Issues	
	Q1
Lost Notes/PID	4
PID sent to wrong address / person	20
PID in wrong record	24
Records Error	2
PID Saved / Stored Insecurely	8
NHSMail not used for PID	7
PID found in public place	3
Breach by staff - Deliberate	2
Breach by staff - Unintentional	7
Printing Issues (left on printer / wrong printer)	3
Other	10
Sub Total	**90**

90 incidents were reported in Q1, 2018/19, which is a slight increase when compared to 2017/18, with the average number of incidents reported in 2017/18 being 27. However, upon review, it has been identified that several incidents reported as "other IG incidents", although have the potential to become an IG incident, are in fact not IG breaches due to mitigating factors e.g. lost laptop which is encrypted, patient complaint over the recording of data which is kept secure and for a legitimate purpose, laptop left in school which is encrypted and collected same day, etc… It is important that these incidents are reported as they allow us to track and review potential IG incidents and ensure that we have the appropriate mitigating factors in place. This type of reporting is positive and a result of training, awareness and an open reporting culture.

When reviewing the other type of incidents reported, the three areas of focus reference areas of most reporting / concern are;

- 20 incidents were reported as PID Sent to Wrong Person / Address; unlike previous incidents, this now mainly link to sending of information via email. The IG Team will be undertaking some awareness and communication on data validation and appropriate processes.
- 9 incidents were reported around Staff Breach, both unintentional and deliberate. This is an increase compared to the previous month. One positive of this is 89% of these cases, due to knowledge after the fact reported themselves and 11% were reported by others who were aware that this type of access is a breach. The IG Team is working on a detailed action plan to address this and is currently being shared by the Trust's Data Protection Officer with the Trust's Senior Information Risk Owner and Caldicott Guardian. This includes a review of education, access controls / audits, alerts, etc… To support this, this year's IG Training includes a statement that states "I must not access information about myself or others without an appropriate work reason to do so"; this is to be signed / ticked by each individual, before they are marked as compliant. Currently the Trust has 65.8% compliance in this area.
- 24 incidents related to PID in wrong record, which is a result of increased awareness through IG Training to report such incidents, due to the potential IG breaches

4.3 *Recommendations*

- IG Team to continue to undertake
  - quarterly IG incident trending and assess the best way to prevent reoccurrence
  - provide bespoke IG Training & Awareness, as this has proved to be successful in raising staff awareness.
  - with lesson learnt based IG scenarios in Staff News and IG Newsletter
- IG Team to assess different ways of ensuring shared learning from incidents is cascaded to staff.
- IG Team to produce and implement a detailed action plan to address staff breaches

5. General Data Protection Implementation

The Trust met the minimum requirements of GDPR, when it was implemented on the 25th May 2018. This was support by the Trust's independent audit of compliance. One of the greater achievements is the Trust's comprehensive Privacy Notice "Your Information Your Rights" and its training of staff. To date this financial year 65.8% of staff have completed GDPR / IG Training and regular communications are cascaded to staff on GDPR.

The implementation of Privacy by Design has proven effective and is evident by the number of queries and confirmations requested of the IG Team.

6. Summary

Solent NHS Trust has made a significant improvement in its Information Governance compliance and awareness within the last financial year and this has continued into the first quarter of this financial year. Examples of increased compliance are;

- Ranking 2nd out of 55 Mental Health Trust's on the IG Toolkit
- Outstanding GDPR Compliance Audit Report
- Vast improvements with its compliance percentage for legal requests for information, above mandated Information Commissioner's requirements.

The Trust's objectives for 2018/19 are to continue with this compliance, as well as;

- Continue to achieve outstanding IG compliance
- Navigate new challenges introduced by the new Data Protection and Security Toolkit
- Strive for a level of assurance above average compliance for GDPR, by providing greater transparency
- Help our partners and the public understand GDPR, and assist in providing expert advice, where perspective of the law may be mis-understood.
- Support our working partners with the wider Health and Social Care integration, whilst ensuring IG compliance.

Areas of concern around IG incidents are to continue to be monitored, awareness raised through training and changes to practices made where applicable. A particular area to be address are Unintentional / Deliberate staff breaches, which although are the rarity, are an area the Trust will continue to mitigate.

Appendix A: IG Toolkit Compliance Breakdown

Req No	Description	Attainment Level
Information Governance Management		
101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Level 3
105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Level 3
110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Level 3
111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Level 3
112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Level 3
Confidentiality and Data Protection Assurance		
200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Level 3
201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Level 3
202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Level 3
203	Individuals are informed about the proposed uses of their personal information	Level 3
205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Level 2
206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Level 3
207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Level 3
209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Level 3
210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Level 3
Information Security Assurance		
300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Level 3
301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Level 3
302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Level 3
303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Level 3
304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Level 3
305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Level 3
307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Level 3

308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Level 3
309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Level 3
310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Level 3
311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Level 3
313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Level 2
314	Policy and procedures ensure that mobile computing and teleworking are secure	Level 3
323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Level 3
324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Level 3
Clinical Information Assurance		
400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Level 3
401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Level 3
402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Level 3
404	A multi-professional audit of clinical records across all specialties has been undertaken	Level 3
406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Level 3
Secondary Use Assurance		
501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Level 3
502	External data quality reports are used for monitoring and improving data quality	Level 3
504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Level 3
506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Level 3
507	The Completeness and Validity check for data has been completed and passed	Level 3
508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Level 3
514	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	Level 3
516	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	Level 2
Corporate Information Assurance		
601	Documented and implemented procedures are in place for the effective management of corporate records	Level 3
603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Level 3
604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Level 3

Appendix B: IG Toolkit Scores – Mental Health Trusts

Name	Total (%)
Derbyshire Healthcare NHS Foundation Trust	98
Solent NHS Trust	97
Lincolnshire Partnership NHS Foundation Trust	96
South Staffordshire And Shropshire Healthcare NHS Foundation Trust	95
Cumbria Partnership NHS Foundation Trust	94
Cheshire And Wirral Partnership NHS Foundation Trust	94
Bradford District Care Trust	94
Norfolk And Suffolk NHS Foundation Trust	93
Sussex Partnership NHS Foundation Trust	93
Kent And Medway NHS And Social Care Partnership Trust	91
Tavistock And Portman NHS Foundation Trust	90
Northamptonshire Healthcare NHS Foundation Trust	90
South London And Maudsley NHS Foundation Trust	90
Southern Health NHS Foundation Trust	90
Mersey Care NHS Foundation Trust	89
Tees, Esk And Wear Valleys NHS Foundation Trust	88
Central And North West London NHS Foundation Trust	86
Cambridgeshire And Peterborough NHS Foundation Trust	85
Leicestershire Partnership NHS Trust	85
2gether NHS Foundation Trust	85
Hertfordshire Partnership University NHS Foundation Trust	85
Nottinghamshire Healthcare NHS Foundation Trust	84
Oxleas NHS Foundation Trust	84
Barnet, Enfield And Haringey Mental Health NHS Trust	83
Berkshire Healthcare NHS Foundation Trust	82
Greater Manchester West Mental Health NHS Foundation Trust	82
Cornwall Partnership NHS Foundation Trust	81
Camden And Islington NHS Foundation Trust	81
North West Boroughs Healthcare NHS Foundation Trust	80
Humber NHS Foundation Trust	80
Lancashire Care NHS Foundation Trust	80
Leeds And York Partnership NHS Foundation Trust	78
Devon Partnership NHS Trust	78
Oxford Health NHS Foundation Trust	77
West London Mental Health NHS Trust	75
North Staffordshire Combined Healthcare NHS Trust	75
Northumberland, Tyne And Wear NHS Foundation Trust	75
Birmingham And Solihull Mental Health NHS Foundation Trust	75
Worcestershire Health And Care NHS Trust	74
Surrey And Borders Partnership NHS Foundation Trust	74
Coventry And Warwickshire Partnership NHS Trust	73
Essex Partnership University NHS Foundation Trust (R1I)	72
North East London NHS Foundation Trust	72
South West London And St George's Mental Health NHS Trust	72

Pennine Care NHS Foundation Trust	71
Black Country Partnership NHS Foundation Trust	70
Dudley And Walsall Mental Health Partnership NHS Trust	68
Sheffield Health & Social Care NHS Foundation Trust	68
Avon And Wiltshire Mental Health Partnership NHS Trust	67
Dorset Healthcare University NHS Foundation Trust	66
Somerset Partnership NHS Foundation Trust	66
Rotherham Doncaster And South Humber NHS Foundation Trust	66
South West Yorkshire Partnership Foundation NHS Trust	66
East London NHS Foundation Trust	47
Caswell Clinic (We3fv)	0

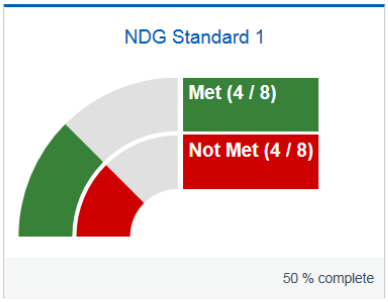
Appendix C: Data Protection and Security Toolkit Current Compliance

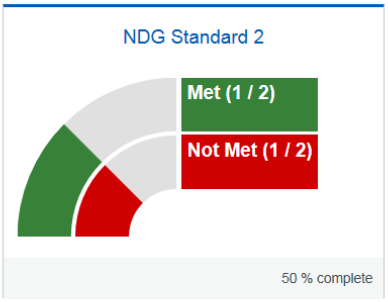
Compliance

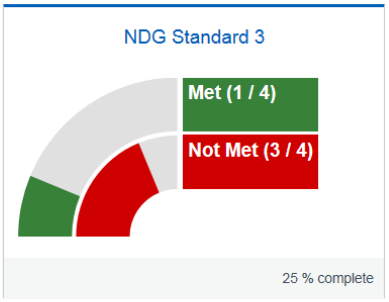
NHS Digital provides organisations a summary of their current compliance with the Data Security and Protection Toolkit. This is calculated using the number of assertions Solent NHS Trust has indicated as compliant and is able to produce evidence for, compared to the total number of mandatory assertions (thirty-two).

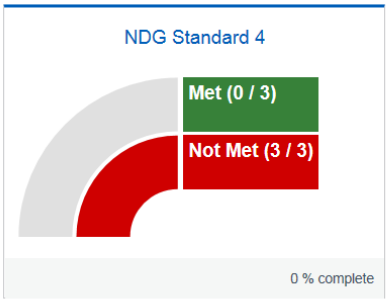
Compliance is shown for each of the ten National Data Guardian Standards in which all thirty-two assertions are categorised under. Each standard has an indication of how many assertions it has, alongside how many of these assertions have or have not been met to date. This then provides a percentage of overall compliance for each standard.

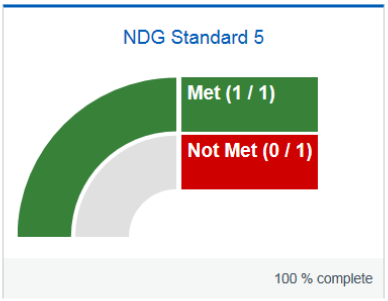
The Trust's overall compliance at present is 37.5%
Below is a summary of Solent NHS Trust's compliancy with the Data Security and Protection Toolkit as of **19th July 2018.**

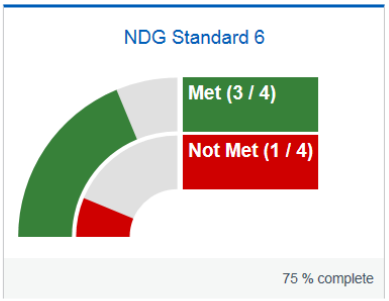


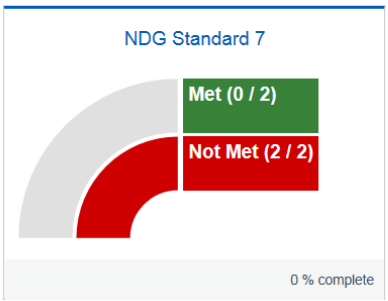


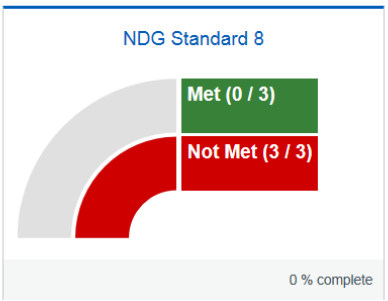


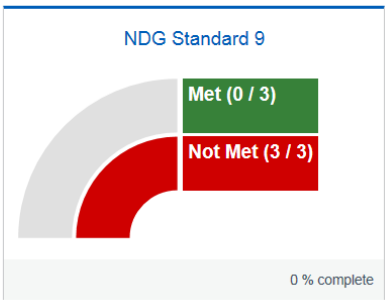


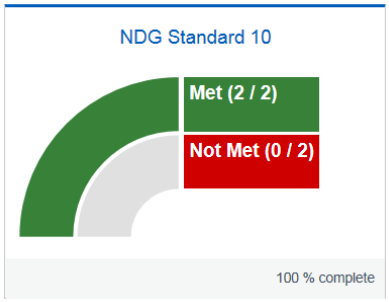












***compliance will be updated in the next reporting period**

Appendix D: Information Request Compliance Breakdown

	Q1, 2017/18	Q2, 2017/18	Q3, 2017/18	Q4, 2017/18 *TBC	Year Total to date 2017/18
Number of requests received	198	240	202	202	842
Number of requests responded to within 21 days (best practice)	110	150	156	138	554
Number of requests responded to within 40 days	43	45	33	45	166
Total Compliance	153 (77%)	195 (81%)	189 (94%)	183 (91%)	720 (86%)
Number of breaches (in excess of 40 days)	45	45	13	18	121
Not Due	0	0	0	1	1

* final figures are subject to change, as some requests are currently not due to date.

	2017/18	2016/17
Total	**841***	**715**
Total Compliance	720 (86%)	592 (83%)
No. breaches (in excess of 40 days)	121 (15%)	120 (17%)

*figures are total number of requests, minus those requests who are currently not due, to show current level of compliance. Final figures are subject to change once outstanding requests are closed.

Freedom of Information Requests

	2017/18	2016/17
Total	**294**	**303**
Total Compliance	264 (90%)	264 (87%)
No. breaches (in excess of 40 days)	30 (10%)	39 (13%)

Appendix E: GDPR Compliance

Action Required	Time Frame	Person Accountable	Status
Review of all Existing Information Sharing Agreements, to ensure that information sharing arrangements comply with the new requirements and restrictions of the GDPR. Ensuring that all legal basis(s) are documented.	July 18 – October 18	Data Protection Officer	All new agreements cover GDPR legal basis. Existing agreements are still compliant and as and when require renew will be reviewed under the new GDPR template.
Privacy Notice	Ongoing Next detailed Review September 2018	Data Protection Officer	This is in place and in compliance with GDPR. To provide a level of assurance above average compliance, the Trusts Data Protection Officer will be adding more information periodically to its "Your Information Your Rights" website. This will offer greater transparency. The Trusts Data Protection Officer will also be working with individual service lines to produce service line specific Privacy Notices. This is already in place for Sexual Health and Occupational Health.
IG Policies	November 18 – December 18	Data Protection Officer	IG Policies will be reviewed to make them more concise and more comprehensive, to greater allow our staff's understanding and compliance with law.
Contracts	July 18 – December 18	Data Protection Officer	All contractors have been issued with new GDPR Clauses for their contracts. To provide a level of assurance above average compliance, the Trusts Data Protection Officer is working with services and contractors to attached Data Processing Agreements to all contracts. Commercial and ensuring they liaise with the Trusts Data Protection Officer to implement these for all new contracts.

Embed a culture within the Trust where the Data Protection Officer is seen as central to the working practices of the Trust, with regards to any change or addition, which directly or indirectly affects personally identifiable and/or special category data. E.g. • Contract Review • Information Sharing Agreements • Privacy Impact Assessments • IG Audits • IG Training	July 18 – December 18	Data Protection Officer	This culture has been embedded. To ensure this continues the Data Protection Officer will be attending key meetings across the Trust. In addition to this the IG Team will undertake six monthly checks on service lines compliance and provide a “Compliance Check Report”
Inventory / documented list of all information held on our Network Drives to be undertaken. Ensuring retention dates are associated with all documents. Review of resources required for this piece of work will need to be undertaken in advance to this	Project Plan to be produced by December 18	Senior Records Officer	Electronic archives are documented and listed, but continual reviews are still required. It was hoped that the SharePoint project would undertake this piece of work for electronic records. A new project plan is to be produced to review the content of our network drives, the majority is believed to be corporate and therefore not GDPR, but is required for FOI.

Item 17

Presentation to	[x] In Public Board Meeting [ ] Confidential Board Meeting		
Title of Paper	Safe Nurse Staffing – six monthly report		
Author(s)	Angela Anderson, Head of Professional Standards and Regulation	**Executive Sponsor**	Jackie Ardley, Chief Nurse
Date of Paper	June 2018	**Committees presented**	QIR; Assurance Committee, Board
Link to CQC Key Lines of Enquiry (KLoE)	[x] Safe [x] Effective [x] Caring [x] Responsive [x] Well Led		
Action requested of the Board	[x] **To receive** [ ] **For decision**		

The purpose of this paper is to provide the required six monthly update on the nurse staffing position within the inpatient wards/units directly provided by the Trust. The staffing position within the community teams is also reviewed within this report.

Introduction

This report aims to provide the Board with;

- Assurance that nurse staffing levels within each ward/unit are appropriate to meet the needs of patients and service users in our care and explain the approaches in place to monitor and manage staffing levels.

- Details of the Trusts' progress against the revised National Quality Board (NQB) guidance issued in July 2016.

- The Board is asked to note the current reported position and endorse the action being taken to maintain safe nurse staffing levels.

Background

The Trust continues to meet the requirements within the regulatory framework for publication of staffing levels. In-patient data is published via an upload to Unify each month and a monthly summary is submitted to commissioners and uploaded to the Trust internet as required. Service Line Professional leads report by exception to the Quality Improvement and Risk, (QIR), group which reports in turn to the Assurance Committee and onto the Board.

It is a further requirement as outlined in the NQB Guidance, that there is a report on safe nurse staffing provided to the Board every Six months. The last report was presented in January 2018 covering the period June 2017 to November 2017. This report covers the period December 2017 to May 2018.

Current Position

The Trust continues to work with services to ensure staffing levels are appropriate to meet the identified needs of patient/service users. National monitoring mandates a focus on appropriate skill mix and the level of nursing staff are appropriate to provide safe and effective care and reflect the acuity and dependency needs of individual patient groups. However, Solent recognises that safe staffing must also acknowledge the contribution other disciplines, within the overall establishment, make to ensure that clinical teams deliver safe, effective and high quality care in an increasingly complex environment.

In July 2017 the Trust approved the proposal for ensuring that there is a clear process in place for the professional review and sign off for establishments. In February 2018 the Chief Nurse introduced a system to review safe staffing and initially met with the professional leads for each service line and members of the service line leadership. The Chief Nurse, members of the workforce team and the Associate Director of Professional Standards have been meeting every two weeks with each of the service lines. The service line professional lead agrees in advance which team will be the focus of the discussion.

These meetings concentrate on roster management, bank and agency usage, mandatory training, sickness and turnover rates. The aim is to understand the challenges teams are facing and to support resolution. It also offers the opportunity for the workforce team to help services to overcome some of the difficulties with the systems they encounter.

These discussions have proven very useful and there is engagement from the team managers which has led to constructive discussions and resolution of issues. Although in the early stages, there is evidence of improvements in peoples understanding of the roster, in roster management practice as well as some early indications of improvement in mandatory training compliance. The discussions have also highlighted the dependence on clinical staff to complete the rosters as not all teams have access to good admin support. This is an area for consideration and an update will be provided in future reports.

Work is continuing to identify a suitable acuity and dependency tool for the different in-patient areas and it is intended to undertake a data collection exercise in July 2018 and progress against this will be provided in the next report. There continues to be difficulties finding a suitable acuity and dependency tool particularly for the rehabilitation wards and those providing end of life care. The Trust previously considered implementation of the SafeCare module to support delivery of CHPPD and formalise recording of patient acuity and dependency but was put on hold pending the introduction of the establishment review process. This position will be reconsidered over the summer 2018 and a decision will be taken on how to proceed.

In-patient units

The Trust has continued to comply with the requirement to upload to Unify details of the staffing position in each of the in-patient areas and uploading the reports onto the internet has been consistently achieved. The reports at ward level outline the actual numbers of staff on duty on each shift and compare this with the planned levels awarding a RAG rating which has been nationally defined. For the unify report the information is presented as a percentage compliance against planned, the data for this reporting period is included in **appendix 1** for reference.

The data demonstrates that teams continue to experience difficulties achieving planned staffing levels and where they are under plan it is in the main due to sickness levels and vacancy factor. Where wards are over plan this will be linked to either increased acuity and dependency levels or because it is more appropriate to adjust the skill mix and have staff available who know the ward and the patients rather than rely on agency staff who are not familiar with the clinical area.

The position in the first 3 months of this reporting period was much improved but has deteriorated in the second half of the reporting period. This will be reviewed as part of the establishment review discussions with services and the Chief Nurse in order to better understand the position and to review the establishments in this context. Where indicated adjustments will be made to better reflect the needs of the service and identify and manage any associated risks.

All clinical areas actively manage staff sickness and employ a number of strategies to successfully recruit to vacancies. In the first part of 2018/19 there appears to be a reduction in sickness rates across the Trust and this position will be monitored and correlated with the staffing levels. The

mental health wards face particular challenges and continue to develop their plans to introduce band 4 roles which will be underpinned with a clear competency framework in an attempt to target those hard to recruit to areas.

The Limes (Brooker organic and functional) continues to be an area of concern in relation to safe staffing and have continued to experience some instances of red and amber staffing. The reasons for the difficulties remain staff sickness combined with difficulty recruiting to vacant positons; however it is pleasing to note the team have successfully recruited to some vacant posts with staff joining the team over the summer months.

As reported previously some areas continue to achieve above 95% planned staffing on the majority of occasions. This will be achieved through a number of actions such as good roster management, low sickness and turnover rates.

The table below summarises the incident reporting in relation to key indicators which are considered when looking at safe staffing.

	Assault - Non-Physical	Assault - Physical	Medication Errors / Management	Pressure Injuries	Slips, Trips And Falls	Grand Total
Bramble Ward (Lower)	0	0	1	0	0	**1**
Brooker Ward (The Limes) - OPMH	7	42	8	2	66	**125**
Crisis AMH (Orchards)	2	2	0	0	0	**4**
Fanshawe Ward	0	0	0	0	0	**0**
Hawthorns Ward - Acute AMH	8	27	9	0	14	**58**
Jubilee House	0	0	0	0	0	**0**
Jubilee Specialist Palliative Care Team	0	0	0	0	0	**0**
Kite Unit - Acquired Brain Injury	5	20	4	0	17	**46**
Maples Ward - PICU	41	97	8	0	7	**153**
Maples Ward	5	11	3	0	0	**19**
Oakdene - Rehab	24	2	3	1	14	**44**
Orchards - Admin AMH	1	1	0	0	1	**3**
Orchards CRHT Team	0	1	1	0	0	**2**
Snowdon At Home	0	0	0	0	0	**0**
Snowdon Therapies	0	0	0	0	0	**0**
Snowdon Ward	0	0	0	0	0	**0**
Spinnaker Ward	0	0	0	0	0	**0**
Grand Total	**93**	**203**	**37**	**3**	**119**	**455**

The review of the incidents for The Limes show a slight decrease in the numbers of physical assaults reported but an increase in the number of slips, trips and falls. A more detailed review of these specific incidents is needed to understand if there is any correlation with staffing levels at the time of the incidents.

It will be noted that Maples ward has seen a significant increase in the number of reported physical assaults in this reporting period. The ward team have been caring for a small number of patients who were experiencing significant distress and increased acuity and dependency and this is reflected in this data. The team have responded professionally and effectively and appropriate support is in place for the team.

During the reporting period December 2017 to May 2018 there were 6 formal complaints received which related to the inpatient wards a reduction of 3 from the previous reporting period with only 1 service concern recorded, a reduction of 3. The complaints are spread across the services as outlined in the table below with Hawthorns the area receiving the highest number of complaints. The analysis does not at present identify any correlation to safe staffing.

Ward Area	Number of complaints relating to clinical care	Number of Service concerns	Themes
The Limes	1	0	- Medication side effects - Feels patients are over sedated
Jubilee House	1	0	- Observations on patients not kept up - SI and Reports (concerns about panic alarms)
Maples	1	0	- Failure to follow procedures
Hawthorns	3	0	- Discharge arrangements
Lower Brambles	0	1	- Patient suffered bruising when transferred – on right shin
Spinnaker	0	0	

In all areas the Matrons and Ward managers continue to assess safe staffing using clinical judgement, in line with NQB guidance, to determine whether the staffing was safe for the numbers and dependency levels of the patients on the ward at that time. It is clear from the Matron and Ward manager's reports that the decision making and flexible approach to moving staff to cover areas within the same speciality is based on maintaining quality and patient safety and ensuring patients' needs can be met.

Community Teams

The Southampton and Portsmouth teams continue to review the national and local information available to support safe caseload management and to identify safe staffing levels. This work is not yet developed nationally and so the Trust is continuing to explore possible caseload allocation tools which could be available through either TPP SystmOne or from Health Assure.

The community nursing service in Southampton has adapted a demand and capacity tool to calculate daily demands and the capacity to respond by utilising resources effectively across teams. The tool will provide the teams with accurate and consistent information regarding current demand with supporting algorithms to aid decision making at different levels of increased demand. This will enable the teams to use staff effectively across teams and to escalate appropriately where demand exceeds capacity and the service determines the situation is unsafe. The system is currently being tested and an audit to review is planned. It is intended that the system will be fully operational from September 2018.

If successful it will be appropriate for the tool to be used across the two cities and there are plans for the professional lead from Southampton to share this with other service line leads as there may be an opportunity for wider adoption in Solent.

Recruitment and retention across community nursing teams continues to be a challenge during this reporting period. Over the winter months the system was under significant pressure, particularly in the Portsmouth area. The teams responded professionally and effectively and managed the increased demand through working collaboratively with health and social care colleagues and the third sector to facilitate the safe discharge and ongoing care of patients. Planning has commenced for the coming year to ensure collaborative solutions are agreed and in place to deliver safe care.

Children's Services

Recruitment to key roles within children's community nursing coupled with staff sickness has been a concern for the children's service line, however in the latter part of the reporting period the service has had success with recruiting and those who started earlier in the year have completed their induction.

Portsmouth and Southampton teams reorganisation of clinical leadership has been completed with the matron taking a key role in Portsmouth and the introduction of a matron development role in Southampton.

Specialist Dental Services

The Special Care Dental Service takes a proactive approach to managing the challenges they face recruiting dentists. The team ensure business continuity by moving staff to different clinics where necessary and when it is safe to do so. They have also continued to provide innovative ways to ensure they can meet patient's needs, for example, introducing Saturday morning general anaesthetic lists for people with autism/learning difficulties.

The Service 2018/19 Business Plan aims to deliver a sustainable workforce model by the end of March 2019, and the team continue to provide the Specialist Registrar training programme, developing and up skilling individuals in preparation for the future, including leadership roles, and reviewing the current staff profile, identifying where there is a risk of staff skill mix deficit.

Bank and Agency Usage

As reported previously, and in line with the government directive for NHS Trusts to drive down the use of agency across all NHS sites. The Trust is required to report on a weekly basis to NHSi on off-framework usage and need to include the following detail:

- Details of each shift escalated to Off-framework
- Cost of each shift
- Reason for the escalation.

In addition to this from the beginning of June we are also required to have Executive sign off for any agency shifts that would potentially cost more than £100 per hour. A new process will be introduced to ensure this is captured and reported in line with NHSi guidance.

There has been an overall increase in demand over the last 6 month period. The highest demand currently remains within mental health services in Portsmouth, this is attributed to hard to fill vacancies for registered mental health nurses, continued high levels of cover required for patients requiring 1 to 1 nursing and high levels of acute admissions to the mental health wards.

There has been a significant increase in demand for our Community Nurse team in Portsmouth, this was due in part to winter pressure and assisting PHT with the overflow of patients. Demand has now reduced slightly and there are plans in place for further reduction. Southampton Community Nursing has significantly reduced the level of requests following successful recruitment and monitoring of rosters within this service. Attendance at recruitment fairs and universities has also

helped to raise the profile and career opportunities to be found within these services and promotes Solent as an employer of choice.

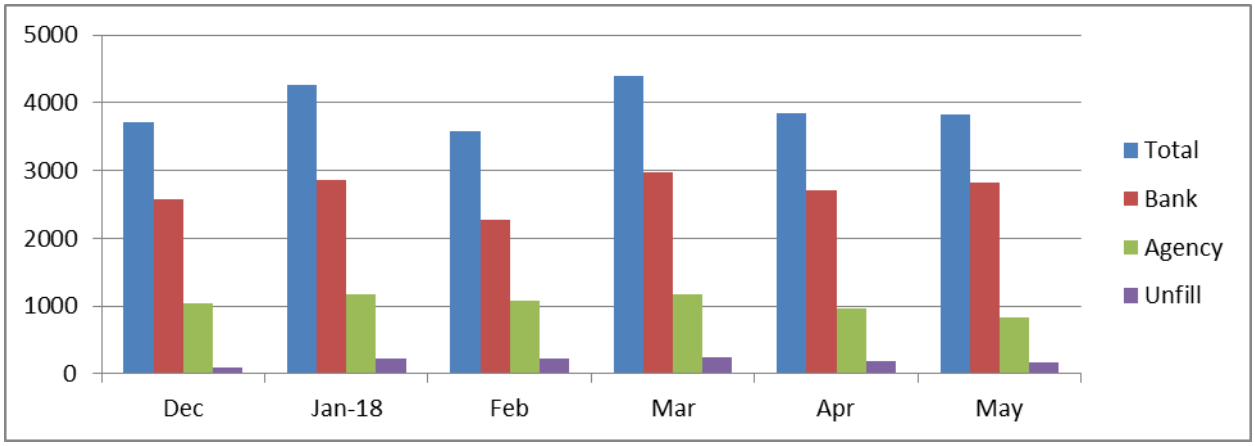
The Bank team continue to have rolling recruitment in place for Nurses and HCA. Progress has been made in increasing the number of staff employed on the bank and we now have a small number of community bank nurses able to assist with covering demand rather than agency.

Although we are beginning to see an overall reduction in demand for agency RN's the number escalated to Off-framework still remains high, and more inroads need to be made in further reducing this number.

The below table highlights level of Bank & Agency requests for clinical areas for 31.12.2017-31.5.18

Clinical Dec 17- Jun 18	Req	Bank	%	Agency	%	Unfilled	%
AMH SERVICES	6462	3826	60%	2413	37%	223	3%
PORTSMOUTH ADULT SVS	4484	1808	41%	2127	47%	549	12%
PORTSMOUTH CHILDREN SVS	750	750	100%				
SOUTHAMPTON ADULT SVS	4388	2909	66.50%	1152	26.5%	332	7%
PRIMARY CARE	1689	1689	100%				
SOUTHAMPTON CHILDREN SVS	867	867	100%				
SEXUAL HEALTH SERVICES	477	477	100%				
TOTALS	19117	12326	64.5%	5692	29.5%	1104	6%

This table demonstrates level of Bank/Agency requests over last 6 month period.



Roster Quality

Work continues with services to improve roster quality. Whilst more services are now producing rosters ahead of work time (ideally 6 weeks) there is still improvements to be made to the quality of rosters produced which is evidenced in the high number of emails, in excess of 100 per day, to the Healthroster team. Following the introduction of two weekly Safe staffing meetings with the Chief Nurse there is now more scrutiny on rosters and this is followed up directly with service and roster review sessions are then taking place. This will continue through the coming months to ensure our roster compliance continues to improve across all service areas. New training sessions for managers will also be introduced from July 2018 onwards. Agency spend continues to be a key driver in keeping a focus on the requirement for improvement across our clinical areas.

A review continues into the procurement of an additional element of the rostering software system to monitor safe staffing. This will provide services with real time information on staffing hot spots and will enable better planning for both short and longer term staffing.

Conclusion/Next Steps

Positive progress continues to be made in strengthening the approach the Trust is taking in relation to understanding the staffing position across the organisation. The recent workforce focussed discussions with services has further improved the level of understanding and the inter dependencies across some teams. However it is recognised that work needs to continue and the improvements made to date need to be sustained.

Concern remains regarding the ongoing challenges in both recruiting and retaining staff particularly across the mental health services and the continued reliance on temporary staffing to ensure safe staffing levels. The system introduced by the Chief Nurse has supported closer scrutiny of staffing levels and will support effective clinical decision making. A number of innovative approaches to recruitment are being trialled and their effectiveness will be monitored.

Based upon the data and information available it is difficult to evidence patient harm as a direct result of staffing levels. However, service managers remain diligent and are continuing to work with professional and workforce leads to focus on retaining staff with the necessary skills and competence to meet the increasingly complex patient needs as well as recruiting into current vacancies.

The work on agreeing the appropriate acuity and dependency tool for services will continue and it is hoped that a solution will be agreed over Q2 and will be complimented by the process for achieving professional sign off for establishments already in place.

Key Priorities for the next six months:

- To formally agree the implementation of the SafeCare module across the organisation and to facilitate greater scrutiny on a more frequent basis
- To develop, agree and implement the appropriate acuity and dependency tool for each area as part of the SafeCare implementation plan

Board Recommendation

The Board is asked to note this report and support the priorities identified

Appendix 1

Ward Name	Main two specialties	Dec-18 Day Fill Rate		Dec-18 Night Fill Rate		Jan-18 Day Fill Rate		Jan-18 Night Fill Rate		Feb-18 Day Fill Rate		Feb-18 Night Fill Rate	
	S1	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff
AMH Crisis Resolution	710 - ADULT MENTAL ILLNESS	78.6%	94.4%	100.0%	100.0%	76.2%	103.2%	103.2%	96.8%	93.2%	96.4%	100.0%	96.4%
AMH Oakdene	710 - ADULT MENTAL ILLNESS	103.5%	101.6%	100.0%	100.0%	114.7%	102.4%	100.0%	100.0%	77.9%	101.8%	100.0%	100.0%
AMH Orchards - Hawthorn	710 - ADULT MENTAL ILLNESS	96.8%	134.4%	100.0%	105.4%	93.5%	129.0%	96.8%	111.8%	99.1%	135.1%	98.2%	108.3%
AMH Orchards - Maples	710 - ADULT MENTAL ILLNESS	141.9%	107.3%	200.0%	147.3%	146.8%	117.7%	200.0%	168.8%	149.1%	108.9%	200.0%	160.7%
The Limes	715 - OLD AGE PSYCHIATRY	94.6%	100.8%	86.0%	116.1%	98.9%	103.8%	83.9%	112.1%	93.5%	103.0%	83.3%	112.5%
Jubilee House	315 - PALLIATIVE MEDICINE	94.0%	120.3%	77.4%	151.6%	100.0%	129.0%	86.0%	159.7%	110.1%	126.5%	92.1%	139.3%
Spinnaker	314 - REHABILITATION	96.1%	104.5%	101.6%	103.2%	95.5%	118.1%	100.0%	138.7%	91.4%	119.3%	100.0%	117.9%
Lower Brambles	314 - REHABILITATION	101.3%	112.9%	98.4%	98.4%	96.8%	112.9%	98.4%	101.6%	99.3%	110.2%	98.2%	142.9%
Fanshawe	314 - REHABILITATION	98.1%	104.8%	100.0%	100.0%	98.7%	110.8%	100.0%	100.0%	103.6%	101.2%	100.0%	98.2%
Snowdon Ward	314 - REHABILITATION	86.3%	123.2%	164.5%	111.3%	100.0%	112.9%	135.5%	100.0%	106.3%	122.1%	142.9%	91.1%
Kite	314 - REHABILITATION	104.0%	94.0%	100.0%	127.4%	111.3%	90.3%	100.0%	122.6%	102.7%	88.4%	100.0%	107.1%

Ward Name	Main two specialties	Mar-18 Day Fill Rate		Mar-18 Night Fill Rate		Apr-18 Day Fill Rate		Apr-18 Night Fill Rate		May-18 Day Fill Rate		May-18 Night Fill Rate	
	S1	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff
AMH Crisis Resolution	710 - ADULT MENTAL ILLNESS	84.9%	93.5%	100.0%	90.3%	82.3%	95.8%	103.3%	93.3%	83.7%	87.1%	100.0%	96.8%
AMH Oakdene	710 - ADULT MENTAL ILLNESS	77.4%	100.0%	109.7%	100.0%	74.0%	107.5%	123.3%	98.3%	76.8%	104.8%	109.7%	100.0%
AMH Orchards - Hawthorn	710 - ADULT MENTAL ILLNESS	93.5%	150.5%	98.4%	98.9%	94.2%	140.0%	111.7%	110.0%	103.2%	131.2%	108.1%	110.8%
AMH Orchards - Maples	710 - ADULT MENTAL ILLNESS	154.8%	111.7%	206.5%	160.2%	145.0%	120.4%	223.3%	170.0%	141.9%	115.7%	212.9%	161.3%
The Limes	715 - OLD AGE PSYCHIATRY	83.3%	108.3%	81.7%	115.3%	83.9%	117.2%	86.7%	140.8%	89.2%	105.6%	92.5%	112.9%
Jubilee House	315 - PALLIATIVE MEDICINE	102.8%	121.2%	84.9%	141.9%	110.0%	123.8%	100.0%	165.0%	116.6%	101.4%	78.5%	158.1%
Spinnaker	314 - REHABILITATION	91.6%	108.4%	98.4%	100.0%	93.3%	111.3%	95.0%	100.0%	97.4%	112.9%	100.0%	100.0%
Lower Brambles	314 - REHABILITATION	98.7%	111.5%	100.0%	137.1%	99.3%	108.1%	100.0%	101.7%	96.1%	111.5%	98.4%	101.6%

Fanshawe	314 - REHABILITATION	98.7%	102.2%	100.0%	98.4%	98.0%	102.2%	100.0%	98.3%	98.1%	100.5%	98.4%	100.0%
Snowdon Ward	314 - REHABILITATION	90.3%	136.1%	132.3%	88.7%	72.5%	135.3%	123.3%	118.3%	76.6%	136.8%	109.7%	101.6%
Kite	314 - REHABILITATION	100.8%	78.2%	100.0%	106.5%	101.7%	97.5%	100.0%	150.0%	106.5%	93.1%	100.0%	148.4%

Item 18.1

Exception and recommendation report

Committee /Subgroup name	Audit & Risk Committee	**Date of meeting**	30th July 2018
Chair	Jon Pittam, Non-Executive Director	**Report to**	Board

Key issues to be escalated

A verbal summary was shared at the May Board of the key items for approval by the Board following recommendation by the Committee, however a summary of the key business transacted at the meeting is as follows:

- The Director of Finance and Performance presented the draft Trust annual accounts and financial statements
- The Committee were updated on Breakeven Duty and noted a breach due to the accumulative deficit position.
- The Audit Results Report for the year ended 31st March 2018 was approved and external auditors briefed the Committee on the anticipated opinions being issues as unqualified Value for Money and unqualified financial statements. The Letter of Representation was also presented.
- The Committee noted the Internal Audit Annual Report including the Head of Internal Audit Opinion - and the Opinion as being 'Generally satisfactory with some improvements required'.
- The draft Annual Account and Quality Account were presented subject to amendments highlighted.
- The Committee were informed of a reduction in the level of fraud referrals nationally and of ongoing work to reduce fraud opportunities. The Annual Counter Fraud Plan was noted.
- Single tender waivers and losses and special payments were noted.
- The Benchmarking Annual Report for 2016/17 was shared and the Committee noted work to ensure improvements from lessons learnt.
- The Committee noted the Internal Audit Plan for 2018/19. Further areas for review were discussed.
- The Freedom to Speak up Report was shared and challenges associated with the balance between Trust processes and the use of guardians. Continued staff uncertainty with the process and confidentiality levels was also acknowledged.
- The Committee Annual Report was approved.
- Potential contentious issues were highlighted and it was agreed to update the Board when further information was available.
- An asset control report for missing laptops was shared. The importance of establishing clear governance procedures and ensure all lessons are learnt were noted.
- An update was provided on an unannounced visit to the Orchards Ward.
- The Committee were briefed on work in progress to improve quality issues and planning around clinical audit. The Clinical Audit Annual report was noted.

Decisions made at the meeting

-

Recommendations

Due to the timing of the May Audit Committee meeting, the Committee recommended the following for approval at the May 2018 Board;

- **The annual accounts**
- **The annual report**
- **The Annual Governance Statement**
- **The Quality Account**

Other risks to highlight (not previously mentioned)
There are no risks to highlight.

Item 18.2

NHS Solent NHS Trust

Audit & Risk Committee Annual Report 2017-18

Introduction

The Audit & Risk Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activities for the year to 31st March 2018.

Meetings

During 2017/18 the following meetings were held:

- 26th May 2017
- 3rd August 2017
- 9th November 2017
- 2nd February 2018

Membership & Attendance

Attendance by members is outlined as follows:

	Meeting				
NAME	26th May 2017	3rd August 2017	9th November 2017	2nd February 2018	**% attendance**
Jon Pittam- Chair Non Executive Director	P	P	P	P	100%
***Stephanie Elsy** Non Executive Director	n/a	n/a	P	P	100%
***Mike Watts** Non Executive Director	P	P	P	P	100%

P= Present A= Apologies

*Stephanie Elsy joined the Trust in September 2017
An additional private meeting was held in Feb 2018.

Terms of Reference

A minor amendment was made to the Committee Terms of Reference and approved via Chair's action and noted at the August 2017 meeting.

Status against the achievement of the Committee's Objectives

Objectives	End of year review status
To liaise with the Chair of the Finance Committee and Assurance Committee to seek assurance that proper budgetary and management accounting systems and procedures are in place and are being complied with.	*Ongoing*
To monitor the position in respect of the Trust's Break Even Duty (acknowledging the	*Update to be provided at May 2018 meeting following NHSI guidance*

need to understand the treatment of a deficit position for three consecutive years).	
To liaise with the Chair of the Assurance Committee to seek assurance that proper risk management procedures and monitoring are in place.	*Ongoing*
To ensure compliance with CQC recommendations following the inspection in June 2016, in relation to any internal control processes, in liaison with the Assurance Committee	*The committee received regular updates on reviews/CQC inspections/unannounced visits*
To ensure that the Internal and External Auditors continue to be fit for purpose.	*Comprehensive procurement exercises conducted for both Internal and External Auditors in according with national requirements*
To seek assurance that there are robust processes in place regarding Whistleblowing and the Trust is compliant with its policy	*An FTSU report was presented to the May 2017 meeting. An update report was circulated to members after the November 2017 meeting.*
To ensure compliance with any new requirements regarding Audit Panels and the appointment of auditors.	*Comprehensive procurement exercises conducted for both Internal and External Auditors in according with national requirements*

Summary of business conducted in year

The main business conducted by the Committee is summarised as follows;

Internal Audit

- Each Committee received a progress report on internal audits being undertaken for discussion and consideration.
- The May 2017 meeting noted the Internal Audit Annual Report and Head of Internal Audit Opinion.

The following final internal audit report for 2017/18 were presented as follows, as summarised within the Annual Governance Statement for 2017/18 :

Audit title	Opinion
Key financial systems	Low risk – Fixed Assets
	Low risk – Capital Expenditure
	Low risk – Cash
	Low risk – Budget Control
General Data Protection Regulations	Medium Risk
Information Governance Toolkit	Medium risk

Clinical Data Quality	Opinon tbc
Clinical Supervision	High Risk[1]
Review of the Assurance Committee	Medium Risk

Audit title	Opinion
Clinical Supervision (PWC)	*High risk*
Key Financial Systems (PWC)	*Low risk*
Information Governance Toolkit (PWC)	*Low risk*
General Data Protection Regulations (GDPR) (PWC)	*Medium risk*

External Audit

- The May 2017 Committee noted the external Audit Results Report for the year ending 31st March 2017.
- The May 2017 Committee received the Annual Audit Fee letter 2017/18 and noted there to be no changes to last year.
- A proposed unqualified Value for Money was report which was an improvement to the last 2 years, was noted. The Committee noted that a Section 30 had been issued to the Secretary of State due to having a cumulative deficit position over a 3 year period.
- The Committee received a costing assurance review for 16/17 and was informed of issues from a data quality perspective due to a change in data management systems causing the need for 2014/2015 data to be provided for the report. A resolution of issues identified and sign off at appropriate levels was confirmed.
- The Outline Audit Plan was noted at the November 2017 meeting.

Internal Control

- The Committee received regular updates on inspections/reviews and unannounced visits.
- The draft Quality Accounts were noted at the May 2017 meeting for onward approval of the Board.
- The Risk Management report was noted at the August 2017 meeting and it was agreed to review as business as usual through the Trust Annual Report. The final draft of the Risk Management Framework was shared at the February 2018 meeting for onward recommendation to the Board to approve.
- A six monthly review of the Clinical Audit Plan was presented at the May and November 2017 meetings.
- The Committee received an update on the impact of the NHS cyber-attack and future actions.

Financial Assurance

- Regular updates were provided on single tender actions and losses and special payments at each meeting.
- The draft Annual Accounts were presented to the 26th May 2017 meeting and it was agreed to present to the Board for approval.

[1] The audit identified the following recommendations: 1x high risk, 7 x medium risk, 1 x low risk and 1 x advisory point

- Confirmation was provided that the Trust remained a 'going concern' and was to be articulated within the Annual Report.
- The Committee received regular updates on the Trust's financial status.
- Work in progress to achieve more accurate reference costs information within community trusts was noted at the May 2017 meeting. An update was provided at the November 2017 meeting.
- Consideration was given to the publishing of Trust Accounts during the period of purdah and it was agreed to publish as planned Financial timetable and key NHS Improvement submission dates were reviewed at the February 2018 meeting.

Counter Fraud

- Progress reports were provided at each meeting.
- The Counter Fraud Annual Report was presented and noted at the May 2017 meeting. Changes to the format to include a combination of interim reports already presented throughout the year, were explained.
- The launch of the new NHS Counter Fraud Authority was received at the November 2017 meeting. The Trust's positive position in relation to the final NHS Protect Annual Report was noted.
- Delays in E-Learning staff training were discussed at the February 2018 meeting. An improvement in the 'amber measure' and recommencement of training at Trust induction was acknowledged.

Clinical Audit

- A six monthly review of the Clinical Audit Annual Plan was presented in May 2017 and it was noted that the Trust had participated in 100% of national audits.
- The November 2017 Committee received a Clinical Audit update including a briefing on the return on investment, shared learning and quality improvement outcomes as a result of audits conducted.

Specific Assurance Areas / Other items

- The Annual Audit Letter 2017/18 was noted at the May 2017 meeting.
- The draft Annual Report including the Annual Governance Statement was shared at the May 2017 meeting for onward recommendation of Board approval.

A private meeting was held with internal and external auditors on 8th February 2018.

Exception reports of Committees were presented to the Board following each meeting.

Objectives for 2018-19

- To liaise with the Chair of the Finance Committee and Assurance Committee to seek assurance that proper budgetary and management accounting systems and procedures are in place and are being complied with
- To monitor the position in respect of the Trust's Break Even Duty (acknowledging the need to understand the treatment of a deficit position for three consecutive years).
- To liaise with the Chair of the Assurance Committee to seek assurance that proper risk management procedures and monitoring are in place and notably to conduct a deep dive review to seek assurance that the recommendations identified by the Internal Auditors concerning Risk Management have been addressed and are being embedded.
- To be kept appraised of risks associated with partnership working

• To continue to ensure that the Internal and External Auditors continue to be fit for purpose. • To seek assurance that there are robust processes in place regarding Freedom to Speak Up / Whistleblowing and the Trust is compliant with its policy • To ensure compliance with any new requirements regarding Audit Panels and the appointment of auditors.
Conclusion
The Committee has complied with its Terms of Reference during the period under review.

Report Author(s)	Jon Pittam, Non-Executive Director and Audit Committee Chair Jayne Edwards, Corporate Support Manager, Assistant Company Secretary

Item 18.2

NHS Solent NHS Trust

Audit & Risk Committee Annual Report 2017-18

Introduction

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***Mike Watts** Non Executive Director	P	P	P	P	100%

P= Present A= Apologies

*Stephanie Elsy joined the Trust in September 2017
An additional private meeting was held in Feb 2018.

Terms of Reference

A minor amendment was made to the Committee Terms of Reference and approved via Chair's action and noted at the August 2017 meeting.

Status against the achievement of the Committee's Objectives

Objectives	End of year review status
To liaise with the Chair of the Finance Committee and Assurance Committee to seek assurance that proper budgetary and management accounting systems and procedures are in place and are being complied with.	*Ongoing*
To monitor the position in respect of the Trust's Break Even Duty (acknowledging the	*Update to be provided at May 2018 meeting following NHSI guidance*

need to understand the treatment of a deficit position for three consecutive years).	
To liaise with the Chair of the Assurance Committee to seek assurance that proper risk management procedures and monitoring are in place.	*Ongoing*
To ensure compliance with CQC recommendations following the inspection in June 2016, in relation to any internal control processes, in liaison with the Assurance Committee	*The committee received regular updates on reviews/CQC inspections/unannounced visits*
To ensure that the Internal and External Auditors continue to be fit for purpose.	*Comprehensive procurement exercises conducted for both Internal and External Auditors in according with national requirements*
To seek assurance that there are robust processes in place regarding Whistleblowing and the Trust is compliant with its policy	*An FTSU report was presented to the May 2017 meeting. An update report was circulated to members after the November 2017 meeting.*
To ensure compliance with any new requirements regarding Audit Panels and the appointment of auditors.	*Comprehensive procurement exercises conducted for both Internal and External Auditors in according with national requirements*

Summary of business conducted in year

The main business conducted by the Committee is summarised as follows;

Internal Audit

- Each Committee received a progress report on internal audits being undertaken for discussion and consideration.
- The May 2017 meeting noted the Internal Audit Annual Report and Head of Internal Audit Opinion.

The following final internal audit report for 2017/18 were presented as follows, as summarised within the Annual Governance Statement for 2017/18 :

Audit title	Opinion
Key financial systems	Low risk – Fixed Assets
	Low risk – Capital Expenditure
	Low risk – Cash
	Low risk – Budget Control
General Data Protection Regulations	Medium Risk
Information Governance Toolkit	Medium risk

Clinical Data Quality	Opinon tbc
Clinical Supervision	High Risk[1]
Review of the Assurance Committee	Medium Risk

Audit title	Opinion
Clinical Supervision (PWC)	*High risk*
Key Financial Systems (PWC)	*Low risk*
Information Governance Toolkit (PWC)	*Low risk*
General Data Protection Regulations (GDPR) (PWC)	*Medium risk*

External Audit

- The May 2017 Committee noted the external Audit Results Report for the year ending 31st March 2017.
- The May 2017 Committee received the Annual Audit Fee letter 2017/18 and noted there to be no changes to last year.
- A proposed unqualified Value for Money was report which was an improvement to the last 2 years, was noted. The Committee noted that a Section 30 had been issued to the Secretary of State due to having a cumulative deficit position over a 3 year period.
- The Committee received a costing assurance review for 16/17 and was informed of issues from a data quality perspective due to a change in data management systems causing the need for 2014/2015 data to be provided for the report. A resolution of issues identified and sign off at appropriate levels was confirmed.
- The Outline Audit Plan was noted at the November 2017 meeting.

Internal Control

- The Committee received regular updates on inspections/reviews and unannounced visits.
- The draft Quality Accounts were noted at the May 2017 meeting for onward approval of the Board.
- The Risk Management report was noted at the August 2017 meeting and it was agreed to review as business as usual through the Trust Annual Report. The final draft of the Risk Management Framework was shared at the February 2018 meeting for onward recommendation to the Board to approve.
- A six monthly review of the Clinical Audit Plan was presented at the May and November 2017 meetings.
- The Committee received an update on the impact of the NHS cyber-attack and future actions.

Financial Assurance

- Regular updates were provided on single tender actions and losses and special payments at each meeting.
- The draft Annual Accounts were presented to the 26th May 2017 meeting and it was agreed to present to the Board for approval.

[1] The audit identified the following recommendations: 1x high risk, 7 x medium risk, 1 x low risk and 1 x advisory point

- Confirmation was provided that the Trust remained a 'going concern' and was to be articulated within the Annual Report.
- The Committee received regular updates on the Trust's financial status.
- Work in progress to achieve more accurate reference costs information within community trusts was noted at the May 2017 meeting. An update was provided at the November 2017 meeting.
- Consideration was given to the publishing of Trust Accounts during the period of purdah and it was agreed to publish as planned Financial timetable and key NHS Improvement submission dates were reviewed at the February 2018 meeting.

Counter Fraud

- Progress reports were provided at each meeting.
- The Counter Fraud Annual Report was presented and noted at the May 2017 meeting. Changes to the format to include a combination of interim reports already presented throughout the year, were explained.
- The launch of the new NHS Counter Fraud Authority was received at the November 2017 meeting. The Trust's positive position in relation to the final NHS Protect Annual Report was noted.
- Delays in E-Learning staff training were discussed at the February 2018 meeting. An improvement in the 'amber measure' and recommencement of training at Trust induction was acknowledged.

Clinical Audit

- A six monthly review of the Clinical Audit Annual Plan was presented in May 2017 and it was noted that the Trust had participated in 100% of national audits.
- The November 2017 Committee received a Clinical Audit update including a briefing on the return on investment, shared learning and quality improvement outcomes as a result of audits conducted.

Specific Assurance Areas / Other items

- The Annual Audit Letter 2017/18 was noted at the May 2017 meeting.
- The draft Annual Report including the Annual Governance Statement was shared at the May 2017 meeting for onward recommendation of Board approval.

A private meeting was held with internal and external auditors on 8th February 2018.

Exception reports of Committees were presented to the Board following each meeting.

Objectives for 2018-19

- To liaise with the Chair of the Finance Committee and Assurance Committee to seek assurance that proper budgetary and management accounting systems and procedures are in place and are being complied with
- To monitor the position in respect of the Trust's Break Even Duty (acknowledging the need to understand the treatment of a deficit position for three consecutive years).
- To liaise with the Chair of the Assurance Committee to seek assurance that proper risk management procedures and monitoring are in place and notably to conduct a deep dive review to seek assurance that the recommendations identified by the Internal Auditors concerning Risk Management have been addressed and are being embedded.
- To be kept appraised of risks associated with partnership working

• To continue to ensure that the Internal and External Auditors continue to be fit for purpose. • To seek assurance that there are robust processes in place regarding Freedom to Speak Up / Whistleblowing and the Trust is compliant with its policy • To ensure compliance with any new requirements regarding Audit Panels and the appointment of auditors.
Conclusion
The Committee has complied with its Terms of Reference during the period under review.

Report Author(s)	Jon Pittam, Non-Executive Director and Audit Committee Chair Jayne Edwards, Corporate Support Manager, Assistant Company Secretary

Item 18.3

AUDIT & RISK COMMITTEE
TERMS OF REFERENCE

Reference to "the Committee" shall mean the Audit & Risk Committee.
Reference to "the Board" shall mean the Trust Board

1. Constitution

1.1 Solent NHS Trust Board hereby resolves to establish a committee of the Board to be known as the Audit & Risk Committee ('the Committee'). The Committee is a non executive Committee of the Board and has no executive powers, other than those specifically delegated by the Board in these Terms of Reference which are incorporated within the Trust's Standing Orders.

1.2 The Terms of Reference reflect the particular nature of Audit Committees in the NHS and the role of the Committee in developing integrated governance arrangements and providing assurance that NHS bodies are well managed across the whole range of their activities.

2. Purpose

2.1 The Committee is responsible for assuring the Board on matters concerning: governance (including financial governance, corporate governance and clinical audit): risk management; and internal control, seeking assurance from internal and external audit and counter fraud.

3 Duties

3.1 The duties of the Committee can be categorised as follows:

3.2 Governance, Risk Management and Internal Control

3.2.1 The Committee will seek assurance that the Trust's activities are efficient, effective and represent value for money

3.2.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

3.2.3 In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and will review processes to ensure continued compliance with the Care Quality Commission), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including ensuring effective use of the Board Assurance Framework) and the appropriateness of the above disclosure statements.

- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud (NHS Protect) and Security Management Service

- the Trust's Quality Accounts

3.2.4 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.2.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.2.6 To formally review, on a quarterly basis, contentious issues as escalated by the Executive Team.

3.3 Internal Audit

3.3.1 The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework.

- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise the use of audit resources.

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

- monitoring the effectiveness of internal audit and carrying out an annual review

- ensuring the periodic re-tendering of the internal audit function

3.4 External Audit

3.4.1 The Committee shall review and monitor the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment, cost and performance of the External Auditor, as far as the rules governing the appointment process permit.

- discussion with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.4.2 In accordance with the Local Audit and Accountability Act 2014, the Committee shall establish an 'Auditor Panel' to advise on the appointment of external auditors (membership of the panel will be approved by the Board). The Panel shall recommend the appointment of external auditors to the Board.

3.4.3 To ensure objectivity and independence, the Committee will agree acceptable thresholds and safeguards for non-audit services conducted by the external auditors. Any such work will be disclosed within the Annual Report. Auditors are expected to identify to the Committee principal conflicts of interest that may be reasonably considered to affect objectivity and independence.

3.5 Other Assurance Functions

3.5.1 The Audit & Risk Committee shall review the findings of other significant assurance reviews, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g NHS Improvement, CQC, NHS ~~Litigation Authority~~Resolution etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

3.5.3 In reviewing the work of the below listed committees, and issues around clinical risk management, the Audit & Risk Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

3.5.4 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. The Committee may request that the Chairs of the following Board committees attend to provide exception reports;

Committees include:

- Governance & Nominations Committee
- Remuneration Committee
- Assurance Committee
- Finance Committee
- Mental Health Act Scrutiny Committee
- Charitable Funds Committee
- People and OD Committee

3.5.5 The Audit & Risk Committee will also scrutinise the annual governance review of the Board Committees conducted by the Governance & Nominations Committee, satisfying itself that committees are appropriately constituted and functioning in accordance with their Terms of Reference.

2.5.6 The Committee will also annually review the accounting policies of the Trust and make appropriate recommendations to the Board.

3.6 Counter Fraud

3.6.1 The Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.7 Management

3.7.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.7.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as may be appropriate to the overall arrangements.

3.8 Financial Reporting

3.8.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

3.8.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.8.3 The Committee shall review the annual report/accounts and financial statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted miss-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- qualitative aspects of financial reporting
- reported losses and compensation

3.8.5 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.9 Whistleblowing /Freedom to Speak Up

3.9.1 The committee shall review the effectiveness of the Trust's arrangements for its employees to raise concerns, in confidence, about possible improprieties in financial, clinical or safety matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

4 Membership

4.1 The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members at least one of whom shall have recent and relevant financial experience. One of the members will be appointed Chair of the Committee by the Trust Board

4.2 The Chairman of the Trust Board shall not be a member of the committee.

4.3 In the absence of the Committee Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5 Quorum

5.1 The quorum necessary for the transaction of business shall be 2 members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

6. Attendance

6.1 The Director of Finance and Performance (DoF) and appropriate representatives from External and Internal Audit will normally attend every meeting.

the external auditor shall be afforded the opportunity at least once per year to meet with the Audit & Risk Committee without executive directors present.

the Committee members shall be afforded the opportunity to meet at least once per year with no others present, at their request.

6.2 The Chief Executive shall be invited to attend all meetings (except when the Committee is meeting in private).

6.3 The local Counter Fraud (CF) representative will be invited to attend Committee meetings whenever necessary to report on CF issues. Alternatively the local CF representative may brief the DoF who will provide a report on CF issues.

6.4 The Chief Nurse or ~~Medical Director~~Chief Medical Officer will be required to attend any meeting where clinical assurance is required, whilst other Executive Directors or senior managers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

6.5 The Company Secretary, or their nominee shall attend all meetings.

7 Access

7.1 The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

8. Frequency

8.1 The Committee shall meet at least on a quarterly basis at appropriate times in the reporting and audit cycle and otherwise as required.

8.2 The Committee will meet in private with External and Internal Audit representatives without any member of the Executive present on at least one occasion each year.

8.3 The Accountable Officer, external auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

9. Authority

9.1 The Committee is authorised:

- to investigate any activity within its terms of reference

- to seek any information it requires from any employee of the Trust in order to perform its duties and all employees are directed to cooperate with any requests made by the Committee

- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and

- to call any employee to be questioned at a meeting of the Committee as and when required.

- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

10. Secretary

10.1 The Corporate Support Manager & Assistant Company Secretary or their nominee shall act as the secretary of the committee and will provide administrative support and advice**.** The duties of the secretary in this regard include but are not limited to:

- agreement of the agenda with the Chair of the Committee and attendees together with the collation of connected papers

- taking the minutes and keeping a record of matters arising and issues to be carried forward

- advising the Committee as appropriate

10.2 The agenda and any working papers shall be circulated to members five working days before the date of the meeting. No papers will be accepted after the original documentation is circulated – except with the express consent of the Chair.

11. Minutes of meetings

11.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

11.2 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly**.**

11.3 Minutes of Committee meetings shall be circulated promptly to all members of the Committee once agreed.

12. Reporting responsibilities

12.1 The Committee Chair shall submit an escalation report to the ~~minutes of all meetings of the Audit & Risk Committee shall be formally recorded and submitted~~Board, together with recommendations where appropriate~~ to the Board~~.The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the Board, or require executive action.

12.2 The Committee will recommend to the Board the approval of the Accounts and Quality Accounts.

12.3 The Audit & Risk Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to:

- providing an objective opinion to the Board on the performance of all of the Board Committees (and as included within the Annual Report)

- functions undertaken in connection with the statement of internal control

- the assurance framework
- the effectiveness of risk management within the Trust
- the holistic nature of governance arrangements and
- any pertinent matters in respect of which the Audit & Risk Committee has been engaged

12.4 The Committee shall make necessary recommendations to the Board on areas relating to the appointment, re-appointment and removal of auditors, the level of remuneration and terms of engagement as it deems appropriate.

12.5 The Trust's ~~annual~~ Annual R~~r~~eport shall include a section describing the work of the Audit & Risk Committee in discharging its responsibilities and the Committee's Terms of Reference will be made publicly available. The ~~annual~~ Annual ~~report~~ Report should explain to members:

- how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded
- details of the full external auditor appointment process
- where the Board decides not to accept the recommendations of the Committee with regard to the appointment of an auditor, a statement of the reasons
- where the auditor's contract is terminated in disputed circumstances, the removal process and the underlying reasons for that action.

12.6 Members attendance at Committee meetings will be disclosed in the Trust's Annual Report.

Version	~~16~~17
Agreed at Audit & Risk Committee	Date: ~~Agreed by Chairs action 27th May 2017~~May 2018
Date of Next Review	Date: May ~~2018~~ 2019

Item 19.1

Exception and recommendation report

Committee /Subgroup name	**Assurance committee**	**Dates of meeting**	19th June & 17th July 2018
Chair	**Mick Tutt**	**Report to**	Trust Board

Key issues to be escalated

We received the following:-

- **Freedom to Speak Up quarterly report** – where no new concerns of note were raised, but receipt of the recent NHSI/National Guardian's Office Guidance was noted and it was confirmed that any revision to the current operation would be considered by the Audit & Risk committee
- **Specialist & Associate Specialist Doctors Annual report** * – which highlighted the increasing difficulties in recruitment. We were also informed of changes to funding mechanisms and a continuation of the programme of education for SAS doctors, despite existing uncertainties
- an **up-date on the work of Solent Recovery College** – where we noted:-
  - concern regarding future siting of the college
  - the recent visit from colleagues from the national Mental Health Network
  - the forthcoming national ImpleMenting Recovery through organisational Change conference
- an **up-date on CQC processes**, in the context of a notification of a forthcoming (Well-Led) Inspection. It was suggested that time be set aside during August to ensure all Board members, and colleagues in partner organisations, were appraised of the current understanding of compliance with CQC expectation
- **Learning from Serious Incidents Requiring Investigation** quarterly report – which set out a schedule of service change, as a consequence of learning. It was also confirmed that not all Investigations were being completed within the anticipated timeframe – but assured that this was because of the complexity of the cases involved
- **Learning from Deaths** quarterly report * – which, again, set out a schedule of service change, as a consequence of learning. We also heard of partnership-working, in Southampton; which enabled Solent, including its Primary Care practitioners, to review deaths with colleagues from University Hospitals, Southampton. We asked those working in the Portsmouth system to consider the potential for similar developments there
- an **up-date on revisions to the Clinical supervision process** – which had flowed from the Internal Audit report at the end of 2017. Progress was noted and we agreed to receive a further up-date before the end of the calendar year
- **Safeguarding Annual report *** – where compliance with training expectations was a key concern. There was also a request from Southampton CCG to have more detail regarding Looked After Children in the city
- **Infection, Prevention & Control Annual report *** – where we noted the achievements of this small team of specialist practitioners, who worked across Solent and Portsmouth CCG
- a **review of Quality Impact Assessment** (QIA) **processes** – which we confirmed would be a regular reporting item from now on and would enable comprehensive understanding of the process for agreeing service change; those proposals for

change which required further consideration; the process for when one than one partner organisation was involved in a change and a process for periodic retrospective review of QIAs approved

- **exception reports from the Quality Improvement & Risk group and Chief Operating Officers** – which included
  - up-dates following the recent Serious Incidents at the Orchards, involving the partial closure of one ward (Maples)
  - confirmation of a 'demand-and-capacity' analysis undertaken by PWC, which had identified requirements to achieve 92% occupancy in Portsmouth Hospital. It was agreed that final work proposals to reduce the number of Solent people were to be shared
- **up-dated versions of the Board Assurance Framework** – which will be reflected in Board papers today
  assurance regarding the **processes for addressing NHSI Patient Safety Alerts and Never events** – where no 'never-events' have been notified and confirmation of systems and processes in place for tracking and sign-off was received
- notification of **consideration for joint posts between CCGs and Solent** – building on the joint posts in the IPC team and the Portsmouth & South East Hants system. We received this as a positive development around greater system-working

*reports appearing as part of the overall Board pack

Decisions made at the meeting

It was agreed that

- Executive Directors be asked to review the processes in place to ensure that the Trust reflect the cultural and ethnic diversity of the people who access our services, in all aspects of business
- Policies to note

Ratified at the July meeting (following the June Policy Steering Group):

- IPC10 Policy for the prevention and control of Clostridium Difficile Infection (CDI)
- IPC04 Sharps and Contamination Policy
- OH02 Managing Stress at Work Policy (subject to amendment of scope wording)
- OH12 Health Surveillance Policy

Noted chairs action for the following:

- GO11 Business Continuity Policy

Noted policy extension on the following:

- AP02 Domestic Abuse Policy – extended to September 2018
- IPC12 Decontamination Policy – extended to April 2019

Ratified at the June meeting (following May PSG):

- IPC01 Infection Prevention and Control Framework
- CLS09 Deteriorating Patient and Resuscitation Policy
- Locked Door Policy

(following April PSG):

- IPC10 Policy for Aseptic Technique and Aseptic Non Touch Technique

Noted chairs action to:

- Included appendix to the Medical Appraisal and Revalidation Policy outlining detail concerning Job Planning - the details agreed via the LNC and DDNC.

Noted policy extension on the following: • HR51 Managing Absence and Wellbeing Policy
Recommendations to the Trust Board
The Board are asked to ➢ **note the issues set out above and policies**
Other risks to highlight (not previously mentioned)
None of note

Exception and recommendation report

Item 24.1

NHS Solent NHS Trust

Committee /Subgroup name	Governance and Nominations Committee	**Date of meeting**	19th July 2018
Chair	Alistair Stokes, Chairman	**Report to**	Board

Key issues to be escalated

No issues to be escalated.

Decisions made at the meeting

- The Committee reviewed the Terms of Reference as part of the annual review – non amendments were required.
- The Committee approved the annual report for 2017-18 noting progress made against objectives. Objectives for the year ahead were agreed.
- The Committee reviewed the Board Assurance Framework (BAF) entry concerning Executive Team Capacity #62 and acknowledged the mitigations in place, including succession planning which was presented separately
- The Committee considered the composition, size, balance of skills/knowledge and experience of the Board and its respective committee's membership – in particularly the NED membership of each Committee and in light of the recent PWC Internal Audit concerning the Assurance Committee where a recommendation was made in relation to reconsidering NED membership. It was agreed that the exec sponsorship of the Mental Health Scrutiny Committee be amended to the Chief Medical Officer as opposed to the Chief Operating Officer Portsmouth due to the changes to the COO's wider system role and potential challenges associated with availability to attend future meetings.
- Chairs action was taken outside of the meeting to reappoint Mick Tutt into the role of Deputy Chair and Jon Pittam into the role of Senior Independent Director.
- The emerging governance associated with system developments was acknowledged.
- The Committee reconsidered the timing of commissioning and completing a 'Developmental review of leadership and governance using the Well-Led Framework' as per the publication by NHS Improvement in June 2017. It was agreed that the Trust consider completing this during Q4 2018-19 with a view to reporting the results in early 2019-20.
- A paper was presented summarising succession planning arrangements – it was agreed that this be reconsidered at an additional Committee scheduled for late September to further consider talent management as well as succession planning for the position of Trust Chair. The Non-Executive Director (NED) tenure log was received.

Recommendations to the Board

The Committee recommend that the Board:

- approve the Terms of Reference (presented separately)
- note the Committee annual report for 2017-18 (presented separately)
- via Chairs action, to approve the reappointment of Mick Tutt to the role of Deputy Chair and Jon Pittam to the role of Senior Independent Director.

Other risks to highlight (not previously mentioned)

No risks to raise

Item 24.2

Solent NHS Trust

Governance & Nominations Committee Terms of Reference

Reference to "the Committee" shall mean the Governance & Nominations Committee
Reference to "the Board" shall mean the Trust Board

1. Constitution

1.1 Solent NHS Trust Board resolves to establish a Committee of the Board to be known as the Governance & Nominations Committee (the Committee).

1.2 As a Committee of the Board, the Standing Orders of the Trust shall apply to the conduct of the working of the Committee.

2. Purpose

2.1 The Committee make recommendations to the Trust Board as appropriate (and informing the Council of Governors once established) regarding the following matters; the governance arrangements for the Trust including Committee structure, the composition and Terms of Reference, nominations to the Boards Committees and key roles, and succession planning.

3. Duties

3.1 The Committee will:

- review recruitment documentation including job descriptions for Board members, including non-executive directors and the wider executive team.

- consider and keep under review governance arrangements for the Trust including Committee structure, membership and Terms of Reference, making proposals and recommendations to Trust Board as appropriate

- consider the candidates for appointment as Associate Hospital Managers identified by the Mental Health Act Scrutiny Committee and recommend candidates to the Board.

- be mindful of the role of the Audit & Risk Committee in providing assurance to the Board regarding the effectiveness of governance arrangements.

3.2 The duties of the Committee can be categorised as follows:

3.2.1 regularly review the structure, size and composition of the Board, evaluate the balance of skills, knowledge and experience and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment of both Executive and Non Executive Directors, including the Chairman and make recommendations with regard to any changes.

3.2.2 support the identification and nomination of suitable candidates to fill Executive Director vacancies as they arise, as required, to make recommendations to the Chairman, the other Non-Executives and, except in the case of the appointment of a Chief Executive, the Chief Executive, who are then responsible for making the decision on the appointment of Executive Directors.

In support of identifying suitable candidates the Committee shall ensure that there is a formal, rigorous and transparent procedure for the appointment of new Non Executive and Executive Directors to the Board which fits the criteria set out by the Committee, namely;

- use open advertising and consider also the services of external advisers to facilitate the search;
- consider candidates from a wide range of backgrounds; and
- consider candidates on merit and against objective criteria, taking care that appointees have enough time available to devote to the position;

The Committee is responsible for identifying and nominating a candidate, for approval by the Board, to fill the position of Chief Executive.

3.2.3 to give full consideration to succession planning in respect of Non Executive, Chief Executive & Executive Directors, taking into account the challenges and opportunities facing the Trust, and the skills and expertise required on the Board.

3.2.4 keep under review the leadership needs of the Trust, both Executive and Non-Executive, with a view to ensuring the continued ability of the Trust to compete effectively in the marketplace;

3.2.5 review regularly the time commitment required from Non Executive Directors. Performance evaluation should be used to assess whether the Non Executive Directors are spending enough time to fulfil their duties; and

3.2.6 ensure that on appointment to the Board, Non-Executive Directors receive the appropriate documentation and a formal letter of appointment from NHS Improvement and the Trust setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside board meetings.

3.2.7 The Committee shall also make decisions and advise the Board accordingly concerning:

- formulating plans for succession for both Executive and Non Executive Directors and in particular for the key roles of Chairman and Chief Executive;

- suitable candidates for the roles of Senior Independent Director and Deputy Chair;

- the re-appointment of any Director having due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required.

- any matters relating to the continuation in office of any Director at any time including the suspension or termination of service of an Executive Director as an employee of the Trust subject to the provisions of the law and their service contract.

4. Membership

4.1 Members of the Committee shall be appointed by the Board and shall comprise;

- Chairman
- Chief Executive
- Chair of Audit & Risk Committee (Non Executive Director)
- Chair of Assurance Committee (Non Executive Director)

4.2 The Chief Executive will not be present when the Committee is considering the succession or appointment of the Chief Executive.

4.3 The Board shall appoint a Committee Chairman who should be either the Chairman of the Board or an independent Non Executive Director. In the absence of the Committee

Chairman and/or an appointed deputy, the remaining members present shall elect one of the remaining Non Executive Directors to chair the meeting.

4.4 When dealing with the matter of succession to the Chairmanship, the Chairman of the Board shall not chair the Committee and will be present only by invitation.

4.5 Membership of the Committee shall be reviewed annually.

5. Attendance

5.1 Only members of the Committee have the right to attend Committee meetings. However, other individuals such as the Chief People Officer, and external advisers may be invited to attend for all or part of any meeting, as and when appropriate.

5.2 The Associate Director of Corporate Affairs and Company Secretary shall be invited to attend every meeting.

6. Quorum

6.1 The quorum necessary for the transaction of business shall be 2; one Non-Executive Director and one Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. Frequency of meetings

7.1 The Committee will meet as often as necessary to manage the process for the identification and recommendation of appointment of Non Executive and Executive Directors of the Board.

8. Secretary

7.1 The Associate Director of Corporate Affairs and Company Secretary or their nominee shall act as the Secretary of the Committee.

9. Notice of Meetings

9.1 Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chairman of the Committee.

9.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend and all other non-Executive Directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10 Minutes of Meetings

10.1. The Secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

10.2. Minutes of Committee meetings shall be circulated promptly to all members of the Committee and the Chairman of the Board and, once agreed, to all other members of the Board, unless a conflict of interest exists.

11. Annual General Meeting

11.1. The Chairman of the Committee shall attend the Annual General Meeting prepared to respond to any stakeholder questions on the Committee's activities.

12. Authority

12.1 The Committee is authorised by the Board to investigate any activity within its terms of reference.

12.2 The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Any decisions of the Committee shall be taken on a majority basis. The Chairperson shall have a casting vote in the event of equality of voting.

12.3 It is for the Non Executive Directors to appoint and remove the Chief Executive.

12.4 The appointment of the Chief Executive requires the approval of the Board

13. Reporting

13.1 The Committee reports to the Board.

13.2 The Committee Chairman shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

13.3 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

13.4 The Committee shall make a statement in the Annual report about its activities, the process used to make appointments and explain if external advice or open advertising has not been used.

13.5 The Committee should make available its Terms of Reference, explaining its role and the authority delegated to it by the Board.

14. Other

14.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

14.2 The terms and conditions of appointment of Non Executive Directors will be made available for inspection on request.

14.3 The Non-Executive Directors will be required to disclose to the Board before appointment, their other significant commitments, with a broad indication of the time involved.

14.4 Members attendance at Committee meetings will be disclosed in the Trust's Annual Report.

Version	7 (July 2018)
Date of Next Review	Date: July 2019

Item 24.3

NHS Solent NHS Trust

Governance & Nominations Committee Annual Report 2017-18

Introduction

The Governance & Nominations Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2018.

Meetings

During 2017-18 the following meetings were held:

- 20th July 2017
- 5th February 2018

Membership & Attendance

Attendance by members is outlined as follows:

	Meeting		
NAME	**20th July 2017**	**5th February 2018**	**% attendance**
Dr. Alistair Stokes – Chair Chairman	A	A	0%
Mick Tutt Non Executive Director	P	A	50%
Sue Harriman Chief Executive	P	P	100%
Jon Pittam Non Executive Director	P	P	100%

P= Present A= Apologies

Terms of Reference

The terms of reference for the Committee were reviewed in July 2017 and agreed at the September 2018 Board.

Status against the achievement of the Committee's Objectives

Objectives	End of Year status
To review non-executive membership of Board Committees upon appointment recommending changes to the Board as appropriate	*Committee membership was considered at the February 2018 meeting to ensure skills are being used effectively. NED attendance and chairing responsibilities of committees were agreed. NED rotational oversight of additional meetings was also considered.*
To review executive portfolios upon new appointments /resignations to ensure appropriate coverage, succession planning and management of director remits	*The Committee received executive portfolios at the February 2018 meeting.*
To consider governance arrangements in light of future organisational changes and the emerging Health and Social Care environment	*The committee was briefed on an internal governance review to enhance arrangements between service line and corporate functions.*
Undertake a comprehensive review of board	*Outputs of the Board Appraisal Analysis were shared at the February meeting. Proposed potential*

effectiveness taking into account the requirements of the Well Led Framework.	*administrative/structural changes were agreed for sharing with the April Board Seminar.*

Summary of business conducted in year

The main business conducted by the Committee is summarised as follows;

July 2017

- Governor Michael North attended the July meeting and shared his and the opinion of fellow governors on the outcomes of the recent Governor Working Group to consider the future governor role.
- Governor attendance at Confidential Board was considered and it was agreed that a written summary would continue to be provided, with the opportunity to view minutes by appointment.
- Governor tenure duration was discussed and the need to be effective in gaining membership interest at the point of tenure renewal and consider how to conduct formal appointments was highlighted.
- The committee annual report was presented and the objectives for 2017-18 were agreed.
- NED attendance and chairing of committees was reviewed and agreed.
- A Well Led Framework update was provided and a proposed timeframe for the completion of self-assessments was noted.
- The committee was briefed on an internal governance review conducted and of a workshop held with clinical leaders to review the purpose of the People and OD Group.
- It was agreed to re-appoint existing Associate Hospital Managers for a further period of 3 years (until 2020).
- The NED tenure log was shared. The need to include future tenure expiries into the Board succession planning considerations was agreed.
- Amendments to the committee terms of reference were considered.

February 2018

- The February 2018 committee considered and noted the mid-year review of objectives.
- Up to date NED membership to Board committees, NED lead roles and executive portfolios were noted.
- Output of the Board appraisal analysis was shared and areas for improvement were discussed.
- The Fit and Proper Persons Test Standard Operating Procedure (SOP) was shared following amendments made to include up to date CQC guidance. The committee agreed to incorporate the wording within the Trust's Standing Orders.
- Amendments to the Mental Health Act Scrutiny Committee Terms of Reference were highlighted.
- NED and Chair tenure was discussed and it was agreed to hold an additional meeting in September 2018 to specifically consider this in more detail.

The business of the Committee was presented to each subsequent Board.

Objectives for 2018-19

- To review non-executive membership of Board Committees upon appointment recommending changes to the Board as appropriate
- To support the drafting of the role profile and person specification for the appointment process of a new Chair
- To review executive portfolios upon new appointments /resignations to ensure appropriate

coverage, succession planning and management of director remits. • To consider governance arrangements in light of future organisational changes and the emerging Health and Social Care environment • Undertake a comprehensive review of board effectiveness taking into account the requirements of the Well Led Framework.
Conclusion
The Committee has complied with its Terms of Reference during the period under review.

Report Author(s)	Dr. Alistair Stokes, Chairman and Governance & Nominations Committee Chair Jayne Jenney, Corporate Support Manager and Assistant Company Secretary