Agenda
Solent NHS Trust In Public Board Meeting

Monday 24th September 2018 09:30am – 13:30pm
Kestrel 1&2, 2nd Floor, Highpoint Venue, Southampton, Hampshire, SO19 8BR

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 – Hydrotherapy and Rheumatology Service** *To receive*	Chief Nurse	W7
3	09:55	20mins	**Staff Story –Community Emergency Discharge Team (CEDT)** *To receive*	Chief People Officer /Chief Nurse	W1-8
4	10:15	10mins	**Board reflection on patient story and staff story and discussion**	Chairman	W7
5	10:25	5 mins	***Minutes of Last Meeting and action tracker** *To agree*	Chairman	-
6			**Register of Interests & Declaration of Interests** *To receive*	Chairman	-
7	10:30	5mins	**Matters Arising**	Chairman	-
8	10:35	5mins	**Any Other Business**	Chairman	-
9	10:40	10mins	**Safety and Quality First and Feedback from Board to Floor Visits** *To receive*	Chief Executive / Chief Nurse	W3

Strategy & Vision					
10	10:50	30mins	**Chief Executive's Report -** *to receive* **To include:** • **Hampshire & Isle of Wight Sustainability & Transformation Partnership (STP) System Reform Proposal -** *to agree*	Chief Executive	W1-W8
11	11:20	5mins	**Portsmouth & South East Hampshire Operating Plan 2018/19** *To receive*	Director of System Delivery	W2
12	11:25	30mins	**Performance Report** - including • Business Plan Qtr 1 Report • Operational Performance • Quality Performance • Financial Performance • Workforce Performance • NHSI Single Oversight Framework *To receive*	Executive Leads	W5, W6
13	11:55	10mins	**Quality Framework** *To approve*	Chief Nurse and Chief Medical Officer	W6,W6
14	12:05	10mins	**A Framework of Quality Assurance for Responsible Officers and Revalidation, Annual Board Report and Statement of Compliance** *To receive and agree*	Chief Medical Officer	W1 W4, W6
15	12:15	10mins	**Freedom to Speak Up Assessment** *To agree*	Lead FTSU Guardian / Chief Nurse	W7,W8
***Reporting Committees and Governance matters**					
16	12:25	5mins	**NHS Constitution Compliance** *To receive*	Associate Director of Corporate Affairs	W4
17	12:30	5mins	***Audit & Risk Committee** *To receive exception report from August meeting including:* • *Risk Management Deep Dive Report*	Committee Chair	W5
18	12:35	10mins	***Assurance Committee Chair's Update** *To receive verbal exception report from September meeting. Including* • *Learning from deaths report – to receive*	Committee Chair	W4, W5, W6, W8
19	12:45	5mins	***People and OD Committee** *To receive verbal update from September meeting*	Committee Chair	W1-8
20	12:50	5mins	***Charitable Funds Committee Minutes & Chairs update** *Verbal update to be provided*	Committee Chair	W4
21	12:55	5mins	***Complaints Review Panel** *To receive verbal update of 11th September meeting*	Committee Chair	W5-6

22	13:00	5mins	*** Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update** *To receive exception report from September meeting. Including:* • *S136 Operations Report – to receive*	Committee Chair	W5, W6, W8
23	----	-----	***Governance and Nominations Committee** *No meeting held to report*	Committee Chair	-
24	13:05	5mins	**Finance Committee – Scheme of Delegation** - *to approve tracked changes on pg 29-30, as presented at the July Finance committee*	Director of Finance	W4
Any other business					
25	13:10	10mins	**Reflections – lessons learnt and living our values**	Chairman	
26	13:20	5 mins	**Governor comments and questions**	Chairman	
27	13:25	5 mins	**Any other business & future agenda items**	Chairman	
28	13:30	------	**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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The well-led framework is structured around eight key lines of enquiry (KLOEs):

Date of next meeting: 26TH November 2018

Minutes

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

Chair: Alistair Stokes, Chairman (AMS)	
Members: **Sue Harriman,** Chief Executive (SH) **Andrew Strevens,** Director of Finance (AS) **Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA) **Dan Meron,** Chief Medical Officer (DM) **Jackie Ardley**, Chief Nurse (JA) **Helen Ives,** Chief People Officer (HI) **Mick Tutt,** Non-Executive Director (MT) **Jon Pittam,** Non-Executive Director (JPi) **Mick Tutt,** Non-Executive Director (MT) **Francis Davis,** Non-Executive Director (FD) **Stephanie Elsy,** Non-Executive Director (SE)	**Attendees:** **Jayne Jenney,** Corporate Support Manager and Assistant Company Secretary (JE) **Sam Stirling,** Corporate Affairs Administrator (SS) **Emma Palmer**, Corporate Support Adminstrator (EP) **Anna Martin**, Patient Experience Team (AM) (item 2) with Carer **Kayode Osanaiye**, Clinical Director- Mental Health (KO) (item 2) **Suyog Dhakras**, Director of Clinical Education (SD) (item 10) **Elaine Peachey**, Emergency Planning and Business Continuity Lead (EP) (item 11) **Sadie Bell**, Head of Information Governance & Security and Data Protection Officer (SB) (item 12) **Apologies:** **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Mike Watts,** Non-Executive Director (MW)

1	**Chairman's Welcome & Update, Confirmation that meeting is Quorate**
1.1	Apologies were received as noted above. AMS welcomed the Board to the meeting and also welcomed the patient carer, KO and AM for item 2.
1.2	The meeting was confirmed as quorate.
2	**Patient Story**
2.1	JA provided a background to this story and explained the learning to be taken as an organisation. The patient carer shared her story with the Board and explained her experience of the service received. The Board were informed of the differences that could be made, including the environment and ensuring consideration of empathy towards carers and relatives.

2.2	JA offered formal apologies to the patient's wife/carer, on behalf of the Board. JA highlighted learning that has been undertaken to ensure this experience was not repeated. A conversation took place about the care and experience the patient and his family received whilst at the Brooker Ward, St James Hospital. It was noted that a video had been filmed to be used as a learning tool for staff across the organisation. It was also noted that the carer did not wish this to be shared outside of the organisation. The Clinical Director, Kayode Osanaiye (KO) provided an overview of changes made as a result of the complaint, and commented that JA and the carer had previous met to discuss key aspects of care. . KO explained how the changes in practice and improvements had made a difference to improve our provision of a dementia friendly environments, particularly within the elderly mental health site.
2.3	KO informed of ongoing discussions with the Chief Pharmacist and pharmacy team to ensure that patients, carers and relatives fully understand the management of medications. JA emphasised assurance of actions taken and AMS thanked the carer for sharing experiences and contributing to change.
2.4	SE reiterated thanks to the patient carer and asked KO about the potential reasoning behind these issues, for example lack of resource. KO confirmed a wide range of challenges and provided assurance regarding the new structure and leadership processes in place. SE queried engagement with community organisations to support staff in providing appropriate Occupational Therapy activities. KO confirmed staff training and options being explored to implement effective change.
2.5	The carer thanked the Board for the notice taken of the complaint and actions to improve and benefit all patients. SH highlighted gratitude to the carer for attending and providing continuing assistance to ensure the Trust fully understands the impact on relatives. . SH thanked KO for fresh and insightful leadership provided since his appointment to the Clinical Director role. **The Board noted the Patient Story provided**. *The carer, KO and Anna Martin left the meeting.*
3	**Board discussion**
3.1	The Board discussed the fundamental issues at the time of this complaint. SA emphasised the importance of oversight to ensure that appropriate care and environment were provided. The Board agreed and discussed the importance of a culture for continuous improvement.
3.2	AS reflected on learning surrounding the complaint process and the usefulness of receiving powerful and emotive stories to Board. JA agreed and confirmed that we will rotate our patient stories to ensure a balanced view.

4	**Minutes of Last Meeting and action tracker**
4.1	The minutes of the last meeting held on 29th May 2018 were agreed as an accurate record subject to amendments.
4.2	The following actions were confirmed as complete: 613, 614, 615, 616, 617.
5	**Register of Interests & Declaration of Interests**
5.1	There were no further updates to report.
6	**Matters Arising**
6.1	No matters arising were discussed.
7	**Any Other Business**
7.1	There were no items of any other business.
8	**Safety and Quality First and Feedback from Board to Floor Visits**
8.1	Board to Floor- Oak Park Sexual Health Clinic SE provided feedback following the visit and commented on challenges regarding location and access via public transport. SE highlighted hard work of the staff and excellent service being provided despite resource challenges and commented on improvements required to the appointment booking process. SA explained ongoing work to improve the online service.
8.2	Board to Floor- Looked after Children Service SE reflected on the visit and staff highlighted the excellent level of support to them following a staff death.
8.3	JP queried review into the pressure on services due to the extreme heat. SH shared work completed in hot spot areas and proactive work in facilities to ensure that mobile air conditioning units were available. JA also confirmed alternative uniform policies in place to ensure comfort of staff in periods of hot weather.
Strategy & Vision	
9	**Chief Executive's Report**
9.1	NHS 70 celebrations SH briefed the Board on events attended across the country with many different members of the Solent team and highlighted celebratory stories shared. SH formally noted thanks and commendation to Rose Bennett, a domestic assistant at St James' Hospital who received a Lifetime Achievement Award at the NHS70 Parliamentary Awards.

9.2	<u>Research and Improvement (R&I) Conference</u> The Board discussed the recent well attended event acknowledging the involvement of Side by Side, which has enabled the Trust to achieve the 'Paitent Accreditation' award. Comments were made on the depth , range and complexity of research and learning within the organisation. DM commented on the high level of work from the R&I team, enabling high benchmark against other Trusts for R&I studies. DM informed of improvements made through the year, including interventions for smoking, obesity and care plans to 100% of patients.
9.3	DM highlighted accolade regarding results of GMC survey showing the Trust as a top placement for trainees. DM also explained excellent benchmarking data received for medical data and revalidation.
9.4	<u>CQC inspection</u> SH explained the approach being taken to not overcomplicate or stress staff during the inspection period, and to ensure the emphasis remains on business as usual. JA confirmed closure of Provider Information Return (PIR) request period and the considerable amount of time taken to collate and submit the data required. JA acknowledged further in depth requests ahead of the inspection process.
9.5	<u>CQC Local System Review Hampshire</u> SH reported ongoing review into a coproduced Local System Review Action Plan to ensure joint working and review areas where services are fractured and disconnected.
9.6	<u>Sustainability Transformation Partnerships (STP)</u> SH presented progress within the system and confirmed paper expected to November Confidential Board to formally highlight plans and early findings of system reform. The Board were informed of Task and Finish Groups created to lead on key papers, which will be considered and debated through individual Boards to support material changes to the way services are delivered.
9.7	<u>Estates- St James' Hospital Phase 2</u> SH confirmed that approval had been received by the Department of Health and Social Care.
9.8	<u>Complaints</u> SH reported an increase in complaints reported compared to last year and commented on further work being undertaken to triangulate potential trends.
9.9	<u>Board Assurance Framework (BAF)</u> It was confirmed that full discussions would be held at Confidential Board, including considerations of review at In Public Board going forward.

9.10	Maples Ward Due to the supply issues of bespoke equipment, it was confirmed that Maples will not fully reopen until late August. MT queried position of recovery costs and AS informed of claims assessor confirmation of the receipt of costs for expended income. MT queried potential update on the individual that had caused the damage to Maples. **Action- SA to request update.**
9.11	MT commented on themes regarding capacity challenges and queried if this was a national or local trend to consider. SA highlighted general supply and demand issues nationally and SH discussed potential STP considerations and ongoing work surrounding small sustainable services. SH highlighted work with PWC to ensure continued engagement and review around focused capacity and demand challenges.
9.12	SH clarified an update to wording within the report regarding the launch of the new Risk Management Framework. **Action- JE to update.** **The Board noted the Chief Executive's Report.** *SD joined the meeting.*
10	**Director to Medical Education (DME) Briefing Paper**
10.1	Suyog Dhakras (SD) briefed the Board on training provided to under-resourced and vulnerable services and opportunity to capitalise as core business planning. SD shared financial challenges and highlighted the opportunities for raising standards of training.
10.2	The Board were informed of difficulties regarding trainee inductions and associated IT challenges. AS provided assurance regarding new processes introduced for equipment turnaround and suggested outstanding issues were passed to the new Director of IT, Neil Shazell. DS reported challenges regarding Outlook and general log on details. HI confirmed that challenges had been escalated to the IT Committee and further issues raised regarding information sharing across delivery systems. It was confirmed that full discussion would be held at individual system groups.
10.3	SD informed the Board of letters sent to all organisations in order to ensure full understanding of liability and manage the risk and governance structure regarding on-call. It was agreed that SH review letters sent and follow up outside of the meeting in order to ensure full re-engagement and escalation. **Action- SH.** **The Board formally thanked SD for strong leadership and noted the Director to Medical Education (DME) Briefing Paper.** *SD left the meeting and EP joined.*
11	**Emergency Planning Resilience Update Report**

11.1	Elaine Peachy (EP) provided an overview of the report and explained changes to requirement standards which could create potential challenges for future submission. *Sadie Bell joined the meeting.*
11.2	JP queried potential plans being considered following the Brexit announcement. SH confirmed a lack of planning/focus from a Hampshire Isle of Wight STP perspective, and the Board discussed potential NHS business continuity planning required. HI informed of ongoing discussions regarding overseas working and surrounding challenges, particularly within acute Trusts.
11.3	In light of recent national incidentsFD queried policies regarding suspicious substance issues. EP confirmed substantial emergency planning and full 'Hazmat' training provided. **The Board noted the Emergency Planning Resilience Update Report**. *EP left the meeting.*
12	**Information Governance Briefing Papers & Information Governance Strategy**
12.1	Sadie Bell (SB) provided an overview of compliance within the toolkit and reported a reduction due to changes in requirements. SB assured the Board that the Trust was compliant despite these changes and confirmed a focus on information security. It was confirmed that an Information Security Group had been established in order to ensure suitable governance was in place and information security concerns documented. SB explained that all other toolkit requirements would be reviewed as projects.
12.2	SB informed the Board that the Trust was GDPR compliant and explained further work required regarding auditing and assessment to ensure continued improvements.
12.3	JA highlighted excellent Information Governance work undertaken and SA formally commended SB and the team for their hard work ensuring that the Trust was compliant and safe, as well as taking the lead within the system.
12.4	SE queried further support required from the Board and SB highlighted constructive changes to culture and awareness of Information Governance in recent years, including the usefulness of the restructure within the team to support this. **The Board noted the Information Governance Briefing Papers & Information Governance Strategy.** *SB left the meeting.*
13	**Performance Report**

13.1	<u>Operational</u> • AS provided an overview of the hotspots, also noted within the CEO report. • AS explained changes regarding a contract performance notice given and confirmed that a full update would be provided at Confidential Board. • SA provided a Portsmouth system update following urgent care challenges. • MT noted challenges regarding mixed sex accommodation and reporting of breaches on Maples Ward. MT queried the position on Brooker Ward and SA confirmed different challenges that were being addressed appropriately. JA assured the Board that issues had been logged onto the Risk Register.
13.2	<u>Quality</u> • JA informed of 2 new advanced nurse practitioners appointed within mental health and emphasised the importance of growing staff within the Trust and considering alternative roles such as apprentice nurses. • JA reported 2 trend SIs and improvements and learning being reviewed. • A positive reporting culture for IG breaches was discussed and JA provided context surrounding the increase, due to the volume of data inputting required. • JA explained review into a change in practice within community teams for providing insulin injections and ensuring appropriate module for training, confidence and supervision was in place for health care support workers to provide. SA emphasised full support of this change. • Regarding the Gosport War Memorial Hospital Report, JA confirmed there had been an internal end of life care meeting to consider any potential implications for Solent, and assured the Board of comprehensive review through QIR and Assurance processes. • SH suggested that the Board review the report, particularly chapter 4, regarding ownership accountability and learning. It was suggested that a future Board Seminar provide time for reflection on the potential learning arising from the Gosport War Memorial Report. **Action- JE/RC to arrange.**
13.3	<u>Finance</u> • AS informed of current position and confirmed that a full update would be provided at Confidential Board. • Regarding capital spend, AS informed the Board that the Department of Health had signed off work at St James' Hospital, expected to begin in September.

13.4	Workforce • HI highlighted a reduction in sickness absence rates reported in month, with an improved rate of 3.6% and informed of 14% steady turnover rate. • HI informed of cultural approach taken to ensure we were competitive as an organisation and commented on reflection of this within the Staff Friends and Family Test (FFT). • The Board discussed concerns regarding high off framework agency spend, particularly in Portsmouth. HI explained improved recruitment to the internal Bank Staffing Service and the focus on providing flexibility to promote and market this service. • AMS queried analysis required regarding further work to reduce off framework agency spend and HI highlighted cultural changes required throughout the Trust. • HI briefed the Board on commissioned work regarding the intensity of emotional labour and compassion fatigue and intended receipt of research this autumn to review new ways of working. • Regarding statutory and mandatory training, it was confirmed that the Trust has a current compliance rate of 85%. The new rate has been set as 90% from Q1, and staff are working towards that. The Board discussed the importance of clarity surrounding expectations and ensuring appropriate planning to justify increase in target figure agreed.
13.4	NHSI Compliance The Board were informed of challenges regarding a diagnostic breach, out of area beds, and high agency spend. **The Board noted the Performance Report.**
14	**Greater Together: Our strategy for community engagement**
14.1	The Board were briefed on the proposal and alignment to values to produce a longer term strategic plan. JA explained the work completed to date and informed of the importance of recognition of national policies. JA presented the key aims, objectives and next steps for consideration.
14.2	MT offered full commitment to the community engagement approach proposed and emphasised the need for careful consideration of next steps suggested. MT reported agreement to disband the current Members Council however confirmed their commitment to this approach and ensuring the use of key skills from this group.
14.3	SE commented on the importance of leading change and queried the position of the STP in line with this proposal. SH shared challenges surrounding organisational culture and public engagement within the STP however emphasised the Trust's responsibility to openly support, encourage and drive effective change.

14.4	SA referred to specific projects and opportunities to complete focused work within clusters. AMS suggested the usefulness of ensuring work with partners and overall engagement with the community when considering work in the clusters, as well as potential dedicated resource required to lead this. The Board discussed challenges regarding lack of direct patient contact within partner organisations and emphasised the need for a strong citizen voice throughout community care pathways in all organisations. SH reiterated the need for Solent to set expectations and advocate progression of this approach.
14.5	AMS reflected on the capacity of the Board to be able to roll this out and AS highlighted full understanding of priorities and how this strategy could make a difference to the Trust. SH agreed and commented on the need for balance and careful development of organisational culture.
14.6	FD commented on the name/branding given to the strategy and it was agreed to consider alternatives outside of the meeting. **Action- JA.** AMS highlighted the need for flexibility regarding formal strategy launch date to ensure appropriate consultation and feedback.
14.7	**Regarding the proposal to establish a new Committee, the Board agreed and confirmed SE as the designated NED lead.** **It was agreed that JA review potential membership of this Committee outside of the meeting. Action- JA.**
14.8	**The Board supported the strategy in principle, including the purpose and underlying principles, subject to Trust budgeting and planning processes.** **It was noted that, following extensive discussions at Governance and Nominations Committee and Members Council, the Board formally agreed to stand down the Members Council with effect from 30th September 2018.**
15	***Chairs report on Members Council**
15.1	MT reported intention to hold a celebration event at the beginning of October to reflect and consider next steps. It was confirmed that key messages had been sent to the Members Council following the meeting. It was agreed that SA consider wider communication methods for all Trust members outside of the meeting. **Action- SA.**
16	**Health and Safety Annual Report**

16.1	AS shared an increase in the number of incidents reported and confirmed full deep dive incident review to understand the circumstances surrounding this and highlight learning. SH expressed concern regarding identification of increase through the annual report, particularly regarding violence, aggression and falls incidents. AS assured of monitoring through alternative routes however confirmed the importance of full review following the annual comparison data. SH suggested reviewing continuous annual trend on a quarterly basis. **Action- AS to consider outside of the meeting.**
16.2	AS highlighted the importance of clarity surrounding evacuation lock down procedures and confirmed sessions being held in August to review this. **The Board noted the Health and Safety Annual Report and approved the Health and Safety Policy Statement of Intent.**
17	**Safe Nurse Staffing - six monthly report**
17.1	• JA noted hard work of the Southampton Community Adults service and encouraging current position for Safe Staffing. • The Board discussed the usefulness of understanding the level of risk surrounding incidents reported. It was agreed that JA provide within the next report. **Action- JA.** • AMS queried dissemination of messages following constructive roster management discussions and JA confirmed dissemination through the new Safe Staffing meetings established. **The Committee noted the Safe Nurse Staffing report.**
***Reporting Committees and Governance**	
18	***Audit and Risk Committee**
18.1	• JP requested that all further internal audit reviews feed into the Audit and Risk Committee. • The Board were informed of continued monitoring of loss of IT assets. • AMS queried progression of the Freedom to Speak Up model and SH confirmed review and further maturity required regarding process. **The Board noted the Chairs update and the Committee annual report and approved the Terms of Reference.**
19	***Assurance Committee Chair's Update**

19.1	• MT explained factual accuracy comments received regarding the End of Life Care Policy and review taken to ensure concerns were appropriately addressed and processes followed. • MT highlighted request for Portsmouth colleagues to consider lessons and developments regarding Learning from Deaths. • The Board were informed of amendments requested by Southampton CCG to include further information on the work of the Southampton Looked after Children Service within the Safeguarding Annual Report. • SA provided a further update following changes to the Solent Recovery College arrangement with Highbury and highlighted alternative arrangements being sought. • SA shared intention to establish a veteran trauma programme, leading into the wider recovery programmes and confirmed that Solent would be hosting the national Recovery College conference in September. AMS expressed concern regarding timescales for the conference and the Trust's position and SH assured the Board of the short term mitigations. **The Board noted the Assurance Committee Chairs update.**
20	***People and OD Committee**
20.1	• HI reported risks regarding statutory and mandatory training compliance. • The Board were informed of staffing constraints within the People Services team, particularly within Workforce. It was confirmed that a full update would be provided at the next meeting. • HI highlighted downgrading of BAF risk regarding organisational development and commented on high priority given to equality and diversity. **The Board noted the People and OD Committee update.**
21	***Extra Ordinary Charitable Funds Committee Minutes & Chairs update**
21.1	FD briefed the Board on discussions held regarding next steps and confirmed restriction of Chapel funds. **The Board noted the update.**
22	**Complaints Review Panel**
22.1	There was nothing to report at this stage.
23	***Mental Health Act Scrutiny and Deprivation of Liberty (DOLs) Committee**
23.1	There was no meeting held since the last report to Board.
24	***Governance and Nominations Committee**
24.1	**The Board agreed the recommendations presented to:** • **approve the Committee Terms of Reference** • **note the Committee annual report for 2017-18** • **approve Chairs action to reappoint MT to the role of Deputy Chair and JP to the role of Senior Independent Director**
Any other business	

25	**Governor comments and questions**
25.1	There were no governors in attendance.
26	**Any other business & future agenda items**
26.1	No other business discussed and the meeting was closed.
27	**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
618	30/07/2018	9	Chief Executive's Report - Maples Ward update	MT queried potential update on the individual that had caused the damage to Maples. **Action- SA to request update.**	SA		**September 2018 update** - The individual is no longer part of the Solent service and is staying in a Medium Secure Unit in London however after discharge may well reside back in Portsmouth and we are reparing accordingly.
619	30/07/2018	9	Chief Executive's Report - Risk Management Framework (pg 5/6)	SH clarified an update to wording within the report regarding the launch of the new Risk Management Framework. **Action- JE to update.**	JE		**September 2018 update**- Document updated- Complete.
620	30/07/2018	10	Director to Medical Education (DME) Briefing Paper	SD informed the Board of letters sent to all organisations in order to ensure full understanding of liability and manage the risk and governance structure regarding on-call. It was agreed that SH review letters sent and follow up outside of the meeting in order to ensure full re-engagement and escalation. **Action- SH.**	SH		**September 2018** - A follow up letter to chase responses was escalated. Action now complete.
621	30/07/2018	13	Performance Report	It was suggested that a future Board Seminar provide time for reflection on the potential learning arising from the Gosport War Memorial Report. **Action- JE/RC to arrange.**	JE/RC		**September 2018 update**- Added to the agenda cycle for planning. Complete.
622	30/07/2018	15	Chairs report on Members Council	It was agreed that SA consider wider communication methods for all Trust members outside of the meeting. **Action- SA.**	SA		**September 2018 update** - All members for whom we have email addresses, have been emailed regarding the future of membership. A written communication to members who have not registered an email address has been prepared and letters are being sent with SHINE.

Item 10.1

Title of Paper	CEO Report – September 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	14th September 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 operational 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, however highlights are also provided below under updates from our Care Groups.

2. Strategic update

Annual General Meeting (AGM) and Community Engagement Event

We held our 8th AGM on 10th September which was well attended by members of our community, partners and staff. This year we made efforts to ensure the event was more accessible by including easy read information packs, British Sign Language signers to support presenters, avoiding the use of acronyms and using plain English.

Prior to the formal meeting itself we hosted an experimental community event where attendees experienced many of our services located at interactive 'pods' including opportunities to;

- taste speciality food developed for people with swallowing problems and difficulties with textured food
- explore environmental design specifically created to help people with dementia and anxiety disorders
- try mindfulness techniques and virtual reality, used to help people face their fears
- take part in a demo of live chat, our new online sexual health service, and many more.

Attendees also participated in our live artwork with artist Joe Ross – the output will be displayed at St Mary's Community Health Campus in Portsmouth.

Both events coincided with the launch of the Communication Access Symbol.

Community Engagement

A number of meetings have taken place since the approval of the Community Engagement Framework by the Board in July. These include the following:

- External – Discussions have been held with Lord Patel of Bradford exploring a number of opportunities including further work with veterans, as well as discussions regarding the housing sector, and holding a wider community engagement launch working with system partners.
- Internal –the first planning meeting to discuss the establishment of a Community Engagement Committee, to be chaired by a Non-Executive Director, was held. The Terms of Reference, which will seek membership

commitment from external partners, together with the draft business plan to support the implementation of the Framework is expected by the end of the month.

Bringing our Strategy to Life

The Board led the co-production of our Strategy three years ago and since that time we have invested time and resource into making our strategy meaningful to our patients, staff and our partners. We used the power of storytelling to encourage our staff to consider how 'they make a difference' to the people they care for and work with. This has been a powerful and productive process and more recently we have asked our staff to build on this and consider the power of professional curiosity, our values and the Solent Strategy. A short presentation will be given to illustrate.

The Learning disability improvement standards for NHS trusts

In June, NHS Improvement (NHSI) published the first Learning Disability Improvement Standards for NHS trusts. The standards are intended to help organisations measure the quality of service they provide to people with learning disabilities, autism or both. In support of this, a national data collection exercise is being undertaken by the NHS Benchmarking Network to help NHSI fully understand the extent of compliance with the standards. Dan Meron, Chief Medical Officer has been identified as the Executive Lead, working with Matthew Hall, Deputy Chief Operating Officer, Portsmouth, in support of Solent's response to the exercise.

Wheelchair Update

We continue to work with the local wheelchair provider and their commissioners to reduce the delays experienced by our patients when waiting for the supply of wheelchairs and other bespoke equipment. Those waiting are risk assessed and reviewed frequently to reduce any harm as a result of long waits. However we have recently seen an increase in length of waits so held a risk based discussion with the local NHS Improvement and NHS England teams. Our local commissioned service for wheelchairs has been subject to national media interest following the publication of national benchmarking data on length of waits. This continues to be a high risk and priority area for us. (Ref to BAF# 63)

E-prescribing funding bid

We are engaged in a process of transition from paper-based to electronic prescribing (Electronic Prescribing & Medicine Administration, EPMA) and have recently applied for £98k of funding through a national e-prescribing Funding Bid via NHS Improvement. The funding request will support the development and roll-out of our EPMA solution. We have established a clinical reference group and project, including 50 community teams and 10 in-patient wards and pharmacy teams and are currently testing the solution offered by the provider of SystmOne, our electronic patient record system. Funding decisions are expected in late September.

Care Quality Commission, CQC

We have been formally notified that a CQC Well Led inspection will be undertaken 6th-8th November 2018. Both announced and unannounced care service inspections are likely to happen between now and the Well Led Inspection dates. The Trust is well prepared for the inspection and we look forward to welcoming the CQC team. We continue to encourage our staff to;

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

Southampton and County Services

Adult Southampton

- Our performance within our Domiciliary Phlebotomy Service has been the recent subject of consideration by both the operational management team and commissioners due to an increased volume of referrals and the small team being affected by sickness, resulting in challenges in processing incoming referrals in a timely manner. Consequently we have received a Contract Performance Notice. The issues have been discussed at length with the Clinical Commissioning Group and a Remedial Action Plan is underway. Staffing is back to full capacity and we have a fall-back plan for the future if we experience recurrent sickness in such a small team. (Link to BAF#59 BAU/ Operational risk Clinical Capacity)

Primary Care / MPP service line

- We are pleased that our previously reported workforce challenges associated with GPs and Associate Nurse Practitioners (ANPs) within our Primary Care Services over the summer have now been mitigated – in part, thanks to support from our system partners in Southampton Primary Care Limited. (Ref to BAF# 55 &59 / Operational Risk Clinical Capacity)
- We continue to experience a small number of failed calls when patients endeavour to contact our GP surgery (Portswood and Nicholstown) despite conducting a number of technical investigations and interventions. We have recently established a centralised call management and administration cell which has improved our capability to answer calls and manage appointments across our three branch sites, hopefully improving patient experience. (Ref to BAF# 13 /Operational Risk IT)
- As a result of some concerns voiced by our staff within the Podiatry service in our Portsmouth teams regarding caseload and complexity, we have instigated a number of changes to support demand and capacity constraints and to enhance management support. (Link to BAF#59 BAU/ Operational risk Clinical Capacity)

Children and Families (West)

- We continue to experience estates challenges within the Eastleigh and Southern Parishes geography and have recently needed 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 with an identified preferred site, which will also provide opportunities for our Sexual Health and Special Dentistry services to be co-located at this location. (Ref to BAF# 27)
- The previously reported issues of demand outstripping capacity in our Child and Adolescent Mental Health Services (CAMHS) West continues. However, there is evidence of performance improving as a consequence of a number of initiatives being introduced including; demand and capacity remodelling, improved recruitment and enhanced engagement with commissioners. (Link to BAF#59 BAU/ Operational 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 Child Outreach Assessment Support Team (COAST) service. The Board have been informed previously of the suspension of the service pending commissioner review. (Ref to BAF# 55 &59 /Operational risk Clinical Capacity)

Special Care Dental Services

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

Portsmouth and SE Hampshire Care Group

Staffing capacity

Across the care group, staffing capacity challenges continue to be of concern (particularly within our community nursing teams, adult nursing and mental health medics and nursing) caused mainly by vacancies compounded by sickness and maternity leave. This has been an on-going and well reported risk and is mitigated with the use of agency and bank staff; however it is creating an unacceptable cost pressure. Workforce plans that focus on both recruitment and retention continue to be implemented and refreshed alongside analysis of demand and options for changing both skill mix and the delivery approach. (Link to BAF 55&59/ Corporate risk Clinical Capacity)

Information Governance

Information Governance breaches in July showed an unusual spike. Although analysis shows a couple of hot spots, there is no identified single cause –in response the service is considering additional messaging and support.

Pharmacy

The organisation has a number of emerging risks related to the future of pharmacy delivery (with partner organisations reviewing their strategy for delivery which may impact on this organisation), and the growing demands of medicines management which are currently being met causing cost pressures. A business case articulating the problem and solutions is due to be presented to executive directors in this month for consideration.

Pressure Ulcers

I am aware of the recent Pressure Ulcer (PU) incidents in both of our Adults Southampton and Portsmouth services. We are currently reviewing and updating the current PU policy to ensure it is consistent with the new National guidance and also the European PU Advisory Panel's definitions. This will include incorporation of revised PU definitions, categories and NHS number into local incident reporting systems and ensure this is implemented consistently across the Trust. We will also be reviewing and updating local reporting and the validation approaches with implementation of the new approach and definitions in practice from January 2019.

Finance (Link to BAF#53)

The year-to-date position is an adjusted deficit of £734k, which is favourable to plan by £140k. The forecast out-turn remains at an adjusted deficit of £970k, which is the same as the submitted plan.

Estates (Link to BAF #27)

Redevelopment of St Mary's and St James' hospitals

Building work has commenced at St Mary's following the final confirmation of the Public Dividend Capital (PDC) funding. The ground-breaking event for this was on 13 September with plenty of media coverage. The new facility is due to open in October 2019. Discussions with stakeholders are taking place regarding the future development at the St James' site.

Oakdene

The disposal of Oakdene to Portsmouth City Council is expected before the end of the month, with contracts due to simultaneously exchange and complete imminently.

Royal South Hants Hospital (RSH)/Western Community Hospital (WCH) - Outline Business Case (OBC).

The scheme OBC for the relocation of community inpatient and support facilities from the RSH to a new build facility at the WCH in Southampton was ranked first in the Sustainability & Transformation Partnership (STP) prioritised list of capital projects, submitted under 'Wave 4'; it is anticipated that the outcome will be known in November. In the interim, minor investigation exercises including a soil investigation and a parking survey are being undertaken.

Maples and Hawthorn remedial works

Reinstatement works following the separate incidents within the Maples and Hawthorn Wards of the Orchards building in Portsmouth have now been completed. The Psychiatric Intensive Care Unit (PICU) refurbished accommodation is a significant improvement for service users.

ICT

There is a risk that full implementation of Public access WiFi across the entire Solent estate will not be completed by the internally set target of 30 September 2018. While we are confident that our major sites should be enabled in this timescale, it is possible that some of our smaller locations will not achieve public access until mid Oct. This is because in a small number of areas there is currently not a compatible corporate WiFi solution in place. The Solent ICT Team and Commercial Team are actively engaged with our supplier regarding the completion of this work. (Ref to Operational Risk IT issues/ BAF# 13)

Hampshire & Isle of Wight (HOIW) Sustainability and Transformation Partnership (STP) (Ref to BAF# 58)

The Board are asked by the STP to consider 'The System Reform Statutory Board Pack', Appendix 1 (Item 10.2).

The following statements / considerations are directly lifted from the 'The System Reform Statutory Board Pack' and should be considered with Appendix 1 (item 10.2) as reference.

As stated on slide 24, the Board is asked to endorse:

1. The developing role of clusters as outlined on the previous slide (slide 23)
2. The recommendation that partners across Health & Wellbeing Board (HWB) footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development
3. the proposed next steps for the cluster task and finish group which are summarised as follows:

a) Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
b) Describe the support requirements and responsibilities to accelerate full cluster implementation
c) Describe the proposed interplay between clusters and other components of the Integrated Care System (ICS), including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
d) Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

As stated on slide 27, the Board is asked to endorse the following recommendations from the Executive Delivery Group (EDG), informed by the task and finish group work to date:

1. The emerging 'restatement' of the function of partnership working on a HWB footprint as described on the previous slide
2. The proposed next steps for a task and finish group by the end of September, which are to:
   a) define the common functions of the role of HWB footprints in an integrated care system
   b) clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
   c) set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.

As stated on slide 33, the Board is asked to work with geographically aligned partners within the identified four Integrated Care Partnership (ICP) footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

As stated on slide 39, the Board is asked to: endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

(A summary of the recommendations being asked for endorsement by the Board are found in slides 41 and 42)

Solent NHS Trust Board members have been involved in the generation of this System Reform Proposal. The Board should consider:

- The views of this Board on the proposals presented
- The implications (risks and opportunities) for our services
- Wider considerations such as impact on our business plans and regulator relationships
- The mechanism to feed back the Solent Boards' reflections

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 14 September 2018 of complaints data received during August 2018.

We received 17 complaints this month relating to a number of issues, although no trends were identified, these related to appointments, concerns, clinical queries and staff attitude. We expected to close 19 complaints, 5 of these breached the deadline due to executive scrutiny and wanting to ensure we fully answered the complainants questions. We continue to encourage our services to register plaudits and have registered 133 in August.
Some examples of learning we have taken as a consequence of recent complaints is summarised below:

- As a result of a complaint within our Sexual Health services regarding the lack of visibility of clinic waiting times, the service has reviewed the way this is displaced to ensure waiting times are prominently shown in the clinic waiting area.
- We received professional feedback from a social worker in Jersey with regards to the way we transferred a patient from the Adult Mental Health services back to their home (it should be noted that there was no patient harm). As a result of the feedback we have changed our guidance to staff and are developing a Standard Operating Procedure.
- In our Talking Change service, a patient complained about the member of staff using their own personal experience during their consultation. This was discussed with the staff member at their clinical supervision session, and as a consequence it has been agreed that taped sessions will be peer reviewed across the service.

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

No TMT meeting was held in August. An update of the meeting held on 19th September will be provided at the Board meeting.

6. Board Assurance Framework and Corporate Risk Register

Board Assurance Framework –the following table summarises the key strategic risks (≥16):

BAF number	Concerning	Lead exec	Raw score	**Mitigated score (Current score)**	Movement since last reported (and previous score)	Target score
63	Third Party Supplier Risks (links to BAF#13 – ICT and BAF#27 – Estates)	Sarah Austin	S5 X L4 =20	4x L4 =16	⇧	S3 X L2 =6
55	Workforce Sustainability	Helen Ives	S5 X L4 = 20	S4 X L4 = 16	⇔	S3XL3 = 9

Risks scoring ≥ 12 are summarised as follows;

13	ICT (links to BAF#63 –Third Party Supplier Risk)	David Noyes	S4x L4 = 16	S4xL3 = 12	⇔	S2 X L3 = 6
58	Future organisational function (links to BAF#59 – Business as Usual)	Sue Harriman	L4 X S5 = 20	S4xL3 = 12	⇩	L2 X S3 = 6

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

Risks scoring <12 include: #59 – Business as Usual, #27 – Estates and #57 - Quality Governance – all scoring mitigated score of 9.

It is acknowledged that a number of risks are interdependent. Significantly in month,

- Risk #13 concerning ICT has been rephrased to acknowledge the risks associated with contractual oversight and business change efficiencies.
- Risk#63 concerning Third Party Supplier risks has increased in score to reflect the increasing nature of the risk posed.
- Risk #58 concerning Future Organisational Function has reduced in score to reflect the system reform developments associated within the STP and the organisations response including scenario planning for the future
- Risk #59 concerning Business As Usual has been refined to reflect risks associated with clinical capacity and increases in demand
- Risk#62 concerning Executive Team Capacity and Risk#53 concerning Financial Sustainability have both reduced to meet their target score (and will be removed during the October ’18 review).

Operational Risk Register

The ***Introduction to Risk Management Training*** was launched on 16th July 2018 and as at 30 August 2018, 772 (19.2%) staff had completed the training. All staff must complete the training by the end of October.

On **8th August 2018** there were **127 open risks** on the Risk Register. Notable changes in the last period include:

- 19 new risks relating to business continuity and emergency planning which to date had been managed discretely by the Emergency Planning Team. These are being reviewed to determine which need to remain active on the Risk Register due to the high likelihood of occurrence and those unlikely to occur which can be accepted and monitored annually.
- A number of IT risks relating to historical problems with infrastructure, systems and network access have been mostly resolved and therefore closed
- Sexual Health Services risk #793 (availability of premises in Winchester and Eastleigh) has been reviewed and its score reduced from 25 to 16 to more accurately reflect the current level of risk.

The most prevalent risks on the Risk Register as illustrated in the charts below are:

- Workforce – Staffing (25 risks): the number of risks has increased from 15 risks since January 2018. The majority of risks across all services identify issues relating to vacancy levels and difficulties recruiting staff.
- Clinical – Community (20 risks): this has decreased from 26 risks in January 2018 however there are increasing number of teams and services identifying risks regarding clinical capacity and ability to meet rising demand for services.
- Business Continuity (16 risks): summarised above
- Information Technology (13 risks): decreased from 16 risks in January; risks which remain are predominantly at team and service level risks and relate to problems with access to systems and IT connectivity.

There are 17 risks scoring 15+ on the Risk Register and Trust Management Team has oversight of these risks and seeks assurance they are being appropriate managed; there are small clusters of high scoring risks (2 of each) which relate to staffing/ recruitment and clinical capacity.

A summary of the Risk Type and current Risk Score and Risks by Directorate are located in Appendix 2, (Item 10.3)

7. Other matters to report

Sealings - None to report

Signings as reported to Finance Committee since last Board meeting - None to report

Sue Harriman
Chief Executive

NHS
Hampshire and Isle of Wight
Sustainability and Transformation Partnership

Item 10.2

Hampshire and Isle of Wight System reform proposal

Statutory body pack

August 2018

MOVING FORWARD TOGETHER

Contents

Introduction and context

Purpose of this document

This document summarises the system reform proposal as developed to date through the work of the Hampshire and Isle of Wight Sustainability and Transformation Partnership's (STP) Executive Delivery Group (EDG) and informed by the broader health and care system leadership.

It forms the basis for NHS provider board, CCG governing body and local government cabinet consideration at their respective meetings in autumn 2018.

Context

The health and care system across Hampshire and the Isle of Wight has been working together to develop a response to the national ambition to improve the integration of health and care for the benefit of local people.

As the Care Quality Commission put it in its 2016/17 State of Care report:

"People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialties within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support."

National context

The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.

NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's Five Year Forward View (FYFV):

"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three"

Case for change

What do our citizens and our staff tell us?

Our citizens have been consistent in telling us that…

- they want **better and more convenient access** to support to help them to live well for longer. We have diverse communities across Hampshire and the Isle of Wight and people want support better suited to their needs;
- **they value and have confidence in General Practice and the wider primary and community team,** but there is a bewildering array of teams who do not appear to communicate with each other. **People often have to repeat their story** multiple times, making accessing care a frustrating experience. So they want all of the clinicians and care workers involved in their care to know their care plan, to work together and to communicate with one another. Many people also want greater control of their care, from better access to their records through to personalised budgets;
- when they have an urgent care need, **rapid access to the right clinical advice and support** is the most important factor to them. They want the health and care system to make sure they know how to rapidly access a complicated and sometimes confusing system;
- when they are managing a long term physical and/or mental health condition they typically want continuity of relationship with a trusted clinician to support them; they want better support to understand and manage their condition; and they want to ensure that when they travel for specialist advice and support, then the journey is worthwhile. Currently **40% of people** whom have a long term condition tell us they **don't feel supported** to manage their condition.
- they are more **willing to travel a little further for specialist care** if the services they access will give them better outcomes. People also add however, that there is nowhere like home and that they would rather be there, than a hospital bed. Unfortunately a quarter of people in hospital still do not feel involved in decisions about getting them home.

Our workforce are telling us that:

- they are **under more pressure than ever** before. They often feel that there is not enough time in the day, with too many targets to reach and administrative tasks to perform, both of which take time away from patients;
- services are running on such **low staff numbers** that any unplanned sick leave or annual leave has a significant effect. Despite significant efforts of some providers, we continue to exceed our planned expenditure on agency and locum spend;
- care professionals want a means by which to **share information** with other professionals within the system. There is often a poor interface between primary, secondary and community care with time wasted trying to contact other care services;
- whilst it doesn't feel this way in general practice, and in the community and hospital services, our workforce has actually increased over the last few years. However so too has the number of people leaving within two years;
- many frontline staff have spent large parts of their professional careers **trying to integrate care for patients,** often working around policies that construct rather than remove barriers to integrated care at local level;
- they want **better career options** along with opportunities to improve their skills and expertise.

What does the data tell us?

We need to strengthen our approach to prevention, early intervention and supported self-management…

- We have a national reputation for developing innovative models of prevention, case finding and early intervention and supported self-management. However, we have not systematically implemented these innovative models. For example, within three years, 330 heart attacks and 490 strokes could be averted with improved detection and treatment of hypertension and atrial fibrillation. This represents a cost saving of up to £2.5m for heart attacks and £6.7m for strokes through optimal anti-hypertensive treatment of diagnosed hypertensives.
- For cancer services, for example, we have made real progress in improving the early diagnosis of cancers over the past 4 years, and are now are one of the best performing systems in the country. But we still only **diagnose just over half of cancers at stage 1 and 2**.
- The **life expectancy of people with serious mental illness is 15-20 years less** than the average life expectancy in Hampshire and the Isle of Wight, with two thirds of these deaths due to avoidable causes. And yet the number of health checks for people with severe mental illness in HIOW is below the national average.
- We are making improvements, but we are **not yet closing the inequalities gap -** the life expectancy gap (and disability-free years gap) across HIOW is not closing.

The complexity and fragmentation of our current system (including siloed budgets and payment systems) is currently holding back a system focus on this agenda.

We have a significant opportunity to improve discharge and flow across Hampshire and the Isle of Wight…

- Our citizens continue to **stay in hospital for a long time** even though many are medically fit to leave. As we know the longer people stay in hospital, the more likely they are to develop complications and reduced independence; and it is also expensive to keep someone in hospital unnecessarily.
- Our flow and discharge is noted as being in the **lowest performance quartile in the country**
- We continue to be the **second poorest performing system in the country** with regards to **delayed transfers of care**.
- **We are the second poorest performer** nationally with regards to **CHC assessments in the community**.
- Recent data positions us as having one of the greatest opportunities nationally to reduce **excess bed days** and super-stranded patients.
- There has been a relentless focus on improving discharge and flow across all of our systems and yet despite this the number of delayed transfers of care per 100,000 population remains at the same rate it did two years ago*

This data would indicate that continuing to operate as we have done in the past will not yield a different outcome. We need to reform the system in a way that best allows us to tackle the challenges we face.

* with the exception of the Isle of Wight which now operates with three times fewer delays as other HIOW systems.

What do we know about new models of care?

The past four years have seen significant progress in developing 'new care models' which are founded on integration between partners and a systematic focus on the whole population's needs. Nationally we have seen both Multispecialty Community Provider and the Integrated Primary and Acute Care Systems develop. More recently the Next Steps on the Five Year Forward View further articulated the ambition ***'to make the biggest national move to integrated care of any major western country'.***

Within our patch we are reporting very tangible benefits for our citizens as a result of health and care partners working together / integrating more effectively than we have seen before. In the most developed systems we are seeing:

- **1% reduced emergency admissions** compared to an average of 3.5% growth nationally;
- New models of care are successfully managing and treating people more effectively in the community **reducing potentially "avoidable" emergency admissions by 10%** on last year;
- **4% reduction in GP referrals** on last year;
- **Reduction in the number of people experiencing mental health crisis** / emergency admission to acute mental health beds as a result of enhanced support in the community
- **A&E attendances are holding at the same level** as last year compared to demographically similar systems which have increased activity on last year;
- Citizens engaging with integrated care teams are reporting **significant improvements in health status, personal wellbeing, experience and health confidence;**
- **Staff satisfaction rates significantly improving** where they are operating in integrated care teams.

These achievements are both important for citizens, staff and for the financial health of the system. We know that new models of care work, however, our integrated primary and community teams are at different stages of development and so too are their interfaces with local health and wellbeing footprints and the acute physical and mental health system.

Finance and efficiency

Increasing value for money

The current funding and budget systems make it hard to reallocate resources to where they are needed most. This can also be prohibitive to collaborative working between partner organisations. Frustratingly for all, the current payment systems can be unhelpful – rewarding activity rather than outcomes.

Our financial position is unsustainable. Hampshire and Isle of Wight NHS has forecast a 'do nothing' gap of £577million gap by 2020/21 (23% of our £2.5bn allocation) and in addition to this, the pressures in social care and local government more broadly are unprecedented. Whilst the required level of efficiency has been delivered to date we require a step change in productivity and cost reduction to ensure we meet our financial targets.

In many organisations too much resource and energy is focused on seeking to suppress expenditure in providers or generate additional income from commissioners, rather than work in partnership to focus on cost reduction, quality improvement and living within the system's finite resources. **We will require different approaches**, including **collaboration**, e.g. pathology, pharmacy distribution centres; scale, eg: collective procurement; **back-office optimisation**, eg: HR, finance; **greater partnerships**, eg: increasing retention of our workforce, reducing bank and agency costs; and **reduced unwarranted variation** in practice.

If we are to make the transformational changes required to improve outcomes, experience, satisfaction, quality, performance, financial sustainability and address our workforce challenges **we must radically enhance our functionality, removing obstacles to enable far greater collaboration and integration**. These radical changes will become a reality only if there is a collective commitment from all partners to transform and implement a new way of working.

Reducing complexity

- We have **21 NHS and local authority statutory partners** as signatories to our transformation partnership **and three non-statutory partners** (with leadership responsibilities around workforce, innovation and research).
- We have **grown our workforce by 4.5%** over the past three years. Too much of this growth has, however, been in non-clinical roles. One of the key drivers for this is the continuing burden of reporting, assurance and inter-organisational contract management.
- **We are a complex system.** Whilst there has been collaboration between provider, commissioner and regulatory partners, our system reform work over the past six months has demonstrated significantly greater opportunity to reduce system complexity; reduce the burden of assurance and reporting and ensure all partners collaborate towards clearer strategic goals;
- NHS England and NHS Improvement are currently undergoing a national and regional integration programme. The expectation is that locally the Hampshire and Isle of Wight system will develop **simpler but more effective self-regulation and assurance models** that will allow NHSE/I to work more strategically with the system.

The system reform programme is a means by which we can reduce this complexity and develop strong self-regulation and assurance models.

The proposed system

Our vision

“Our vision is to support citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health and care. We will ensure that our citizens have access to high quality consistent care 24/7, as close to home as possible.

Our vision – tomorrow's system

We are taking action to prevent ill-health and promote self care...

- Empowering citizens, patients, service users and communities
- Harnessing technology more effectively to support wellbeing

We are strengthening local primary and community care...

- Developing integrated health and social care teams designed to support the needs of the local communities they serve
- Ensuring a strong and appropriately resourced primary care workforce
- Providing care in the right place at the right time by reducing over-reliance on hospitals and care homes
- Using technology to revolutionise people's experiences and outcomes;

We are improving services for people who need specialist care...

- Identifying, understanding and reducing unwarranted variation in outcomes, clinical quality, efficiency;
- Through consolidating more specialised care on fewer sites;

We will make intelligent use of data and information to empower citizens, patients, service users and support our workforce to be more efficient and effective in delivering high-quality care

Integrated care systems

The HIOW Executive Delivery Group (EDG) – representing the HIOW health and care system – recommend that to deliver our vision for health and care, we need to reform our system to ensure 'form follows function', signalling a shift from the separation of provision and commissioning to integrated planning and delivery. Nationally there is a similar realisation, which has led to the national guidance on Integrated Care Systems.

What is an integrated care system (ICS)?

NHS England defines ICS as those systems in which:

"Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations".

What will an integrated care system do?

National guidance sets a number of expectations for ICS:

- ICS are expected to produce together a credible plan that delivers a single system control total, resolving any disputes themselves.
- ICS will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.
- [ICS] will be given the flexibility, on a net neutral basis, and in agreement with NHS regulators, to vary individual control totals during the planning process and agree in-year offsets in one organisation against financial under-performance in another.
- NHS England (NHSE) and NHS Improvement (NHSI) will focus on the assurance of system plans for ICS rather than organisation-level plans.

There is an expectation that, over time, ICSs will replace STPs.

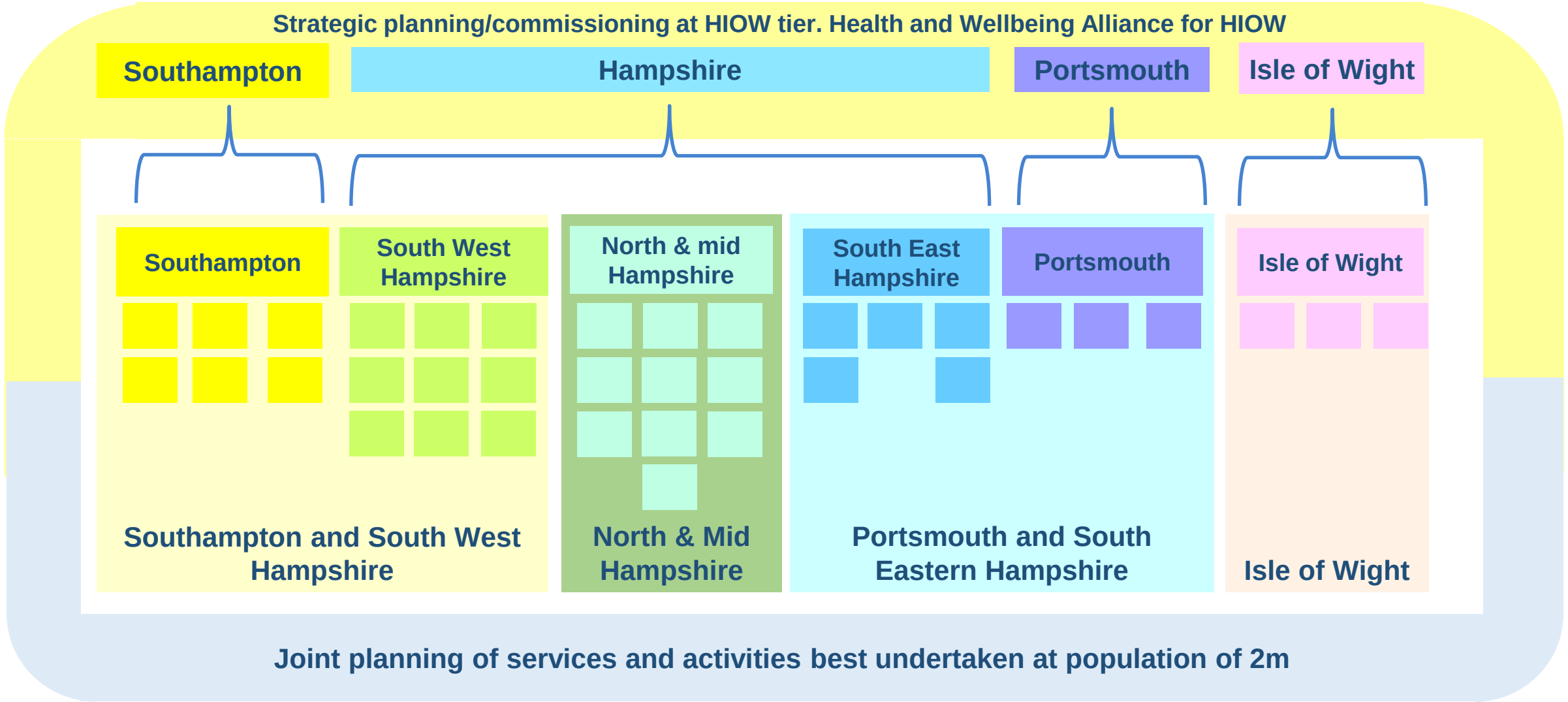
Benefits of ICS – the national view

- Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the health and care;
- Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- Delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- Allowing systems to take collective responsibility for financial and operational performance and health outcomes.

Local alignment

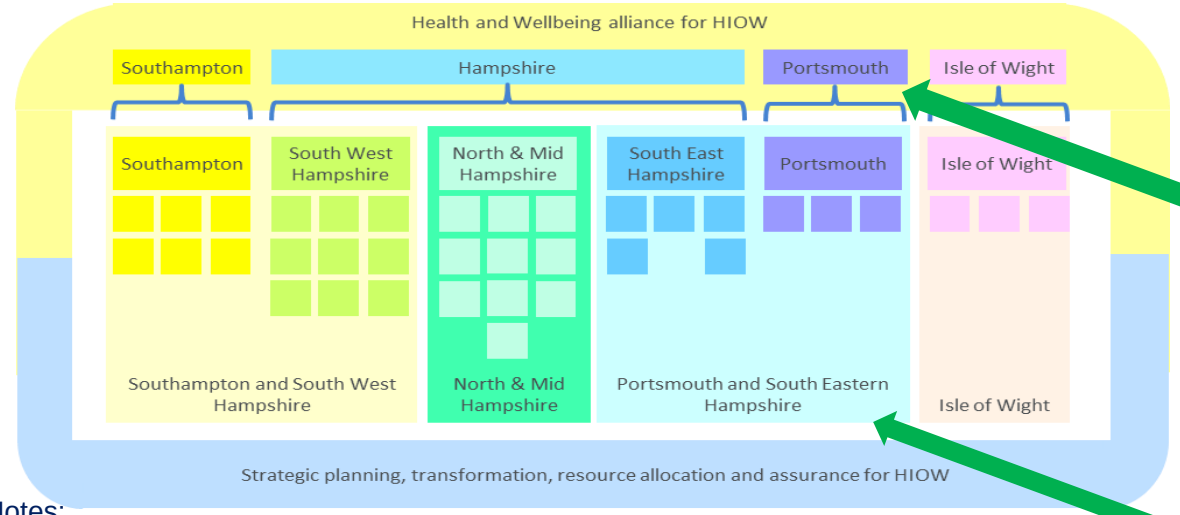
The EDG tasked a sub-set of its members, supported by others, to form a series of task and finish groups to develop the key elements of a proposal for moving the HIOW system towards ICS ("the system reform programme").

How could HIOW look in the future?



The proposed HIOW integrated care system:
A whole system planning, delivering and transforming in collaboration

The proposed reformed system envisages providers, commissioners and local authorities working in ever closer collaboration with each other and with citizens and voluntary sector organisations to address the case for change, empowering and supporting citizens to best manage their own health and wellbeing and frontline teams to provide and sustain the best possible services and care.



Component	Purpose and description
Accelerated implementation of 36 clusters Natural communities of 20-100,000 people	• The foundations of the reformed system • Strengthening primary care • Delivering integrated mental and physical health, care and wider services to cluster population • 36 clusters, aligned to 'natural communities'. • Proactively managing the population health needs
Ongoing development of place based planning Existing Health & Wellbeing Board footprints	• Integrated local authority & NHS planning • Aligned to HWB (local authority) footprints • Health & LA aligned commissioning resource & agreed leadership/management models • Basis of the JSNA, means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health
Simplified structure of 4 integrated care partnerships populations of c600k served by acute partners	• Support the vertical alignment of care enabling the optimisation of acute physical & mental health services • Design and implement optimal care pathways • Support improved operational, quality and financial delivery
HIOW integrated care system Drawing together the above component parts, delivering some functions at a scale of 2 million population	• System strategy and planning • Implementing strategic change across multiple integrated care partnership footprints/places • Alignment of strategic health and LA commissioning • Provider alliances (acute physical & mental health) • Oversight of performance and single system interface with regulators

Notes:

1. The term 'cluster' is used for consistency to describe the foundation of the system where general practices with statutory and voluntary community health and care services work together in 20-100k populations to meet the needs of local residents. A variety of terms are currently used to describe this including localities, extended primary care teams, natural communities of care, neighbourhood teams.
2. Where HWB and integrated care partnerships are coterminous, activities are undertaken together. In areas where integrated care partnerships span more than one HWB footprint, the partners will work together to determine the most appropriate allocation of responsibilities between HWB area and the integrated care partnership to achieve the shared objectives.
3. The Hampshire HWB area also includes North East Hampshire, which is also part of the Frimley Integrated Care System and therefore omitted from the figure above

Conditions for integration

The development of an ICS for Hampshire and Isle of Wight has been based upon a variety of national guidance and evidence from around the country about best practice approaches. We have studied the work ongoing in Surrey Heartlands Dorset, Manchester and South Yorkshire and Bassetlaw and learnt from their experiences.

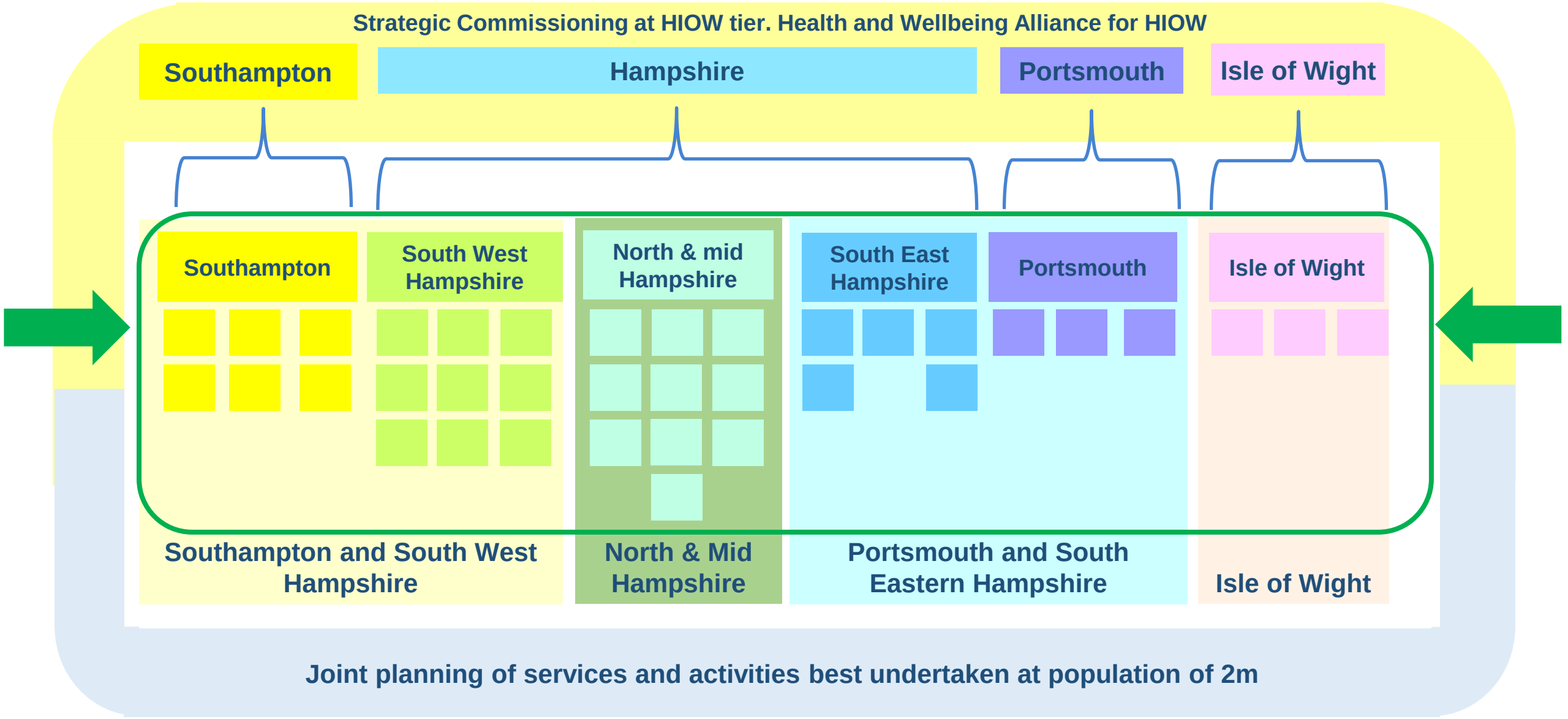
The work of the Kings Fund on integration is also helpful in setting out conditions which support greater integration. Their assessment is that current and future ICS must address the following development needs if they are to succeed in transforming health and care, building on new care models and related initiatives:

- Developing trust and relationships among and between leadership teams
- Establishing governance arrangement to support system working
- Committing to a shared vision and plans for implementing the vision
- Identifying people with the right skills and experience to do the work
- Communicating and engaging with partner organisations, staff and the public
- Aligning commissioning behind the plans of the system
- Working towards single regulatory oversight
- Planning for a system control total and financial risk sharing.

The work involved in addressing these needs is time consuming and cannot be rushed: ‘progress occurs at the speed of trust’, **collaborative rather than heroic leadership holds the key to progress.**

Components of the system

Clusters - integrated primary and community care teams



Clusters - integrated primary and community care teams

Clusters will be the bedrock of the reformed delivery system. The key purpose of our wider system reform arrangements is to support empowered clusters.

Role and benefits of clusters:

- Clusters will see health and care professionals, GPs, the voluntary sector and the community working as one team to support the health and care needs of their local community. They will focus on helping people to manage long term conditions and improve access to information about healthier lifestyles and improving/maintaining wellbeing.

- Evidence shows that the most successful work of this type will reduce the overall number of people who need to be cared for in hospital and improve the health and wellbeing of communities. Clusters will shift the pattern of care and services to be more preventative, proactive and local for people of all ages

Impact of clusters for people

- ✓ People are supported to stay well and take greater responsibility for their own health and wellbeing
- ✓ People can easily access support and advice that is timely, delivered close to home and with the right professional to meet their needs
- ✓ People with chronic or complex illness receive care that is consistent, joined up and centred around their needs and wishes, with fewer hand-offs and reduced duplication
- ✓ People are only in hospital for the acute phase of their illness and injury and are supported to regain/retain independence in their usual place of residence
- ✓ People have greater choice and control over decisions that affect their own health and wellbeing

Impact of clusters for HIOW system

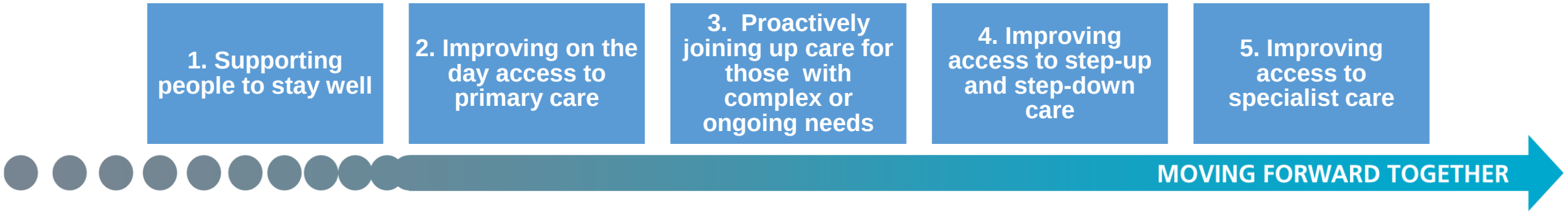
- ✓ Increased capacity in primary and community care to manage local health and care needs
- ✓ Reduction in rate of acute mental and physical acute non-elective activity growth and demand for urgent care services
- ✓ Optimised resource utilisation as a result of better managed chronic conditions and reduction in preventable conditions
- ✓ Reduction in variation in access and outcomes
- ✓ Fewer permanent admissions to residential and nursing care
- ✓ Primary care is sustainable and supported leading to improving GP recruitment and retention rates
- ✓ Attract and retain right workforce in all sectors with particular emphasis on those sectors in greater need such as mental health
- ✓ More efficient bed use and fewer delayed transfers of care

Characteristics of clusters

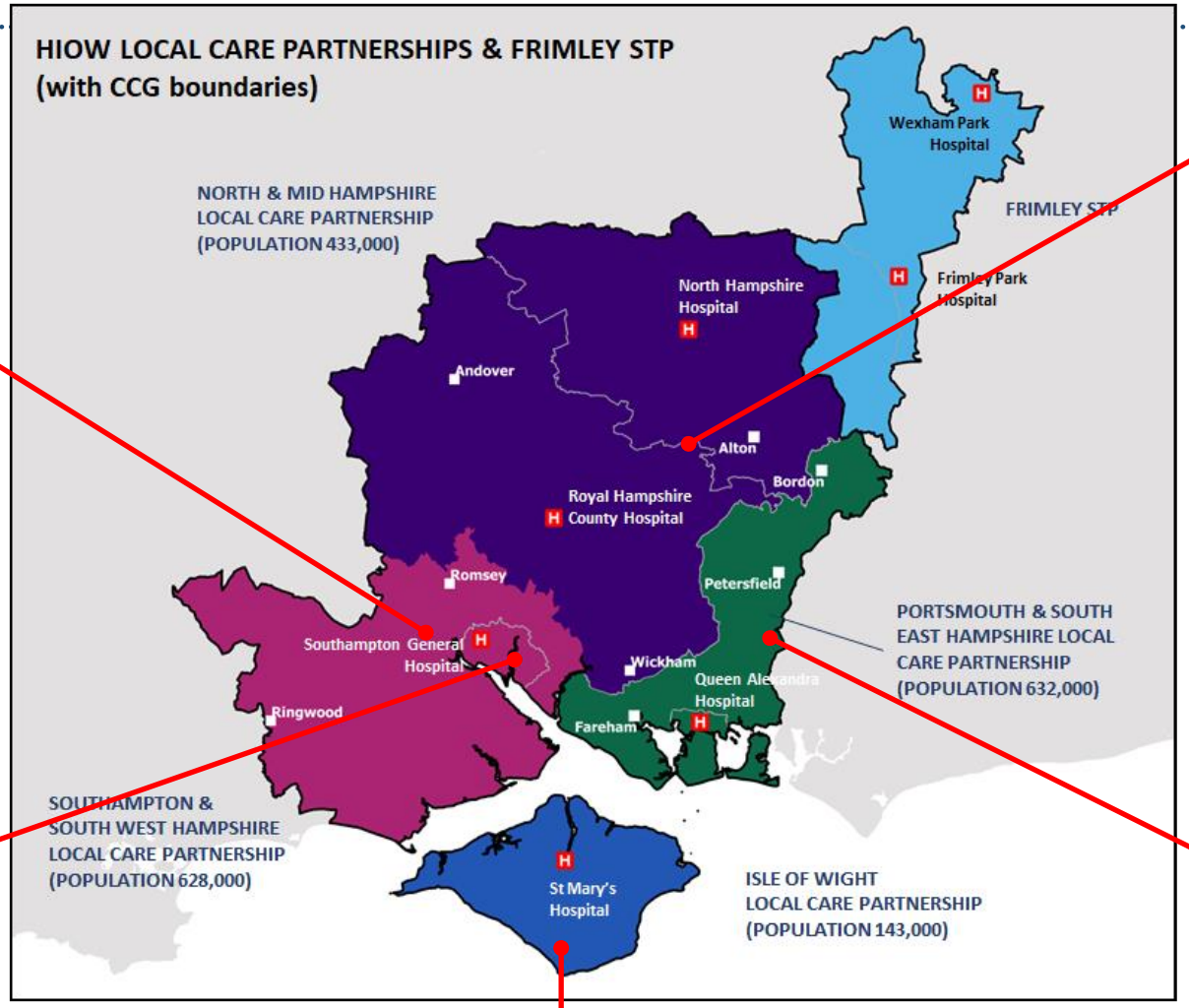
Clusters will vary based on the needs of the communities they serve, but will be built on a common foundation and share common characteristics:

- Clusters will be empowered to innovate in order to best serve their populations. In order to facilitate this, they will work to a specification which is outcome-based, but which is common across HIOW. Developing this specification will be an early priority.
- Cluster footprints align to 'natural communities of care.' Areas must be meaningful to those they serve, as they provide the basis for community-focussed services. Clusters' population range provides flexibility in cluster boundaries to ensure they align with both natural communities and GP registered lists.
- Clusters will include a range of mental and physical health, care and wider services in one place. Multi-professional working will be supported by multi-agency information sharing and, wherever possible, physical co-location.
- Co-ordinate services and teams from across organisations through alignment arrangements (MOU, alliance contract or joint venture) – allowing professionals to maintain their current employment status.
- Multi-professional (including clinical) leadership. Each cluster will have a named lead, and will be supported by a professional managerial team, who will be responsible and accountable for the performance of cluster services and the management of an indicative cluster budget. Clusters will manage their performance based on agreed datasets.
- GP federations will be vital in facilitating clinical leadership in clusters, as well as in leading the transformation of primary care, which will be vital to clusters' capability.
- Clusters will identify, understand and reduce unwarranted variation between their practices. Colleagues and systems across the footprint of HWB and integrated care partnerships will support clusters in this, as well as identifying unwarranted variation between clusters (see below).
- Clusters and acute physical and mental health providers will work together in integrated care partnerships, to ensure alignment of pathways and integrate services to optimise the health and care support they provide, responsive to the populations they serve.

The 5 core functions of a cluster:



36 clusters across HIOW (as at August 2018)



South West Hampshire

1. Eastleigh
2. Eastleigh Southern Parishes
3. Chandler's Ford
4. North Baddesley
5. Avon Valley
6. New Milton
7. Lymington
8. Totton
9. Waterside

Southampton

1. Cluster 1
2. Cluster 2
3. Cluster 3
4. Cluster 4
5. Cluster 5
6. Cluster 6

North and Mid Hampshire 20

1. Mosaic
2. Whitewater Loddon
3. Acorn
4. A31
5. Rural West
6. Andover
7. Winchester City
8. Winchester Rural North
9. Winchester Rural East
10. Winchester Rural South

Portsmouth and South East Hampshire

1. East Hampshire
2. Waterlooville
3. Havant
4. Fareham
5. Gosport

1. Portsmouth North
2. Portsmouth Central
3. Portsmouth South

Isle of Wight

1. North and East
2. West and Central
3. South Wight

Balancing autonomy and standardisation in clusters

A key test of this proposal overall is that cluster governance must accelerate and facilitate, rather than impede, local change and improvement. Therefore clusters will be encouraged to innovate and improve services for their citizens.

This innovation will be facilitated by both their contract /incentive structure and support from HWB and integrated care partnerships (see next slides).

HWB and partnerships will support clusters in identifying and reducing unwarranted variation, including striking the right balance between standardisation / consistency and local flexibility (ie. standardising only where this adds value).

Standardisation may apply across a HWB or partnership footprint, or more widely, as appropriate. We would expect some pathways, services, systems and processes to be standardised across HWB or partnership footprints, some to be standardised across the whole of HIOW. Elements not standardised will allow each cluster to take the approach which works best for them, but with encouragement and support to consider what other clusters are doing and the potential to spread best practice where it adds value (or reduces duplication of effort) to do so.

As part of this freedom to innovate, we recognise that clusters will continue to evolve. The current structure of clusters across HIOW (see next slide) may therefore change as clusters become established and take on an increasing role in service delivery.

Operationalising clusters is a key priority. This will include developing an outcomes-based cluster specification and providing management and development resources to clusters from CCGs

Accelerating the implementation of clusters

Every part of the HIOW system has confirmed the development of integrated cluster teams as a key priority for 2018/19, and every area has a change programme in place to deliver this.

- The 36 cluster teams across HIOW are at variable stages of development and maturity.
- The most established teams, formed under Better Care and Vanguard programmes, offer a wealth of evidence and learning about what works; however we are yet to effectively capitalise on this across HIOW.
- There are currently different names for cluster teams in each care system, reflective of evolutionary local plans.
- However, there are high levels of congruence in the overall description of the function and form of these teams across the system.

Therefore, the ambition for cluster development for 2018/19 is to:

- Accelerate and embed the infrastructure for all 36 cluster teams by March 2019
- Evidence impact on patient outcomes, primary care capacity, hospital admissions and system flow

Current thinking about the development of the clusters by March 2019 and March 2020 is described on the following page.

The developing role of clusters

	October 2018 – March 2019	By April 2020
Strategy and Planning	• Cluster priorities identified and delivery plan in place • Cluster level population data available and used to support priority setting and planning	• Longer-term cluster objectives being shaped, informed by data • Mechanism in place for co-production of plans and services with local people
Care Redesign	• Practices working together to improve access and resilience • Core cluster team membership defined • Integrated primary and community care teams in place with joint assessment and planning processes • Prototypes in place for highest risk groups • Gap analysis undertaken, end state defined for key functions	• Components of delivery model in place for each of key functions (minimum 50% completion) • Active signposting to community assets in place • Shift of specialist resources into cluster teams • Integrated teams fully functioning and include social care
Workforce development	• Cluster workforce plan defined with targeted action to support recruitment/retention of key roles • Cluster level OD/team development plan in place	• Development of new/extended roles in cluster teams to meet local need • Beginning to share workforce and skills within clusters
Accountability & performance management	• Information sharing agreements in place between all partners • Plan for shared care record confirmed • Cluster responsibilities documented via MOU/alliance agreement	• Data used to drive improvement and reduction in variation within and between clusters • Shared care record (health) in place • Cluster monitoring impact on key outcomes
Managing collective resources	• Cluster assets mapped to inform future planning (estate, back office, people, funding) • Resources identified to enable/support cluster plan delivery (eg change management) • Cluster level dashboard including outcomes in place	• Shift of specialist resources into cluster teams • Clusters have sight of resource use and can pilot new incentive schemes • Cluster level plan to optimise use of assets and early components in place
Leadership & governance	• Dedicated professional and operational leadership in place in each cluster • Governance arrangements in place in each cluster, eg cluster board • Cluster partners identified and engaged in the development and delivery of the cluster plan • Cluster engaged in integrated care partnership decision making	• Cluster leadership embedded with defined responsibilities for co-ordination of cluster responsibilities • Mechanism in place to share learning between clusters • Practices have defined how they wish to work together going forward • Cluster is full decision making member of integrated care partnership

Statutory bodies are asked to:

Endorse:

1. **The developing role of clusters as outlined on the previous slide**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **the proposed next steps for the cluster task and finish group which are summarised as follows:**

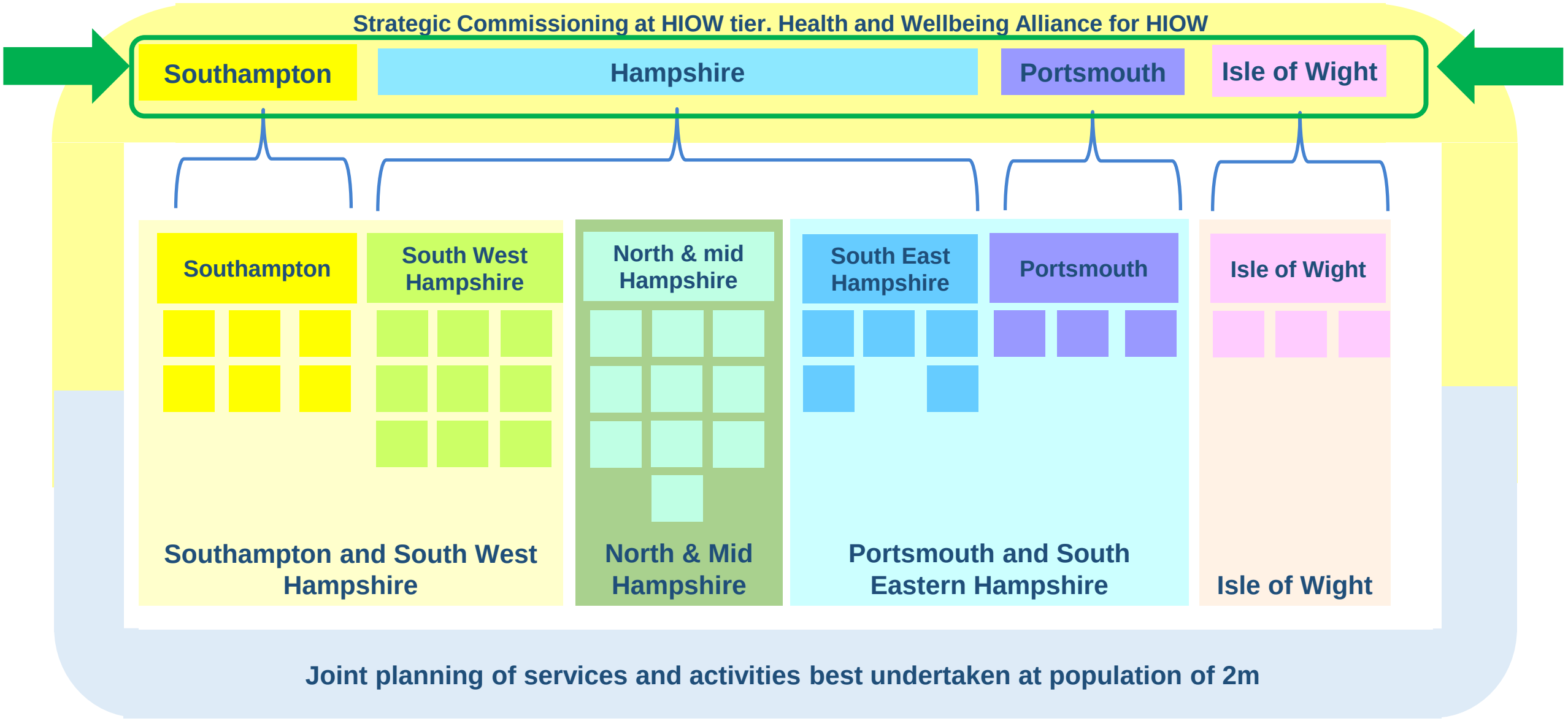
    a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW

    b. Describe the support requirements and responsibilities to accelerate full cluster implementation

    c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures

    d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

Integrated planning for a place: Health and Wellbeing Board footprints



Restating the function of Health and Wellbeing Board footprints within an integrated care system

Local government partners have convened to start work on restating the critical function of integrated health and care planning and delivery on a Health & Wellbeing Board (HWB) footprint.

An early draft definition of the function is summarised below:

HWB footprints will continue to be **the focus for place-based planning** (undertaking population needs assessment) and for aligning health, care and other sector resources to focus on delivering the improved outcomes for local people, building on the long-established integrated working arrangements, e.g. Better Care Fund, Section 75 arrangements, etc. Working in collaboration, partners will maximise the potential to further improve wellbeing, independence and social connectivity through the wider determinants of health including public health, housing, employment, leisure and environment.

The statutory role of the HWB with their political and clinical leadership, means that they should be central to the governance of health and care planning for a 'place'. The sustainability of the health and care system depends on public and political acceptability and support – as well as the right systems of design and delivery. So the active and effective democratic engagement at all levels (cluster through to whole HIOW) is vital. Strong and equitable relationships between NHS and local government will provide the necessary collective energy and focus required for system change. Furthermore, cross sectoral partnerships of public, private and voluntary and community organisations have important roles in all components of the system.

Much of our prevention and health improvement activities will continue to be designed and delivered in HWB footprints. We will use our ability to align / pool monies between NHS and local government partners to ensure that a clear focus for each HWB footprint is the resourcing of our 36 clusters (integrated primary and community care teams).

Our HWBs are based on local authority footprints. We will continue to integrate our CCG and LA teams focused on place-based health and care planning on these HWB footprints, reducing complexity and duplication. We will also be deploying some of our health (CCG) and care staff directly to support the operationalisation of our 36 clusters.

All four LAs have committed to meet with health provider and commissioner colleagues during August/September as a task and finish group to further develop the above definition and proposed next steps (see more detailed recommendation on the next page).

Statutory bodies are asked to:

Endorse the following recommendations from the EDG, informed by the task and finish group work to date:

1. **The emerging ‘restatement’ of the function of partnership working on a HWB footprint as described on the previous slide**

2. **The proposed next steps for a task and finish group by the end of September, which are to:**

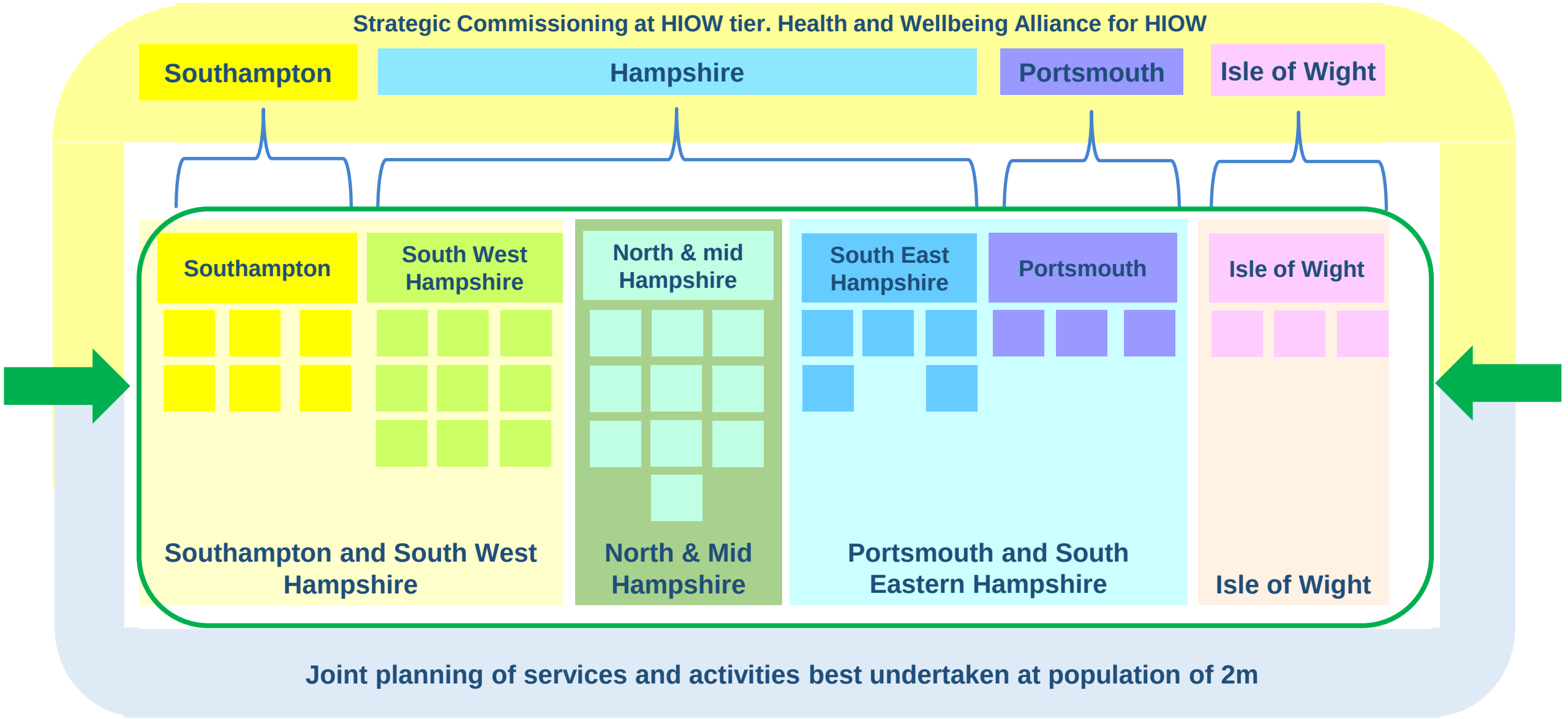
a. define the common functions of the role of HWB footprints in an integrated care system

b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system

c. set out a mechanism for achieving ‘active and effective democratic engagement at all levels’ across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.

Integrated care partnerships



Integrated care partnerships

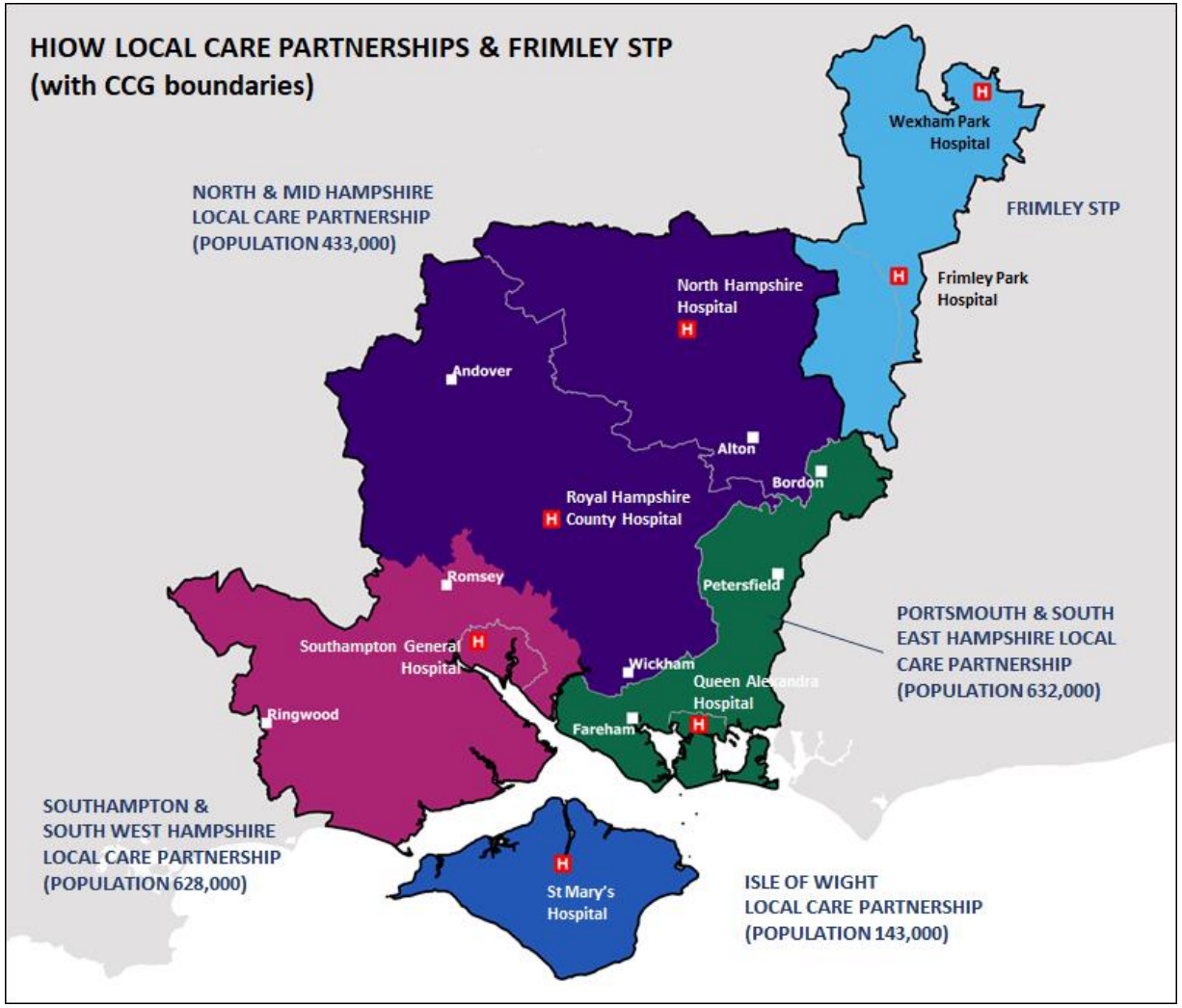
Integrated care partnerships are where we align the work of the local clusters, community services, acute and specialised physical and mental health services, for the benefit of the local population.

Providers of mental and physical health and care services including general practice, NHS commissioners, local authorities and voluntary sector organisations come together in geographies based on the local catchments of acute hospitals to benefit their local population.

The term ‘integrated care partnership’ [ICP] is being used to describe the collaboration of partners on these geographies.

The ICPs across HIOW will reflect local needs and will differ in the extent of their focus and work programme. For some, the focus may be predominately on improving operational ED performance. In others there is already an intent to work together on a more comprehensive basis with established governance structures to deliver agreed improvement programmes.

The balance and focus of the planning and delivery that takes place in HWB footprints and integrated care partnerships will vary in each part of HIOW.



What could integrated care partnerships look like?

The nature of Integrated Care Partnerships [ICPs] will vary according to local circumstances, challenges and opportunities. For some the arrangements will mirror current state. For others their development is such that by **April 2020, integrated care partnerships could be working together to:**

- implement a integrated care partnership delivery plan which sets out the collective priorities of the integrated care partnership, over the medium term (3-5 years) and in the short term (1-2 years) [noting that as previously alluded to, the balance and focus of planning and delivery that takes place in integrated care partnerships is likely to vary in each part of HIOW]
- design and implement optimal care pathways, and to identify, understand and reduce unwarranted clinical, operational and service variation
- make the best use of the collective resources of the integrated care partnership, including workforce, financial resources and estate, maximising system wide efficiencies and encouraging resources to flow to address the key risks facing the partnership
- support the ongoing development of the integrated care partnership:
    - progressively building the capabilities to manage the health of the population, to keep people well and to reduce avoidable demand
    - supporting the ongoing development of clusters, as the bedrock of the local health and care system
    - in some areas, potentially managing the transition to evolved organisational form arrangements that enable members of the integrated care partnership to sustainably meet the population needs

An integrated care partnership board could lead the partnership, providing strong system leadership, actively breaking down barriers that hinder progress in the delivery of integrated care, building trust and acting together to deliver improvements for citizens, for the system as a whole and through which partners hold each other to account for delivery of the shared priorities.

In integrated care partnerships, NHS providers including primary care, commissioners and local authorities work to overcome the barriers to collaboration associated with the separation of provision and commissioning. Whilst recognising the important individual statutory responsibilities of each partner, it is envisaged that:

- CCGs will deploy their people and resources to work collaboratively with other CCGs in the integrated care partnership, focussed on implementation of the integrated care partnership delivery plan – improving services, improving operational performance and delivering cost reduction.
- NHS providers will work together to make strategic and operational decisions that are in the best interest of the integrated care partnership.
- Where possible, in order to reduce duplication and bureaucracy, CCGs, NHS providers and if relevant local authorities, will seek opportunities to optimise corporate support services and infrastructure such as finance, quality, communications and governance teams.

Current thinking about the development of integrated care partnerships by March 2019 and March 2020 is described on a subsequent slide.

ICPs: an example of a different approach

We anticipate seeing:

- CCGs deploying their people and resources to work collaboratively with other CCGs in the local care system and with providers
- Providers making decisions and delivering care together – provider alliances
- CCGs, NHS providers and potentially local authorities sharing corporate support services and infrastructure?
- Over the next 18 months, working through together the impact on financial flows, contractual models and organisational forms (drawing national models such as the ICP contract consultation)

Enabling us to have:

- Better grip on improving the money, performance and quality
- Integrated care partnerships supporting clusters to develop and thrive
- Whole system implementation of improved care pathways, and reduction in unwarranted clinical, operational and service variation
- Collective support for all services in the integrated care partnership to meet operational performance and quality standards
- Reduced transaction costs

The ICP Task and Finish Group has been developing a vision of how the future <u>might</u> look. Each ICP will develop proposals that reflect their local context, challenges and opportunities

A potential timeline for the development of ICPs

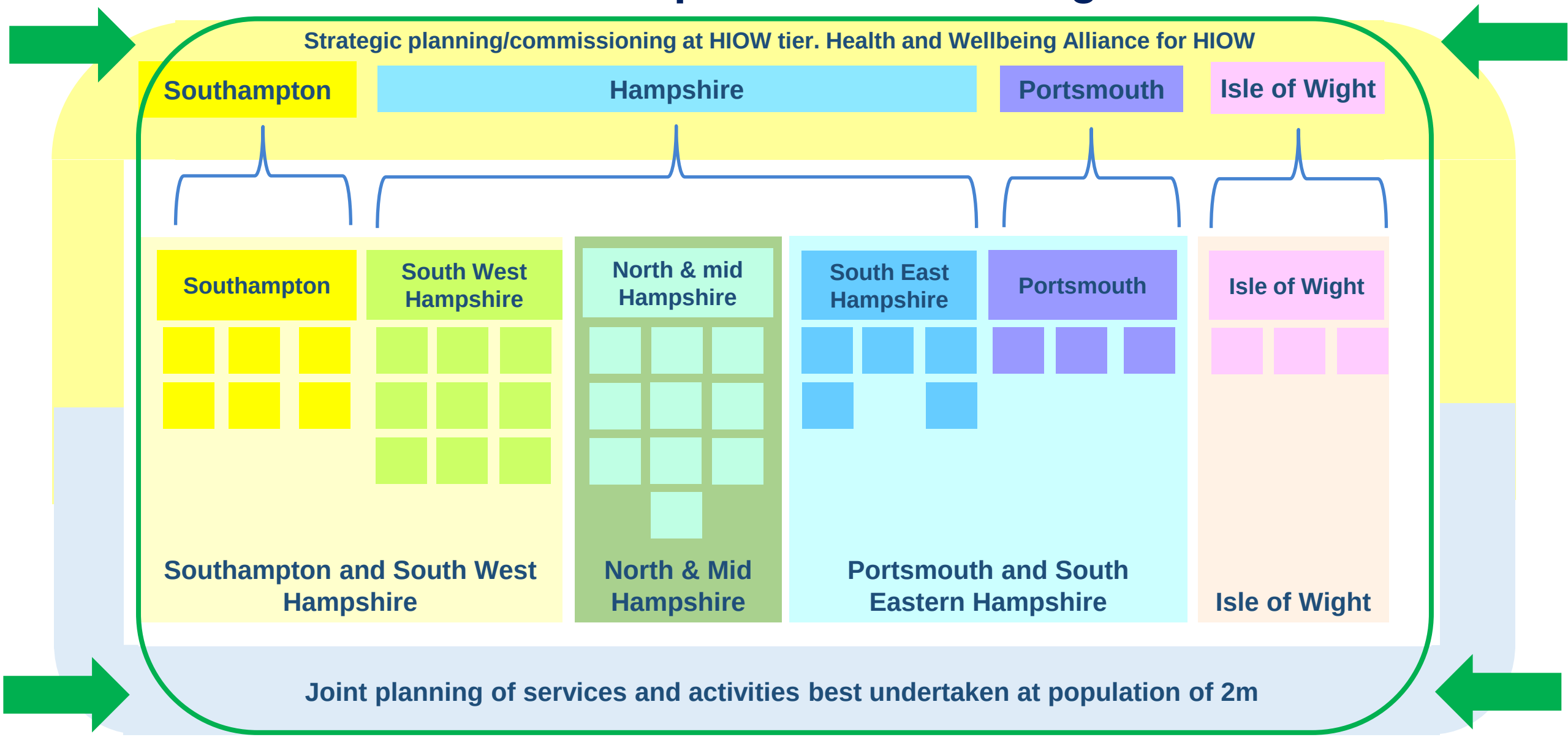
	October 2018 – March 2019	By April 2020
Strategy and Planning	• Develop and agree plan to make optimal use of acute and specialised physical and mental health services • Aligning the work of clusters at HWB footprint with community and acute physical and mental health services	• Agreed single strategy and operational plan for the integrated care partnership describing collective priorities and how those priorities will be delivered • Planning undertaken jointly by CCGs, providers and LAs
Care Redesign	• Implementing Urgent & Emergency Care priorities for the integrated care partnership • Developing optimal care pathways across the integrated care partnership • Agreed plan to support the development of clusters • Engaging staff and local communities in redesign	• 100% of clusters thriving, with lower mental and physical acute care demand as integrated teams support people to stay well at home • Managing a comprehensive programme of service improvement to address the integrated care partnership priorities • Population groups with high service utilisation or unmet need identified and action agreed
Workforce development	• Understanding the workforce issues for the integrated care partnership	• Securing the right workforce, in the right place with the right skills in the integrated care partnership, and ensuring the wellbeing of staff
Accountability & performance management	• Working together to monitor and improve delivery of constitutional standards	• Instigating clinically led quality improvement • Extensive use of data to drive improvement • Oversight of delivery in clusters • Leading recovery of standards without outside intervention
Managing collective resources	• Understand current resource use in the integrated care partnership • Working together to make the best use of the collective resources (workforce, estate, financial) in the integrated care partnership • Test new approaches to manage funding flows (e.g. DTOC) • Maximising system wide efficiencies	• Managing the collective resources of the integrated care partnership • Capable of taking on a delegated budget • Directing resources to address the key integrated care partnership risks • Shared corporate support services • Shared medium term financial plan including efficiencies
Leadership & governance	• Understanding the context, ambitions and challenges of each member of the integrated care partnership, building trust, acting together • Governance structure in place to enable collaboration • Cluster leaders engaged in integrated care partnership planning and decision making • Members of the integrated care partnership working together to agree any changes required to organisational structures	• Joint provider, CCG and LA leadership to enable planning and delivery in the integrated care partnership • Care professionals leading service integration • Governance mechanisms in place to enable decisions to be made in the best interests of the system and residents • Implementing agreed changes to organisational structures to better enable delivery in the integrated care partnership

Statutory bodies are asked to:

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight



Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight

In order to support and add value to the work of clusters, HWB footprints and integrated care partnerships, it is envisaged that providers, commissioners and local authorities will work together to undertake strategic planning, transformation, resource allocation and oversight activities at HIOW level.

This could be achieved, by April 2020, through a single entity for HIOW which, in its mature form, would develop strategy, set priorities and provide strategic leadership and direction to the HIOW integrated care system.

The strategic planning and transformation function in the HIOW integrated care system would:

- include the input and expertise of providers, CCGs and local authorities
- programme manage the implementation of HIOW level transformational change (change that spans more than one integrated care partnership or which is most appropriately managed at HIOW system level)
- proactively support the development of integrated care partnerships
- manage the specialised commissioning budget for HIOW
- align the resources coming into HIOW from a wide variety of sources around the delivery of the agreed strategic priorities, in order to increase the impact for populations
- act as the assurance body for HIOW, providing oversight of operational, quality and financial performance, and enabling the HIOW integrated care system to take action to improve performance without the need for outside intervention.

Whilst recognising the important role of external regulation, it is anticipated that the integrated care system will increasingly develop the capacity and capability to role-model ‘self-regulation’ – where robust processes are in place to ensure that action is taken to identify issues and improve performance without the need for outside intervention.

Creating this strategic planning and transformation function for the HIOW, which involves providers, CCGs and local authorities, is an opportunity to bring together in one place a number of functions including: those CCG functions best undertaken at HIOW level, STP functions, functions currently undertaken by the Director of Commissioning Operations, NHS England/NHS Improvement regulatory functions, specialised services commissioning and potentially other NHS England direct commissioning activities; HIOW clinical networks.

Current thinking about the transition towards this new way of working, by March 2019 and March 2020, is described on a subsequent page.

The characteristics of the HIOW integrated care system

It is proposed that, based upon national ICS, national guidance and evidence of best practice, an entity operating at the scale of HIOW could display the following characteristics:

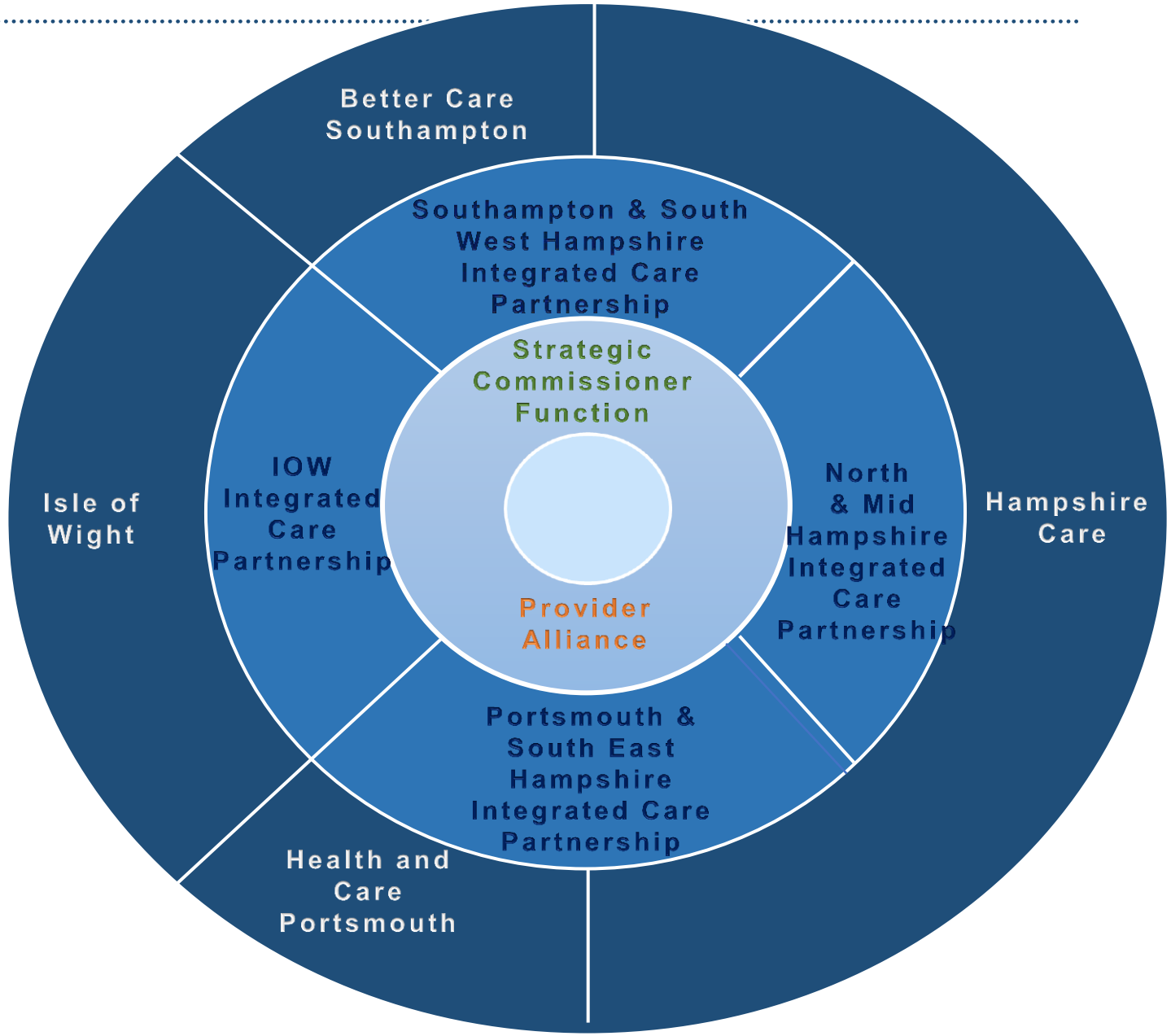
Subsidiarity: only undertaking functions that for reasons of cost or complexity need to be undertaken at the scale of 2m+ population. Unnecessary complexity and bureaucracy are stripped out with 80% of the transformation process led by local place-based teams;

Inclusive: national models / guidance show that prospective ICS are founded on partnership; for HIOW this would draw together:

- A newly established strategic commissioning function
- the four HWB footprints
- the four integrated care partnerships
- provider alliance

Founded on self-regulation: all components of reformed systems have effective self-regulation and enable a model of collective assurance at the scale of the ICS. This allows NHS England and NHS Improvement to deploy resource into the ICS and have a single touch point on delivery to the newly reformed regional and national infrastructure;

Politically-led: prospective ICS all demonstrate strong political leadership and close connection with Health and Wellbeing Strategies and Boards.



Strategic planning/commissioning at the scale of HIOW

As an immediate next step in the transition to this future system model, it is proposed that HIOW CCGs and local authorities establish a strategic planning/commissioning function during Q3 2018/19.

By working together at HIOW level, CCGs and local authorities expect to be able to reduce fragmentation and bring the following immediate benefits:

- stronger alignment of health and local authority commissioning
- the development & agreement of consistent whole system strategic priorities for HIOW
- improved and simplified commissioning decision-making for HIOW wide issues.

The functions of the strategic planning/commissioning function in its initial form would include:

- Setting consistent commissioning strategy and strategic priorities for HIOW
- Managing whole system resilience at HIOW level
- Management and deployment of supra-allocation resources (including capital)
- Demand and capacity planning and commissioning decisions about the future configuration of acute physical and mental health services for the 2 million population of HIOW
- Oversight of NHS constitutional standards, financial performance and quality improvement – with work to be done to ensure this activity isn't duplicated elsewhere
- Work with specialised commissioners, understanding current activity flows and costs, inputting to and aligning decision making
- It is also proposed that the strategic planning/commissioning function incorporates the transformation programme function of the HIOW Sustainability and Transformation Partnership.

Proposed governance:

- Established through a joint committee, in the first instance, during Q3 2018/19
- Members include CCGs, NHS England (specialist commissioning and Regional Director of Commissioning) and local authorities
- Joint committee will have delegated authority to make binding decisions in relation to the in-scope functions and responsibilities
- Expect by April 2019 the governance and organisational arrangements evolve further

The strategic planning/commissioning function is a mechanism through which commissioners can pool skills, expertise, resources and accountability to deliver transformation at HIOW level. There is a strong desire to create a new way of working, rather than add layers to existing ways of working.

The developing functions at a scale of HIOW

	October 2018 – March 2019	By April 2020
Strategy and Planning	• Clear commissioning priorities agreed for HIOW • HIOW system strategy and priorities being refreshed/updated • Demand and capacity planning for HIOW acute services • Agree aligned planning process for 2019/20-2020/21	• CCGs, providers & LAs setting shared strategy & priorities for HIOW with aligned health & LA planning processes • Fully own a single HIOW system operating plan that brings together plans of constituent parts of the system
Care Redesign	• Decisions being made about future configuration of acute physical health and mental health crisis and acute care • Leadership of plans to improve urgent care for HIOW, including oversight of delivery of the Integrated Urgent Care Plan • Decisions about community services provision for Hampshire	• Well developed plans being enacted to support the development of integrated care partnerships • Programme managing the implementation of HIOW level strategic change programme • Leading on implementation of acute service and estate reconfiguration
Workforce development	• Understanding the workforce issues for the system • Influencing the addressing of key workforce issues	• Strategic workforce plan in place and being implemented • Influencing future workforce supply and training requirements
Accountability & performance management	• Oversight of HIOW winter resilience and preparedness • Oversight of delivery of integrated urgent care plan • Acting as interface with assurance bodies for HIOW	• Collective oversight of quality, operational performance and money • Acting as the assurance body for HIOW – supporting the system to take action to improve performance and address challenges without the ned for outside intervention
Managing collective resources	• Agree system wide capital and estate priorities and sign off wave 4 capital allocations • Develop understanding of whole system financial plans and financial risks • Plan for aligned management of specialised commissioning	• Take accountability for a HIOW system control total • Managing collective finances & risk openly and as a system • Aligning resources flowing into HIOW to achieve priorities • Support integrated care partnerships to take delegated budget • Managing the specialised commissioning budget
Leadership & governance	• CCGs operating with a single decision making committee for HIOW level commissioning business • All STP partners involved in the design of the future HIOW level system strategic planning, implementation and assurance function • STP partners providing leadership to strategic change programmes	• A single coherent entity in place that brings together HIOW level CCG functions, STP and NHSE/I functions • Strategic alignment of providers, commissioners and local authorities around the system strategy and priorities • Clear clinical leadership for the system and input from HWB footprints and integrated care partnerships in decision making

Statutory bodies are asked to:

Endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.

2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

Summary of recommendations

In summary, the governing bodies and boards of statutory organisations are asked to endorse the following recommendations from the EDG, informed by task and finish group work to date:

Clusters

1. **The developing role of clusters as outlined earlier**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **The proposed next steps for the cluster task and finish group which are summarised as follows:**
   a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
   b. Describe the support requirements and responsibilities to accelerate full cluster implementation
   c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
   d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

Health and Wellbeing Board Footprints

1. **The emerging 'restatement' of the function of partnership working on a HWB footprint as described earlier in the document**
2. **The proposed next steps for the task and finish group by the end of September, which are to:**
   a. define the common functions of the role of HWB footprints in an integrated care system
   b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
   c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

Integrated care partnerships

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

Strategic commissioning

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

Next steps

System reform programme next steps

A number of recommendations have been set out linked to each component of the proposed ICS. In addition to those associated with the specific components of the proposal, there are a number of overarching 'implementation programme deliverables', some of which will result as a coming together of the outputs from the various task and finish groups. These include:

- System reform implementation programme plan
- Structure and leadership plan – transitionary and end state
- Development and implementation of a communications and engagement plan
- Request for support (endorsement , agreement in principle, technical and financial) from NHS England , NHS Improvement and other arms length bodies such as the Local Government Association, NHS Leadership Academy, Health Education England
- Proposals to replace STP infrastructure (inc. Chair & SRO) to align with future form
- Organisational change plan and talent management plan
- HIOW ICS Chair and relevant leadership appointments
- Indicative budgets and financial framework for all components of the ICS
- Three year financial plans

It is recommended that a working group is formed, reporting to the EDG, to support the development of the above. Members of EDG are asked to nominate a representative to represent the interests of their part of the system.

Glossary

Glossary of terms

Clusters - also referred to locally and nationally as neighbourhoods, localities, primary care networks. Multi-disciplinary teams delivering integrated health, care and wider services to cluster populations based on natural communities of 20-100,000 people.

Health and Wellbeing Board (HWB) footprints – also known as care systems and are based on local authority footprints. The basis of the joint strategic needs assessment (JSNA), means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health. Locally the HWB footprints come under the guise of Better Care Southampton, Health and Care Portsmouth, Hampshire Care and the Isle of Wight Care Board.

Integrated care partnerships – also know as local care partnerships and are based on acute (physical) hospital footprints. Integrating care delivered in clusters with broader community and acute physical and mental health services; optimising the utilisation of acute services; designing and implementing optimal care pathways.

Integrated care system - the Hampshire and Isle of Wight health and care system, serving a population of 2 million citizens.

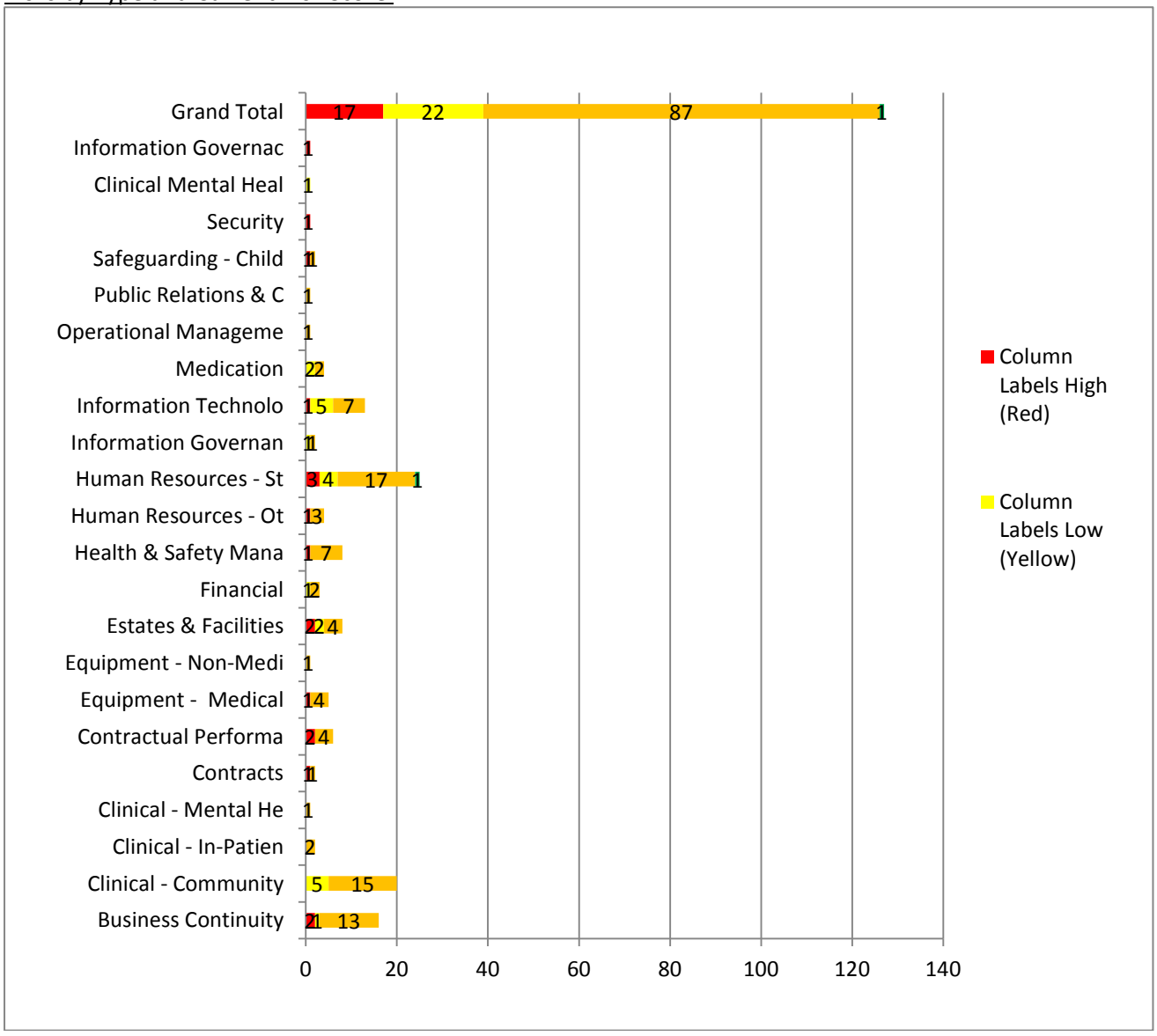
NHS England defines ICS as those systems in which:

“Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”.

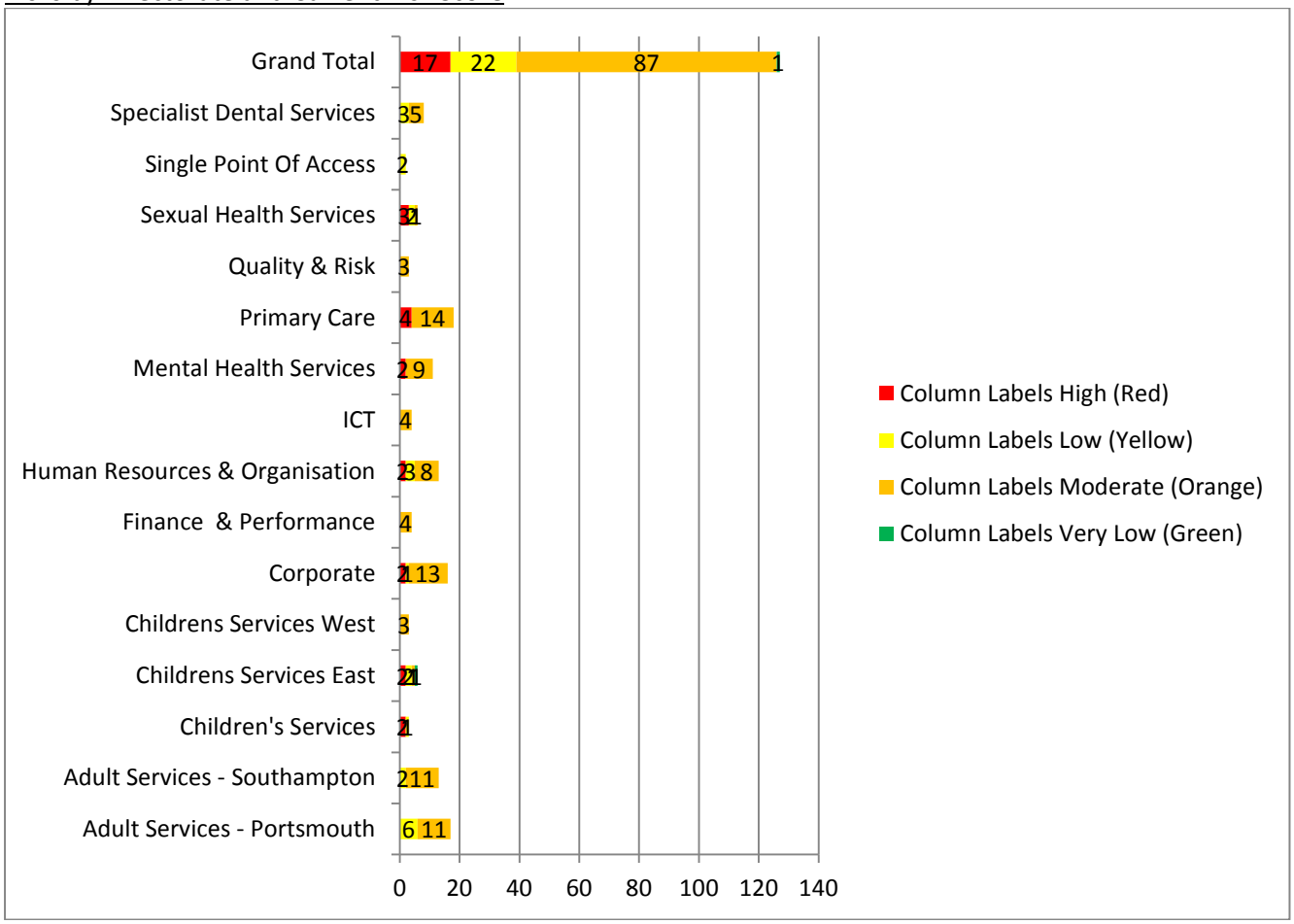
Item 10.3

CEO Report – Appendix 2

Risks by Type and Current Risk Score



Risks by Directorate and Current Risk Score



Presentation to	X	In Public Board Meeting		Confidential Board Meeting				
Title of Paper	**Portsmouth & South East Hampshire Operating Plan 2018/19**							
Author(s) Executive Sponsor	Sarah Austin, Director of System Delivery							
Date of Paper	September 2018		**Committees presented**	PSEH LCP Board				
Link to CQC Key Lines of Enquiry (KLoE)		Safe		Effective		Caring	X	Responsive		Well Led
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy	x	**W3** Culture	x	**W4** Roles & Responsibilities	X
	W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	x
Action requested of the Board	X	**To receive**		**For decision**				

The Local Care Partnership (LCP) have requested that the LCP Operating Plan 2018/19 is taken to and noted by the respective Boards of the Organisations within the Portsmouth and South East Hampshire Local Care Partnership. A full copy of the Operating Plan is found in Item 11.2.

The LCP Operating Plan 2018/19 sets out:

- The financial challenge across the LCP for 2018/19 and a 3 year financial plan
- The 5 Transformation Programmes that are in place for 2018/19 which will support the system in delivering the financial and operational pressures
- Governance and Risk

The process has already started for developing the LCP Operating Plan for 2019/20.

Recommendation:

The Board is asked to formally receive the LCP Operating Plan for 2018/19.

Portsmouth Hospitals NHS Trust | Solent NHS Trust | Southern Health NHS Foundation Trust | Portsmouth Clinical Commissioning Group | Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups

Item 11.2

Portsmouth and South Eastern Hampshire Local Care Partnership (LCP)

Operating Plan 2018/19

10th July 2018

The Portsmouth and South Eastern Hampshire (PSEH) Local Delivery System (LCP) Operating Plan sets out 'what' the PSEH LCP will deliver in 2018/19 and 'how' this will be done in order to meet the objectives that have been set out in the LCP Improvement Plan.

'The What'

The high level objectives from the Improvement Plan state that as the organisations with responsibility for health and care in Portsmouth and South East Hampshire we have come together to deliver the following objectives:

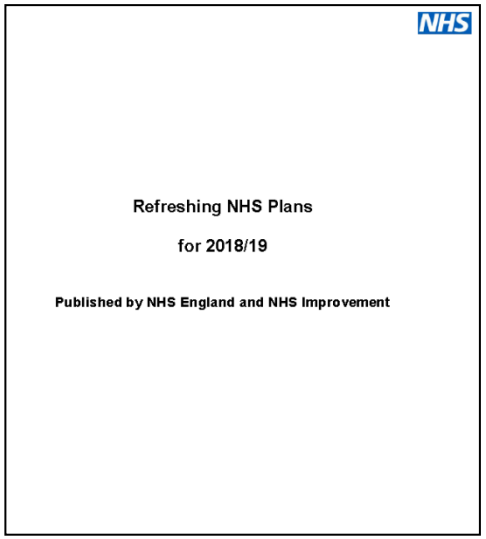
❶ To **deliver long-term improvements in health and care outcomes**, supporting residents to stay well, reducing inequalities and reducing avoidable illness.
❷ To **improve the quality and safety of health and care services**, with all services assessed by the CQC and Ofsted to be 'good' or better, and increasing proportions of people reporting a positive experience of, and greater involvement in their care.
❸ To **deliver the agreed waiting time standards2 for health and care services**, by making fast and tangible progress in urgent and emergency care reform, strengthening general practice, community and social care services, improving mental health and planned care services.
❹ To **manage services within the money available,** delivering substantial system efficiencies and moderating the growth in demand for health and care services.

In order to deliver these objectives we committed to:

❶ **Agree and deliver a single system improvement plan** to restore and improve service quality, performance and financial health, with clear and agreed priorities. The immediate priority is to deliver significant improvements in urgent and emergency care performance.
❷ **Establish a new way of working together,** where our organisations and teams are aligned around a common purpose, with clarity about roles and responsibilities, with stronger operational 'grip' and a culture that enables leaders and frontline staff to work together to drive and deliver the improvement plan. As providers and commissioners we are increasingly taking collective responsibility for population health and resources in Portsmouth & South East Hampshire.

PSEH LCP Operating Plan | Operating Plan Alignment

The Portsmouth and South Eastern Hampshire (PSEH) Local Delivery System (LCP) Operating Plan sets out the areas where the LCP will bring added value through closer system working. This operating plan is underpinned by each of the constituent organisations individual operating plans.



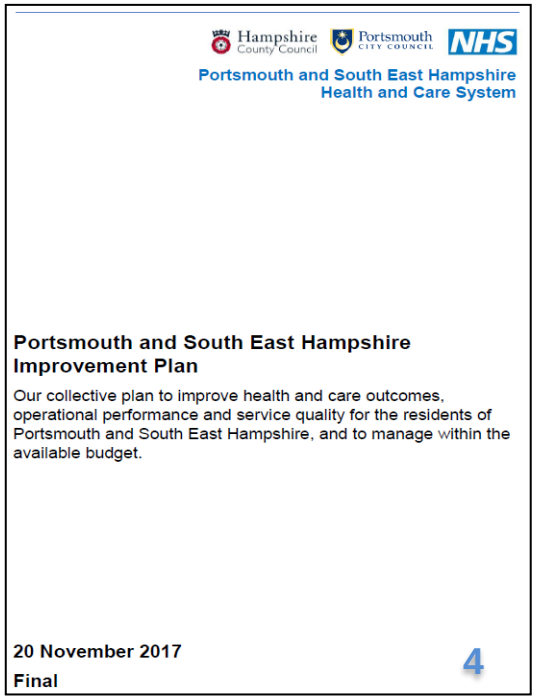
"The task for commissioners and providers is to update the 2018/19 year of existing two-year plans…to ensure that operating plans…are the product of partnership working across STPs, with clear triangulation between commissioner and provider plans and related contracts"

Refreshing NHS Plans for 2018/19

With all organisations committed to working as part of the Portsmouth and South Eastern Hampshire Local Delivery System (PSEH LCP) it is fundamental that we have demonstrated alignment and delivery of system priorities through our individual organisational operating plans

Through our respective individual plans we have:

- ❑ Demonstrated alignment of key assumptions on income, expenditure, activity and workforce between commissioners and providers within the PSEH LCP
- ❑ Ensured that organisational plans underpin and together express the PSEH system's priorities
- ❑ Produce together a credible plan that delivers the system control total



	Notified			Planned				
	18/19 FOT (£000)	CSF/PSF (£000)	In Year FOT (£000) (Control Total)	18/19 FOT (£000)	CSF/PSF (£000)	In Year FOT (£000)	Savings Requirement (£000)	Savings Requirement %
F&G	(4,000)	4,000	0	(4,000)	4,000	0	14,407	5.2%
Portsmouth	0	0	0	0	0	0	10,768	3.4%
SE Hampshire	(2,500)	2,500	0	(2,500)	2,500	0	13,271	4.4%
Commissioner Total	**(6,500)**	**6,500**	**0**	**(6,500)**	**6,500**	**0**	**38,446**	**4.3%**
Portsmouth Hospitals NHS Trust	6,844	18,887	25,731	(29,900)	0	(29,900)	35,280	5.8%
Solent NHS Trust: *55% share*	(1,425)	891	(534)	(1,425)	891	(534)	3,901	3.7%
Southern Health NHS Foundation Trust: *20.5% share*	(145)	838	693	(145)	838	693	2,624	4.0%
Provider Total	**5,274**	**20,616**	**25,890**	**(31,470)**	**1,729**	**(29,741)**	**41,805**	5.4%
Total	**(1,226)**	**27,116**	**25,890**	**(37,970)**	**8,229**	**(29,741)**	**80,251**	

2018/19 System Savings Plan

	Planned Savings £m
Workforce Transformation	14.6
Procurement	6.1
Pharmacy and Prescribing	7.6
Productivity and capacity	2.5
Elective & Outpatients	5.9
Unscheduled Care Pathway	2.5
New Care Models	3.1
Non-pay & Commercial	3.4
Other PHT	5.9
Continuing Healthcare	4.0
Primary Care	2.0
Income Generation	1.5
Other CCG	3.3
Unidentified	17.9
TOTAL	**80.3**

3 Year System Financial Plan

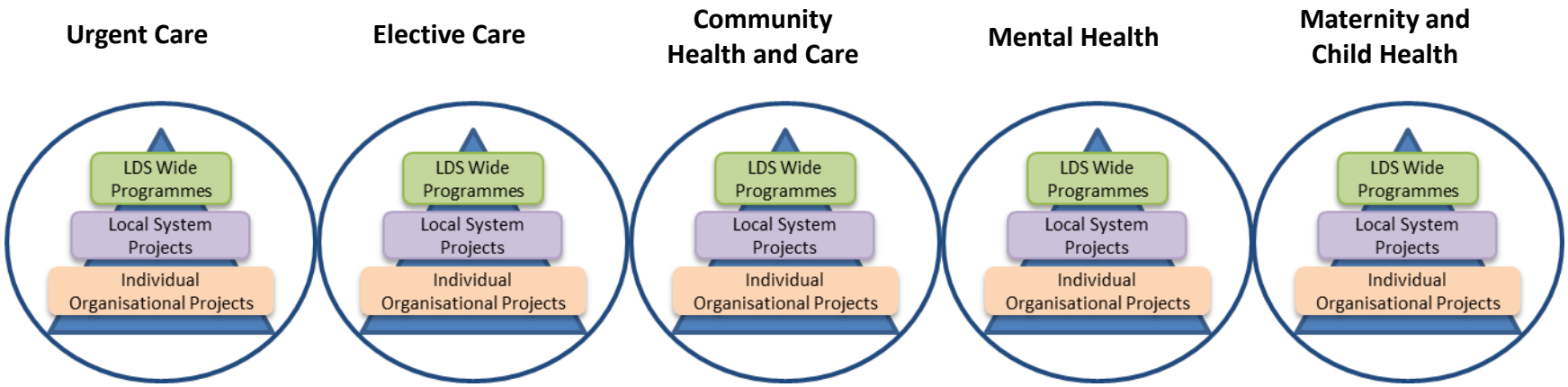
	2018/19			2019/20			2020/21		
	Income/ allocation £'m	Expenditure £'m	(Deficit)/ surplus £'m	Income/ allocation £'m	Expenditure £'m	(Deficit)/ surplus £'m	Income/ allocation £'m	Expenditure £'m	(Deficit)/ surplus £'m
Portsmouth Hospitals NHS Trust									
Gross Spend	539	604		561	609		593	617	
CIP		-35	-30		-28	-20		-25	1
Solent (55%)									
Gross Spend	102	105		103	106		105	108	
CIP		-3	0		-3	0		-3	0
Southern (20.5%)									
Gross Spend	64	65		66	66		67	67	
CIP		-3	2		-2	2		-1	1
PROVIDER TOTAL	**705**	**733**	**-28**	**730**	**748**	**-18**	**765**	**763**	**2**
CCGs									
Gross Spend	895	941		915	950		950	968	
QIPP		-39	-7		-35	0		-18	0
CCG TOTAL	**895**	**902**	**-7**	**915**	**915**	**0**	**950**	**950**	**0**
TOTAL SYSTEM SAVINGS REQUIREMENT		**-80**			**-68**			**-47**	
SYSTEM SURPLUS/ (DEFICIT)			**-35**			**-18**			**2**

'The How'

All PSEH organisations are committed key partners of the PSEH LCP and the Operating Plan demonstrates the systems contribution to delivery of the PSEH LCP objectives. Through this, the Plan aligns and contributes to delivery of the priorities set out within:

- The 2018/19 planning guidance
- The Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Partnership plan
- The Improvement and Assessment Framework

In 2018/19 these will be delivered across 5 PSEH LCP priority Programmes. These are:



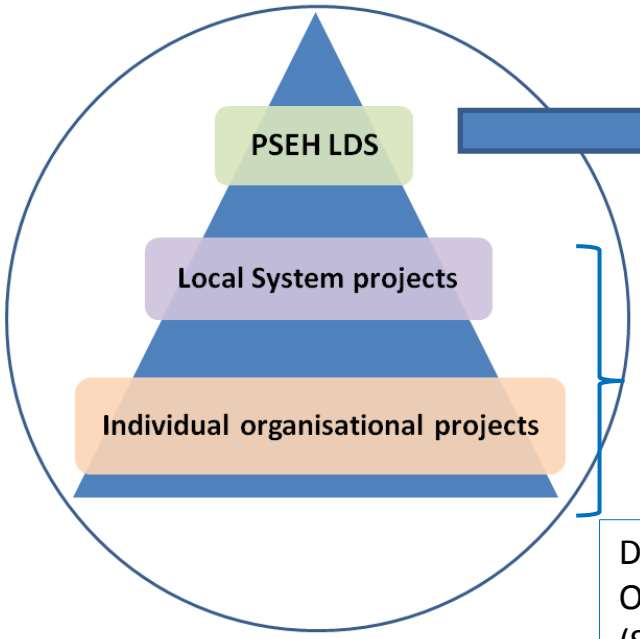
The PSEH Operating Plan:

- Summarises the key LCP programmes of work as above
- Describes 'how' these will be achieved through delivery of the underpinning projects - outlining the milestones; KPIs; timelines; associated impact (activity and finance); risks; outcomes etc. for each
- Lays out the appropriate level of Governance that is in place to manage and monitor delivery
- Provides assurance that the appropriate level of reporting is provided to the LCP Board, individual organisations Boards, STP, NHSE/NHSI to provide the level of assurance required

PSEH LCP Operating Plan | Community Health and Care

To prevent ill health, increase early intervention and build the strong, sustainable primary and community care services required to proactively manage the needs of the population at home and in the community

Community Health and Care Programme



1819 Project Focus:

- Enhanced Care Home Team roll out
- Front Door Admission Avoidance
- LTC Hub Development
- Neighbourhood Teams (Integrated Care Teams)

Detailed in individual Organisational Operating Plans (See Annex A)

Deliverables:

Reduce avoidable acute care episodes by delivering LCP care home and end of life programmes

Redesign community services to deliver sustainable models to maintain health and independence of frail elderly

Integrated health and care model to enable people to stay independent and better manage their LTCs.

Programme Quality and Performance Outcomes and Benefits

- Extended access to GP services for 100% of population Reduction in avoidable acute care episodes
- Reduction in ambulance call outs/conveyances and subsequent admissions
- Increased effectiveness of ED and MAU to avoid ED attendances unnecessarily converting into admissions

IAF Measures impacted:
Patient experience of GP services
Primary care workforce - GPs and practice nurses per 1,000 population
Primary care access
Effectiveness of working relationships in the local system
Delayed transfers of care attributable to the NHS and Social Care per 100,000 population
% patients admitted, transferred or discharged from A&E within 4 hours
Emergency admissions for urgent care sensitive conditions per 100,000 population
Injuries from falls in people aged 65 and over per 100,000 population
Personal Health Budgets per 100,000 population

Programme: Community Health and Care

Enhanced Care Home Team Roll Out

Aims & Objectives

- Expand the existing care home team models in each of the localities in a way that is best likely to have maximum impact. Work with the care homes in each area to develop a trusted assessor approach to supporting 7 day per week discharge.
- Reduce avoidable acute care episodes by delivering LCP care home and end of life programmes. Key enabler is delivery of a shared care record across all localities.

Deliverables

- Reducing ambulance call outs, conveyances and subsequent admissions of care home residents where these could be better managed in the community.
- Reduction in conveyances, A&E attendance, reduced admissions, reduced LoS, better patient experience
- More patients being cared for in their usual place of residence, fewer unnecessary hospital admissions, and free up rehabilitation beds for complex patients who cannot be cared for at home.

Key actions & timelines	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Completion of the business case to support roll-out of the team; to include data and financial analysis. This will include review of the effectiveness of the Red Bag scheme				
Red bag scheme to be established as business as usual, based on evaluation, across all relevant homes, ambulance trust and acute and community hospitals				
Roll-out of the enhanced care home team, as agreed				
Pilot a trusted assessor model to support 7 day a week discharge for care homes in one or more localities.				

Programme: Community Health and Care

Enhanced front door admission avoidance team

Aims & Objectives:

- A Frailty Intervention Team is based within A&E to identify and screen those at risk of frailty at the front door of hospital. To ensure frail patients are supported to return to home, or their place of residence sooner.

Deliverables:

- Increasing the effectiveness of ED and MAU to avoid ED attendances unnecessarily converting into admissions, where there is not a clinical lead.
- Reduce the conversion rate to 30% through enhanced FIT and appropriate ambulance conveyance and handover
- Reduction in inappropriate admissions where this might be due to a social care need, ensuring existing care packages can be kept open for 5 days and increasing the number of people able to return home with the same package
- Increase the use of the voluntary sector to support people to return home safely following an ED attendance
- Strengthen and increase the ability of the FIT team to manage short stay admissions, of less than 24 hours.

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Increase social work support into ED, with additional admin support to also identify those people who have an existing package which has been kept open for the first few days of admission and pro-actively work with teams to identify possible PDDs within this timeframe				
Pilot use of home from hospital VCS services from ED.				
Work with FIT team to identify blocks in achieving 72 hour discharges and identify opportunities to increase the numbers discharged within 72 hours.				

Programme: Community Health and Care

Reduction in SCAS non-conveyance to QA

Aims & Objectives:

- Improve the ability of paramedic teams to see, treat and refer rather than convey to QAH ED, thereby reducing conveyance of patients who could be better managed in community settings
- Reduce end of life conveyances
- Increase use of effective anticipatory care planning for key cohorts of patients
- Improved information sharing between primary care and SCAS teams through use of the summary care record

Deliverables:

- Reduction in conveyances, A&E attendance, reduced admissions, reduced LoS, better patient experience
- More patients being cared for in their usual place of residence, fewer unnecessary hospital admissions, and free up rehabilitation beds for complex patients who cannot be cared for at home.

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
To be determined by first meeting of project group				

Programme: Community Health and Care

Long term conditions hub development

Aims & Objectives:

- To improve long term condition management, (including self care) within primary and community care. Ensuring more proactive care model for respiratory care, diabetes and heart failure, based on agreed inclusion criteria to improve patient outcomes and avoid hospital admissions in future.
- Establish locality based , primary care led models of LTC care
- Agree secondary care input across PSEH
- Agree single model for community based specialist services

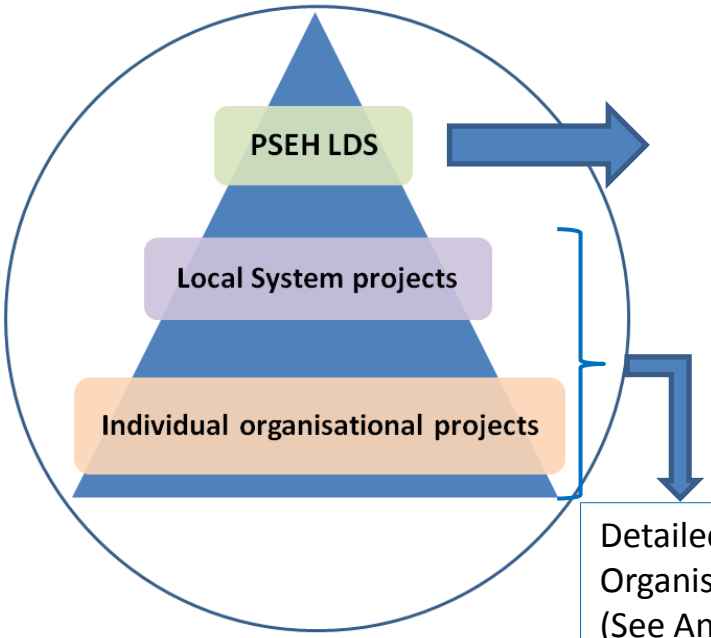
Deliverables:

- Patients receive enhanced support and care planning, improving outcomes and enabling patients to manage their conditions, maintaining independence
- Positive impact on frailty pathway through increased GP capacity to support this cohort
- Reduced clinical risk through all staff accessing full medical records

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
To be determined by first meeting of project group				

To improve urgent care access and performance, reduce demand, reduce harm, and manage clinical variation, enabling the system to meet A&E and Delayed Transfers of Care targets

Urgent & Emergency Care Programme



1819 Project Focus:

High impact change discharge actions

GP streaming in the Emergency Department (Urgent Care Centre)

Deliver new 111 integrated urgent care model

Detailed in individual Organisational Operating Plans (See Annex A)

Deliverables:

Early discharge planning; Systems to monitor flow; Integrated discharge teams; Home first D2A; 7 day services; Trusted assessors Focus on choice; (Enhancing health in care homes)

Urgent care centre development to make it more effective, improve the efficiency of GP streaming in the Emergency Department, improve A&E Waiting times.

Co-design and procure an effective 111 integrated urgent care service in collaboration with Hampshire partners

Programme Quality and Performance Outcomes and Benefits

- Achieve 85% A&E access target by September 2018
- Improved patient experience with care being given in the right place at the right time – Home first wherever possible
- Delayed transfers of care – Reduced to 3.5% national target
- Reduction in excess beds days
- Inpatient admissions growth reduced by 2%
- Stranded and super-stranded reduced to 40% of inpatient population

IAF Measures impacted:
% patients admitted, transferred or discharged from A&E within 4 hours
Delayed transfers of care attributable to the NHS and Social Care per 100,000 pop'n
Emergency bed days per 1,000 population
Emergency admissions for urgent care sensitive conditions per 100,000 pop'n
Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population
Ambulance waits

Programme: Urgent & Emergency Care

Discharge to assess (D2A) – 8 High Impact Changes

Aims & Outcomes

- The eight High Impact Changes identify and provide a transformational change model which is nationally recognised as best practice. The High Impact Changes provide a framework which evidences best practice for creating and maintaining discharge flow, such as early discharge planning, multi-disciplinary teams, trusted assessors and care home teams

Deliverables:

High Impact Change (HIC)	Outcome
HIC 1: - Early discharge planning	Outcome - early assessment of discharge needs and more people discharged in line with EDD
HIC 2 - Systems to monitor patient flow	Outcome - Improved ability to manage patient flow
HIC 3 - Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector	Outcome - single team approach within IDS and streamlined process
HIC 4 - Home first/discharge to assess	Outcome - increase in numbers of people discharge home through D2A pathways and reduced assessments in hospital
HIC 5 Seven-day service	Outcome - increase numbers of weekend discharges
HIC 6 - Trusted assessors	Outcome - implementation of a trusted assessor approach to support D2A.
HIC 7 - Focus on choice	Outcome – improved clarity for patients and their families and consistency in expectations
HIC 8 Enhancing health in care homes	Outcome – reduced admissions from care homes and improved discharge processes

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Embed ‘Why not home, why not today?’ culture across all teams and at ward level				
Increase use of proportional assessments				
Introduction of 5Qs and implementation of new CHC guidance				
Introduce Trusted Assessors				

Programme: Urgent & Emergency Care

GP streaming in the Emergency Department (Urgent Care Centre)

Aims & Outcomes

- Urgent Care Centre development to make it more effective
- Improve the efficiency of GP streaming
- Continue the delivery of co-located out of hours services

Deliverables:

- Reduction in A&E attendances
- Improved A&E triage, treat and discharge, achieve the 85%/4hour target.
- Achieve flow of 60 patients per day.

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Relocation of Urgent Care Centre				
Review of redirection model				

Programme: Urgent & Emergency Care

Deliver new 111 integrated urgent care model

Aims & Outcomes

- Co-design and procure an effective 111 integrated urgent care service in collaboration with Hampshire partners.

Deliverables

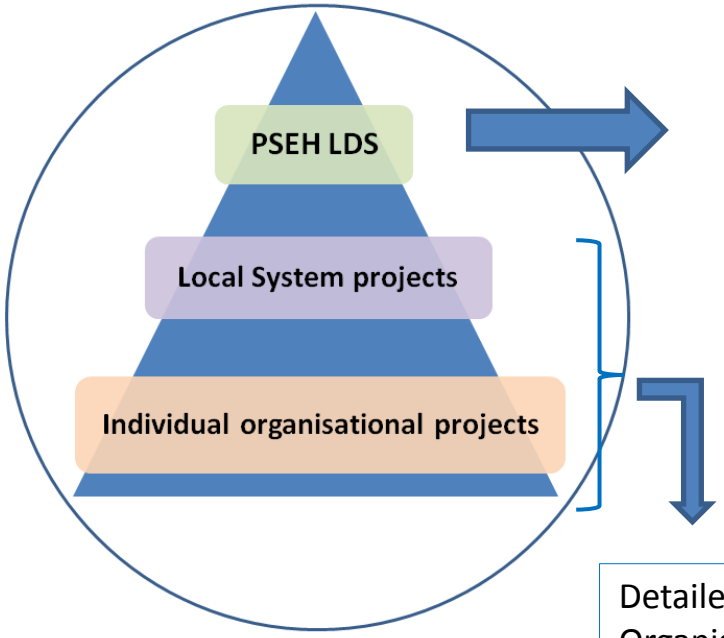
- Reduced A&E/UTC attendances
- Reduced conveyances
- Improved patient experience
- The right capacity and skill sets to support an increase in hear and treat; calls referred to a clinical advisor

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Co-design process to test, adapt and refine models of care				
Robust evaluation of models				
Direct award of interim, fixed-term contracts to cover the time between current contract expiry dates and 31 May 2021				
Competitive procurement process to resume in Quarter 3 of 2019/20 to enable the new IUC service to mobilise by 01 June 2021				

PSEH LCP Operating Plan | Mental Health

To improve the quality of and access to mental health care for adults and children

Mental Health Programme



1819 Project Focus:

Acute MH Assessment Unit

Crisis Pathway

Emotionally Unstable Personality Disorder (EUPD)

MH Acute Beds

Detailed in individual Organisational Operating Plans (See Annex A)

Deliverables:

Deliver a mental health assessment unit in the Emergency Department.

Improve access to 24/7 mental health crisis care for both community and acute provisions.

Improve EUPD pathways

Implement STP acute mental health locality bed model and repatriation

Programme Quality and Performance Outcomes and Benefits

- Improve access to 24/7 mental health crisis care
- Delivery of daily mental health clinic within Same Day Access Service - reduce A&E by 5%
- Increase early intervention in psychosis in line with national markers to an ageless model.
- Continued reduction in Out of Area Treatment Placements (OATs).

IAF Measures impacted:
Out of area placements for acute mental health inpatient care - transformation
People with 1st episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral
Percentage compliance with a self-assessed list of minimum service expectations for Out of Area Placements, weighted to reflect preparedness for transformation
Percentage compliance with a self-assessed list of minimum service expectations for Crisis Care, weighted to reflect preparedness for transformation.
Crisis care and liaison mental health services transformation

Programme: Mental Health

Acute Bed Transformation

Aims & Outcomes

- Portsmouth and South East Hampshire locally managed acute in-patient and PICU bed stock for flexible use across the LCP with aligned, common systems and processes to improve in-patient flow.

Deliverables

- Local bed stock will be used flexibly and seamlessly across providers with aligned admission, management and discharge processes, systems and operating procedures. This will improve patient flow and help to free up beds to decrease the number of Out of Area Placements.

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Review pathways for patient flow across providers				
Clinical Engagement				
Service model review and design				

Programme: Mental Health

Emotionally Unstable Personality Disorder

Aims & Outcomes

- Reduce pathway variation between providers and expand pathway parameters to include emotional dysregulation and Personality Disorder traits. Explore improved models of service delivery.
- Improving and increasing modalities for treatment in the community

Deliverables:

- Reduced Length of Stay
- Reduced Delayed Transfers of Care
- Reduction in Inappropriate admissions and re-admissions

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Obtain validated data				
Review the current pathway, and review wastage and efficiencies to map an agreed pathway across providers				
EUPD Standard operating procedures drafted and agreed across PSEH				
Review data to evidence any issues around LoS, DToC, Inappropriate admissions and re-admissions				

Programme: Mental Health

Mental Health Assessment Unit (MHAU)

Aims & Outcomes

- Develop and commission a service model to provide the right care, in the right place and at the right time for patients attending ED in a mental health crisis.

Deliverables

- Crisis Care plans, alongside the review of acute and community pathways will ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Improve patient experience; right treatment, right place, right time
- Delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Outcome of Capital Bid				
Consultations and design work				
Service spec and SOP finalised				
38 week capital work programme				
Go Live				

Programme: Mental Health

Crisis Response Project

Aims & Outcomes

- Everyone should be able to access an appropriate and acceptable level of support when they need it. Scope to include:
  - A 24/7 offer
  - Self referral to Crisis service
  - All age service offer including older people
  - Potential to include teenagers (as there is no crisis support for CAMHS)
  - Professionals i.e. advice line for GPs and other health professionals
  - Carers
  - Crisis housing

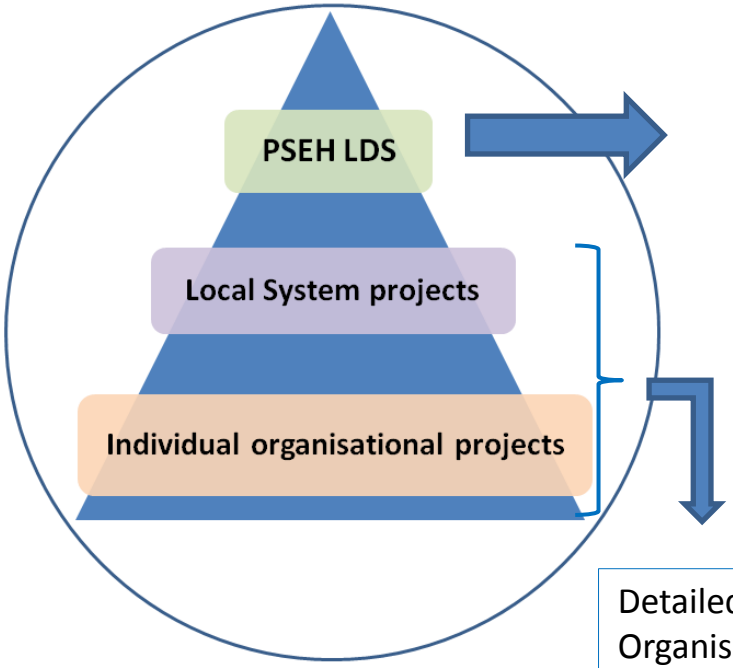
Deliverables

- People in crisis are able to access Mental Health Services to meet their needs
- Improved patient experience of crisis care services
- No further inappropriate detentions for mental health assessment in police cells
- Fewer people reach crisis
- Reduction in the number of suicides

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Alignment of AMH and OPMH Crisis Teams				
Alignment of Crisis, Psych Liaison and MHAU teams and pathways				
Enabling workstream for crisis projects				

To improve how we manage demand for elective care, and to redesign how we provide elective care, ensuring demand and capacity are in balance to enable constitutional targets to be met.

Planned Care Programme



1819 Project Focus:

- Reduction in out-patient attendances and follow-ups
- End to end pathway redesign
- Implementation of ERS
- Improvement in cancer pathways
- End to end system Long term conditions pathways
- Review of diagnostics
- Procedures of low Clinical Priority and threshoLCP

Detailed in individual Organisational Operating Plans (See Annex A)

Deliverables:

- End to end pathway design and Plans agreed & implemented at speciality level
- Improved clinical triage service and increased scope within the community, with an emphasis on self management
- Reduction of Acute referrals and activity
- Increase use of e-referrals to proactively manage demand and capacity within the system

Programme Quality and Performance Outcomes and Benefits

- Sustain reduction in GP referrals
- Reducing length of stay – improving the experience for patients and ensuring best use of resources
- 52 week RTT and 104 day cancer breaches to be reduced– improvement to patient journey and efficiency
- RTT incomplete waiting list to be no higher in March 2019 than it is in March 2018 – maintaining patient pathways

IAF Measures impacted:
Diabetes patients that have achieved all NICE recommended treatment targets
People with diabetes diagnosed less than a year who attend a structured education course
Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population

Programme: Planned Care

End to end pathway redesign

Aims & Objectives:

- Achieving constitutional targets for referral to treatment, diagnostics and cancer waiting time standards
- End to end system Pathway redesign: Cardiology, MSK, Dermatology, ENT, Urology, Digestive Disorders initially with other specialties to follow as the year progresses
- Improved clinical triage service and increased treatments within community services with an emphasis in self management
  Reduction of Acute referrals and activity
- Use of innovation and supportive technologies to improve patient experience and flow
- Ensure robust and timely clinical triage occurs so that patients are seen in the most appropriate service at the right time.
- Focus services around early diagnosis of chronic conditions and self-management in primary care.

Deliverables:

- Reduction in referrals/ acute activity through newly designed pathways to improve patient experience and reduce unwarranted clinical demand
- Reduction in clinical variation
- Development of community clinics where required
- Reduction in waiting times for secondary care services.
- Reduction in demand and capacity gap which has been identified.
- Assist with achievement of RTT trajectory
- Improved access and quality for patients through streamlined pathways, including straight to test where possible.

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
New ways of working such as referral via consultant triage, advice and guidance, straight to test pathways				
Trialling 'virtual clinics' to reduce face to face follow up attendances where clinically appropriate				
Reviewing management of patients on long term follow-ups to ensure all contacts add value to the patient pathway				

Programme: Planned Care

ERS

Aims & Objectives:

- Full implementation of E-Referrals (eRS), incorporating greater use of Advice and Guidance as an alternative to traditional face to face consultation

Deliverables:

- Achievement of 80% of referrals into Consultant led service via ERS
- Improved patient experience and flexibility
- Improved referrer experience
- Fewer unwarranted outpatient attendances
- Reduction in DNAs
- Reduction in acute activity
- Improved demand management

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
All clinics available on eRS across all providers				
Primary care teams work to support the increase in GP utilisation				
Achievement of 80% of referrals into Consultant led service via ERS				

Programme: Planned Care

Long Term conditions

Aims & Objectives:

- End to end pathway design
- Upskilling in primary care
- Focus on increased self-management and citizen activation
- Reduction in follow ups and a move to increase the use of technology in all patient pathways exploring the use of virtual clinics.
- Use of RightCare Analysis of circulation, cancer and respiratory and other long term condition 'where to look packs' to target improvement areas

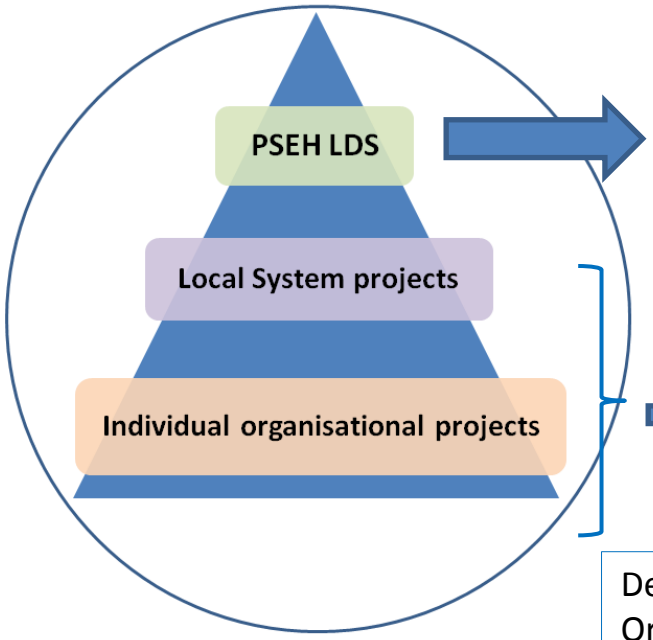
Deliverables:

- Reduced waiting times in secondary care for both new and follow up activity.
- Development of a generic model with the aim of reducing unwarranted referrals and clinical variation
- Reported improvement in self-management
- Reduction in clinical variation
- Reduction in face to face consultations for both new and follow ups
- Reduction in workload for primary care

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Patients feel enabled to better manage their own condition and maintain independence Reduction in acute activity				
Creation of community hubs working in conjunction with the Community Health and Care programme				

Continue to improve the quality of and access to Children and Young Persons Services

Maternity and Child Health Programme



1819 Project Focus:

24 hour paediatric ED department at PHT

Paediatric psychiatric liaison service in ED

COAST in ED

Integrated Children's Community Model

Community Epilepsy Nurse

Detailed in individual Organisational Operating Plans (See Annex A)

Deliverables:

A single point of access for children with urgent presentations via a 24hour ED to improve outcomes and maximise efficiencies.

Creation of a children's Mental Health lead in ED linking with CAMHs

Children arriving at ED will be triaged by COAST to prevent them from being admitted to ED or CAU unnecessarily.

Children and young people can access appropriate community support to prevent unnecessary hospital admissions.

Improved Epilepsy pathways and services to improve patient outcomes.

Programme Quality and Performance Outcomes and Benefits

- Deliver improvements to children's ED pathways
- Improved patient experience
- Reduced admissions
- Reduced referrals for epilepsy patients and improved patient outcomes

IAF Measures impacted:
Women's experience of maternity services
Choices in maternity services
Child Obesity
Neonatal mortality and stillbirths per 1,000 births
MH - CYP Mental Health
Maternal Smoking at delivery

Programme: Maternity and Child Health

Community Epilepsy Nurse

Aims and Objectives:

- To improve the Community Epilepsy Service for Children and Young People.
- To prevent the referral to PHT for those children under the CPMS Service with Epilepsy related to a neurodevelopmental condition.

Deliverables:

- Improved outcomes for the individual, fewer seizures may lead to reduced long term complications.
- High quality care through a clear robust epilepsy pathway
- Reduction in outpatient referrals between community paediatric medical service and PHT
- Hospital admissions are prevented wherever possible
- Children are discharged from hospital in a timely manner
- Improved training for care givers and educators to ensure medication and treatment compliance.

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Community Epilepsy Nurse starts in her post				
Community Epilepsy Nurse to provide CCG with timetable for school visits				
Review first 6 months data and agree baselines and targets				

Programme: Maternity and Child Health

Integrated Children's Community Model

Aims and Objectives:

- Develop an integrated community children's service model which combines Children's Community Nursing (CCN) / COAST and Community Paediatric Medical Services (CPMS)

Deliverables:

- To increase the number of children cared for outside of the hospital by a system wide team
- Removing boundaries and the internal silos within the Provider to enable more efficient use of resources.
- Improved system wide Community Children's Model

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
Agree final CCN Service Specification across 3 CCGs				
Agree final CCN Service Specification - Year 1 System wide CPMS				
Scope options for Integrated Model				

Programme: Maternity and Child Health

COAST in ED

Aims and Objectives:

- Solent COAST (Children's Community Nursing Acute Pathway Team) to be based in the emergency department in the evenings and weekends. To triage patients and see if they could be managed in the community, avoiding an admission.
- Develop and implement new pathways to reduce avoidable admissions and attendances

Deliverables:

- Reduction in number of children admitted to CAU via Paediatric ED
- Improved patient care by providing community based services and preventing unnecessary inpatient stays
- Implementation of the recommendations from “Facing the future”

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
COAST Team to start working within Paediatric ED for evenings and weekends				
Monitoring of admissions avoided and activity deflected				
Solent and PHT to agree monitoring of the scheme				
Solent and PHT to sign SLA				
3 month review				

Programme: Maternity and Child Health

Paediatric Psychiatric Liaison in ED

Aims and Objectives:

- Introduction of a Children and young persons Mental Health Lead in ED, with a specific remit to link in with CAMHs
- Support joint working between ED and CAMHs teams by maximising use of Care Plans
- Develop and implement new pathways to reduce avoidable admissions and attendances

Deliverables:

- Reduction in unnecessary admissions
- Timely and accessible consultation from specialist trained staff
- Improved experience of assessment, reducing the need for young people and families to repeat their story
- Improved relationships and joint working between PHT, MHLT, Hampshire CAMHS and Portsmouth CAMHS

Key actions & timelines:	Q1 1819	Q2 1819	Q3 1819	Q4 1819
3 month pilot of service				
Interim review of service provision				
Full review of pilot and recommendations				
Initiate phase 2/roll out (assuming successful review of pilot)				

RTT, Cancer Standards, Diagnostics and A&E

Key deliverables, and where applicable, improvement trajectories have been set out in the Operating Plans as follows:

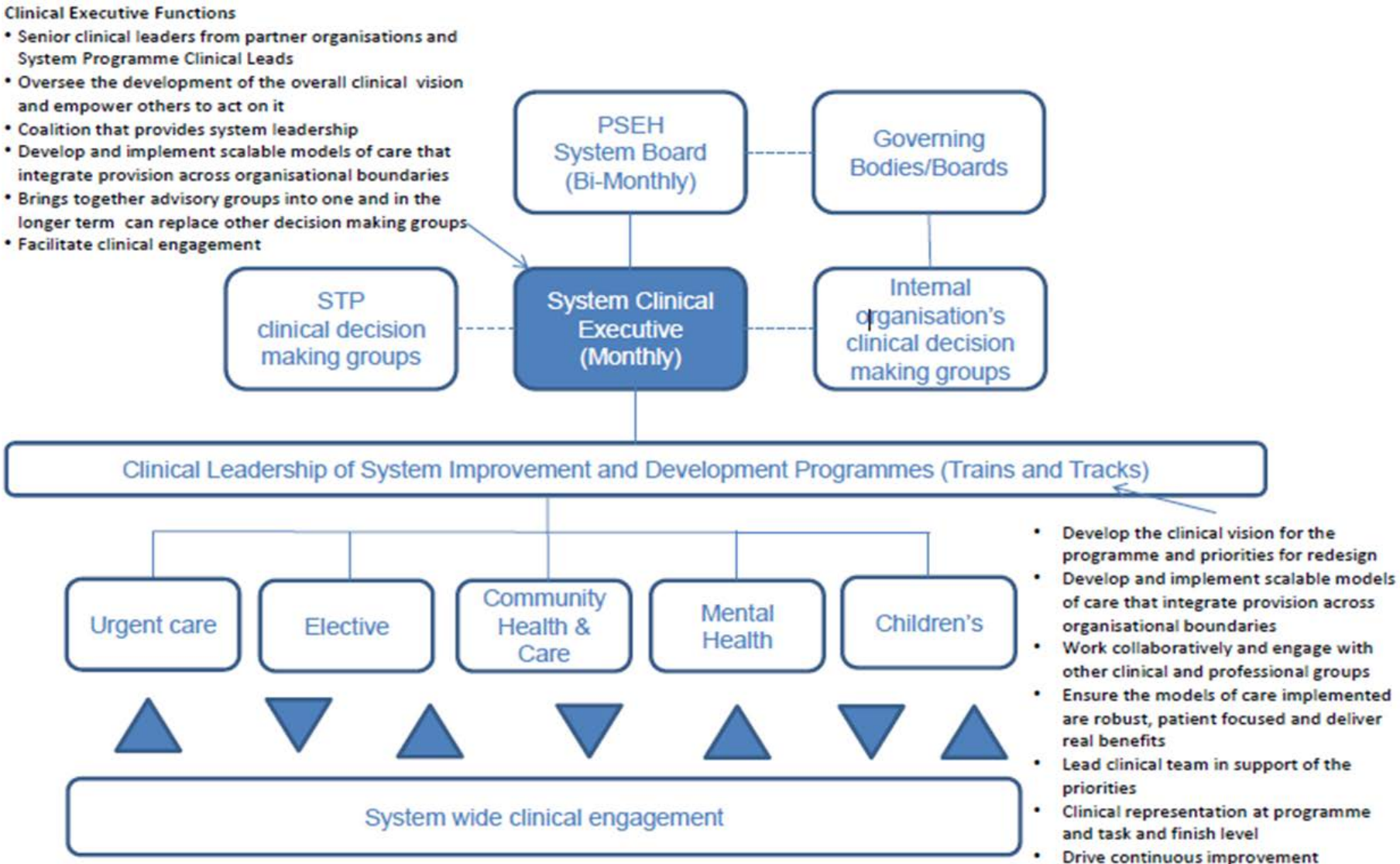
- RTT – 86% for 2018/19, based on holding the March RTT waiting list
  - This is based on PHT expecting to finish the year on circa 86%.
  - This additionally assumes zero 52 week waits using this scenario.
- Diagnostics – 99% to be sustained through 2018/19 from June onwards
- Cancer 62 days – 85% to be sustained through 2018/19
- Delivery of all other cancer standards
- A&E 4 hrs – Trajectory across 2018/19

A&E 4hr Standard - June 2018 Resubmission														
			Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Combined plan	standard 95%	>4 hr attendances		1887	2362	2194	2207	2408	1715	1778	1699	2495	2315	1493	1794
		Total Attendances		16810	18535	18139	18243	17262	17188	17802	17025	17211	16419	14957	17960
		% Performance		88.77	87.26	87.90	87.90	86.05	90.02	90.01	90.02	85.50	85.90	90.02	90.01

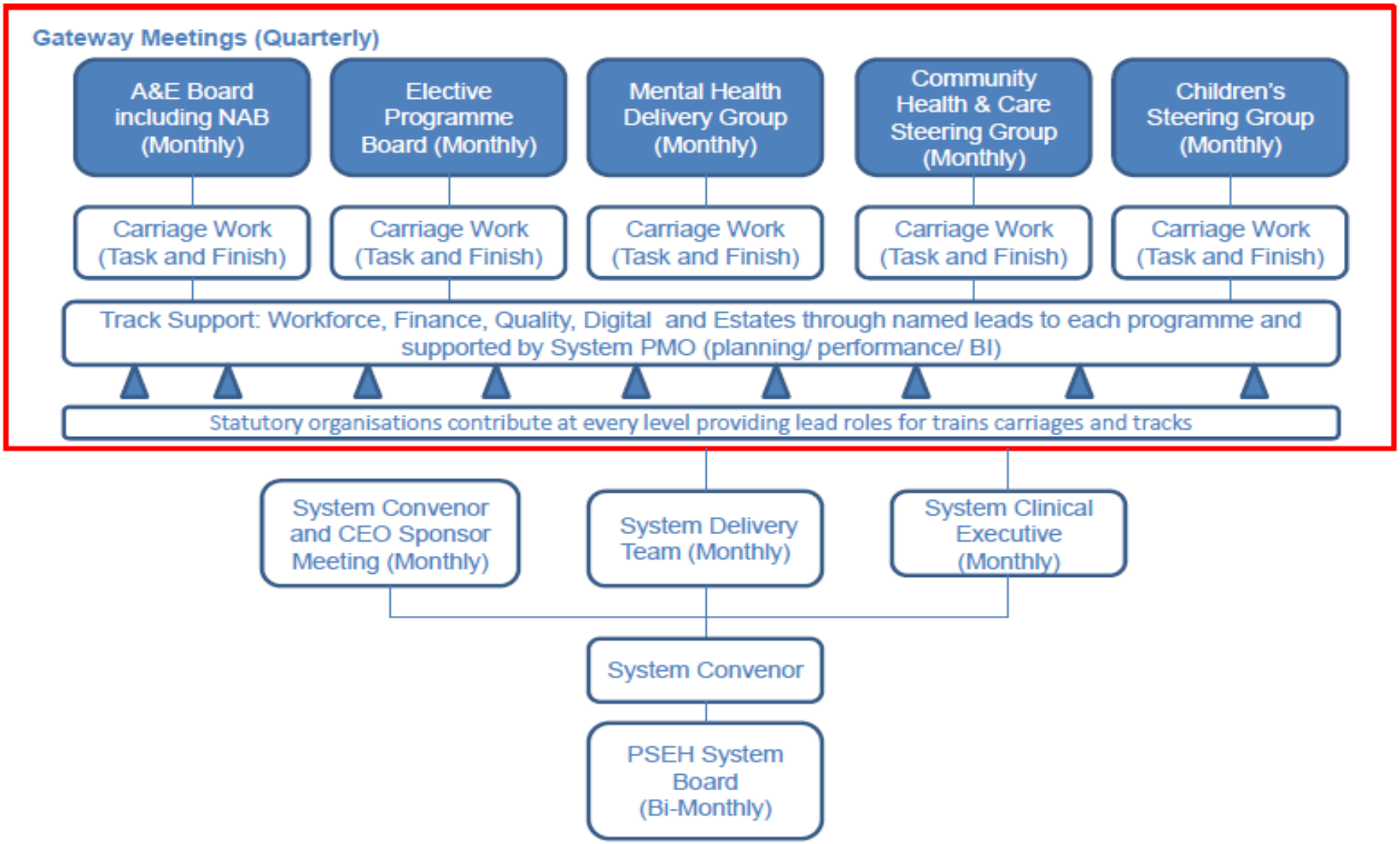
Delivery of IAPT access standards

- Portsmouth CCG - 19% standard not met. The CCG has made a decision to partially fund the LTC expansion at a 17% access rate for 2018/19, not 19%, to fully prove the business case.
- F&G and SEH CCGs - Plan does not meet IAPT standard in 18/19 which is reflective of historic under performance although currently on improvement trajectory.

Collaborative and cross boundary clinical leadership is a critical enabler of accountable care, supported by a clear structure that delivers appropriate accountability and authority



The programme arrangements must be streamlined, transparent and flexible to enable effective and efficient decision making and action



Risks	Mitigating Actions	RAG Rating
Challenging Savings Plans with a high level of unidentified savings	• Establish contracts set at affordable levels for commissioners. • PWC and Turnaround Director providing support to development of PHT CIP Programme. • Aligned Incentives Contract in place to ensure focus remains on system improvement and cost reduction • System workstreams being developed; need to assess and deliver financial impact. • Robust in year monitoring at organisational and system level to ensure schemes deliver expected savings. • Seek NHS England and Improvement support for a longer term transformation programme	
Risk to delivery of key Constitution Standards and potential patient safety issues due to lack of elective capacity in the system	• Robust modelling of demand and capacity on a specialty by specialty basis • Quality teams oversight of quality and safety risks	
Urgent Care system continues to operate suboptimally with associated impact on ED waits and quality	• A&E Delivery Board in place and meeting regularly with exec leadership; system urgent care workstream aimed at improving out of hospital model • Newton review of HCC/ community capacity and PWC system capacity review	

Solent NHS Trust Plan

Southern Health NHS Trust Plan

NHS FGSEH CCGs Plan

NHS Portsmouth CCG Plan

Portsmouth Hospitals Trust Plan

LCP - Community Health and Care

LCP

PRIORITY:- Care Homes (extension across PSEH)

PRIORITY:- Front Door Admission Avoidance (incl. FIT and frailty)

SCAS Conveyance - End of Life – (SCAS – Ticket to Ride)

LTC hubs

Alignment of community model across PSEH

Modelling on impact of changes in workforce, finance and estates based on NCM

ENABLERS

Need to further understand links and work being undertaken across different tiers for:

1. **Population health** – testing and roll-out of Integrated Population Analytics. Learning from FG Integrator to develop locality plans
2. **Estates**

PORTS CCGs

- Integrated 24/7 primary care service – bringing AVS, GP OOHs and extended access into one City wide service – up and running by June 2018 and will also include UTC integration over time
- Practice based MSK Triage
- Enhanced Care home team in Portsmouth (currently operating across 7 homes)
- Local Neighbourhood Teams – MDT Teams in 3 Portsmouth localities, piloting reablement and locality rapid response in South locality from June 2018.
- Shared Care Record SystmOne used by Solent and all practices, ASC to start using SystmOne from Oct 2018.
- Revised social prescribing and care navigator service development
- Delivery of 111 and OOH procurement options

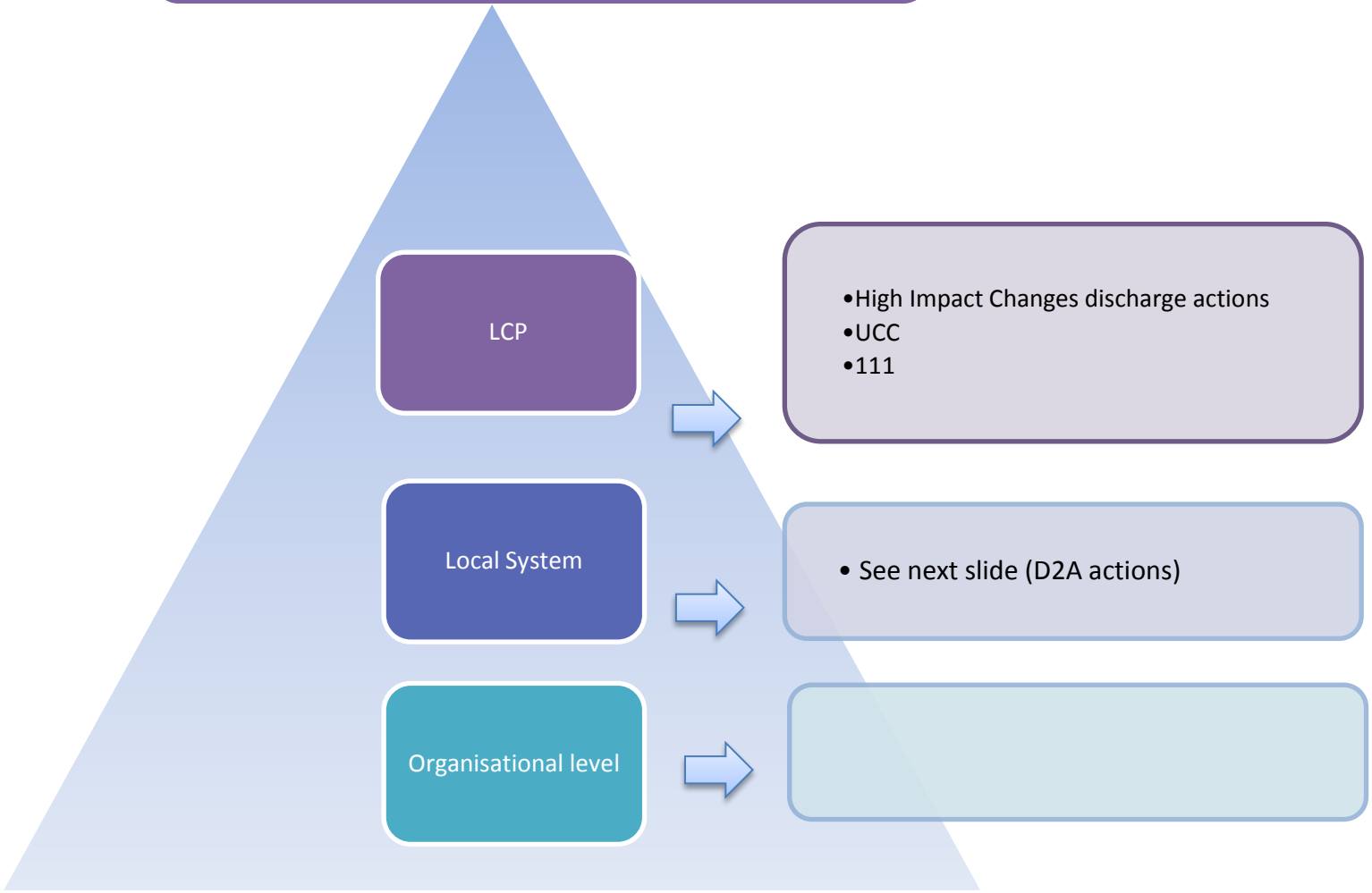
FGSEH CCGs

- Integrated 24/7 primary care service – bringing AVS, GP OOHs and extended access into one service – up and running by June 2019 and will also include GP-led UTC integration over time
- Same Day Access GP hub development in localities
- Practice based MSK Triage
- Plans for local Neighbourhood Teams in place in every locality by May 2018, implementation June 2018 – June 2019.
- Well-being programmes including care navigator s and Patient Activation Measure embedded across localities
- All neighbourhood teams to have access to EMIS Community Shared Care Record by March 2019
- Review of community contracts to align with neighbourhood model including ERS
- Delivery of 111 and OOH procurement options

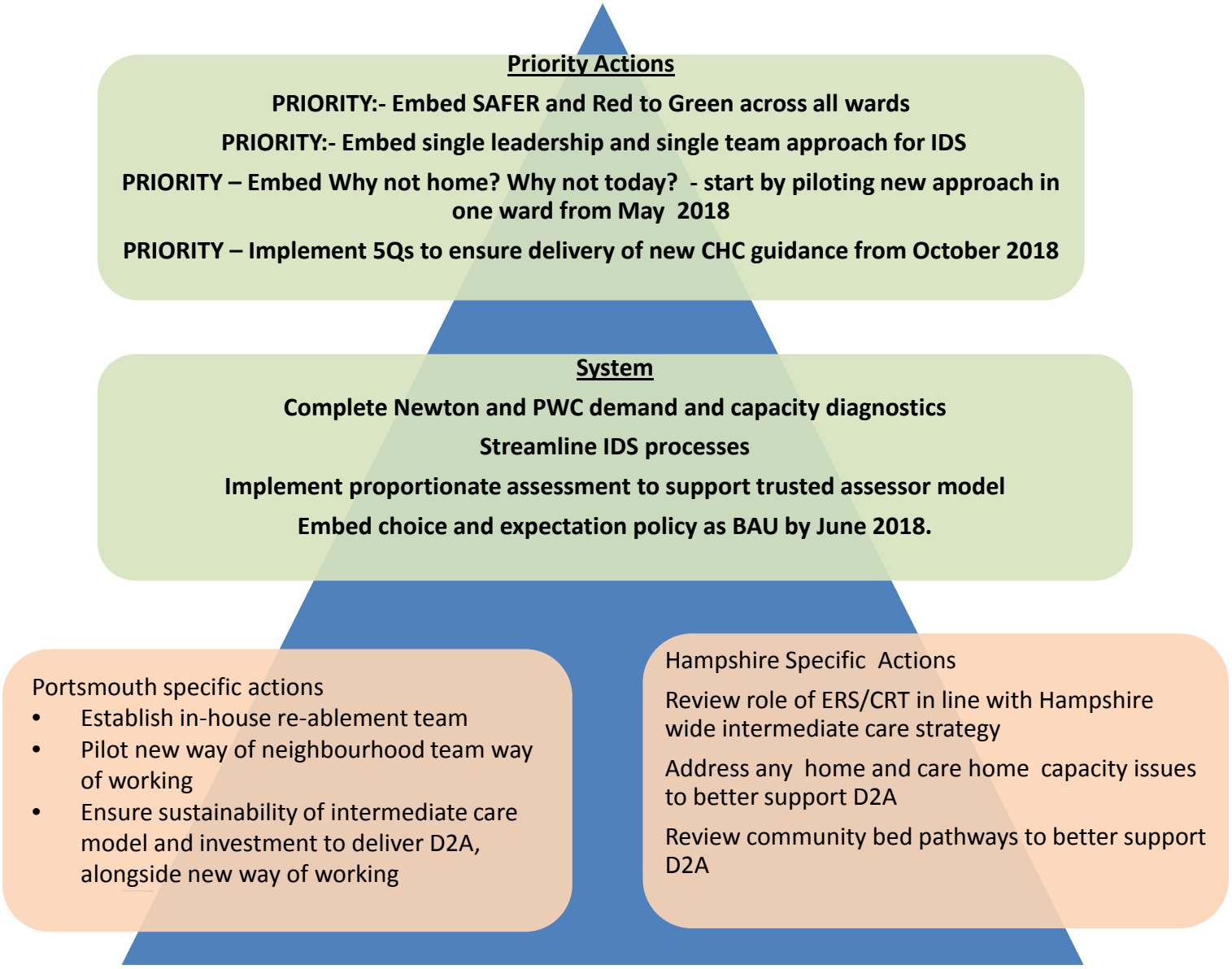
Urgent Care Delivery Programme - Triangle

Urgent and Emergency Care Programme Alignment

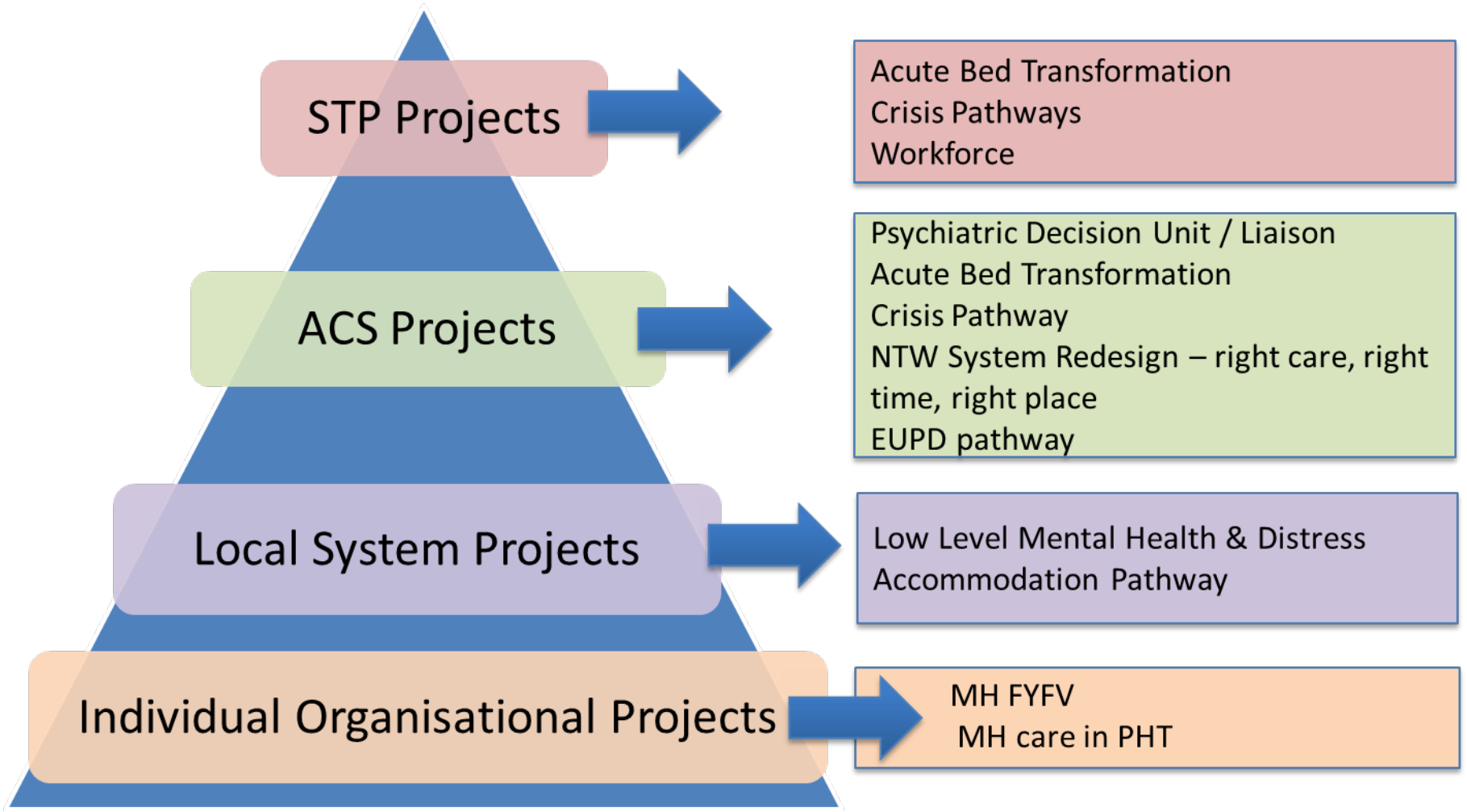
Flow and Effective discharge

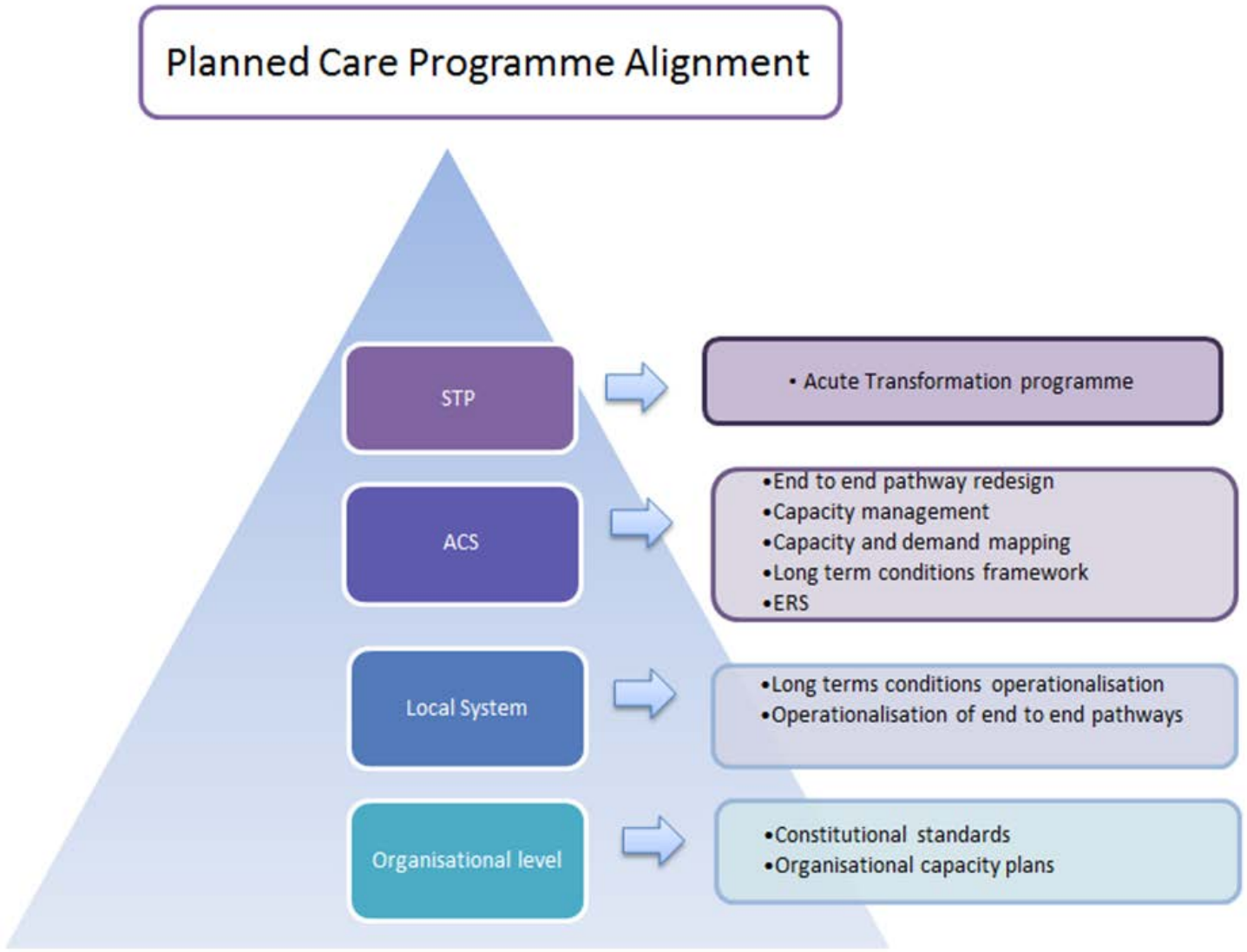


High Impact Change Discharge Actions



Mental Health Programme Alignment




Planned Care Programme Alignment
STP
ACS
Local System
Organisational level
• Acute Transformation programme
•End to end pathway redesign
•Capacity management
•Capacity and demand mapping
•Long term conditions framework
•ERS
•Long terms conditions operationalisation
•Operationalisation of end to end pathways
•Constitutional standards
•Organisational capacity plans

Item	12.1

Solent NHS Trust

Presentation to	Public Board Meeting							
Title of Paper	Trust Board Performance Report Part I – August 2018							
Author(s)	Alasdair Snell		**Executive Sponsor**		Andrew Strevens			
Date of Paper	17/9/18		**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 Business Plan Quarter 1 Report 2018/19

Corporate Programme Management Office

By Aaron Scott and Matthew Rowsell

1. Executive Summary

Following lessons learned from 2017/18, the guidance for setting 2018/19 Business Objectives was updated to be more robust. Service Lines and Corporate Directorates were advised to have no more than 5 Business Objectives, with a common sense approach to the number of milestones for each. This was to ensure that Objectives were more Specific, Measureable, Achievable, Realistic and Timely (SMART). Following this guidance, the Trust reduced the number of Business Objectives and milestones by 63% and 46%, falling from 163 to 61 and 660 to 357 respectively. This decrease will aid the Trust in managing Business Objectives on a quality over quantity basis for 2018/19.

As with the 2017/18 business plans, the delivery of milestones is anticipated to fluctuate throughout the year as the objectives and related projects move into delivery phases and milestones are refined to reflect actual key dates and progress as they occur.

The below table shows 2018/19 Business Objectives and milestones agreed as at end of March 2018.

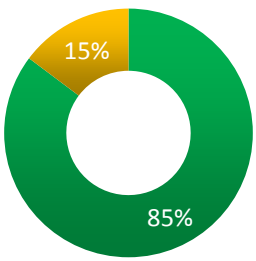
	Number of Objectives	Number of Milestones
Adults Portsmouth	5	23
Adults Southampton	4	13
Child and Family	5	10
Commercial	3	25
Estates and Facilities	5	26
Finance and Performance	5	23
People and Organisational Development	4	33
ICT	3	14
Mental Health	5	24
Primary Care Services	5	29
Quality	5	32
Research and Improvement	3	32
Sexual Health	4	39
Specialist Dental Services	5	24
	61	357

2. Q1 Summary

2.1 Business Objective Progress

Business Objectives are given a 'Red, Amber, Green' status in order to provide a quick reference to the health of the objective.

- **52 objectives (85%)** are rated as **green,** indicating they are on target for completion by intended dates.



- **9 objectives (15%)** are highlighted as **amber,** indicating that they are experiencing problems; however there is mitigation in place to prevent the objective turning red and ensure the objective is brought back on track.

- **0 objectives (0%)** are currently rated as **red**. This means that there are no objectives experiencing issues where insufficient mitigation are in place.

2.2 Early Successes

Although no Business Objectives were due to complete in quarter 1, there have been some key developments across a number of service lines with the progression of their objectives:

Adults Southampton – In order to create a workforce that is fit for the future, Adults Southampton have been reviewing their skill mix in Community Nursing and have implemented some Band 4 roles which have supported the challenges with recruiting Band 5s. However, the service has also been successful in attracting a cohort of 9 newly qualified nurses who will start in post in September 2018 which is an exciting development for the service.

Estates and Facilities – There has been significant positive progress with the plan to deliver the catering transformation project by the end of February 2019. This is an extremely complex and challenging outsourcing project and has been a successful collaboration by numerous stakeholders in developing the strategy, scope, specification and tender documents resulting in three positive tender submissions being received and all within the challenging timeframe set for this project. The remaining activities of this project are fully on track for implementation of the new service at the beginning of March 2019 with the next major milestone being the tasting session scheduled for September 2018 that has generated a significant amount of interest.

Sexual Health – The service have been working with developers to build a safe and secure platform for service users to access live web chats. This platform will provide a 24/7 accessible 'need help' function, with an option to chat to an operator during online hours. They are building a bespoke reporting system to enable comprehensive evaluation of patient journey, including signposting to other services. The service are now in the final stages of testing and development and have been training up clinical and non-clinical operators to support this new service.

Specialist Dental Services – There has been positive progress with the plan to delivering a fit for purpose workforce model by the end of March 2019. Specialist Dental Services had 9 members of staff retiring across a 2 year period. With a strong focus on succession planning the service have undertaken recruitment programmes enabling the service to successfully recruit to several posts; 3 of which will be starting in September 2018, including the new Specialist Registrar. The service have a rolling recruitment programme to keep staffing at an appropriate level.

2.3 Early Challenges

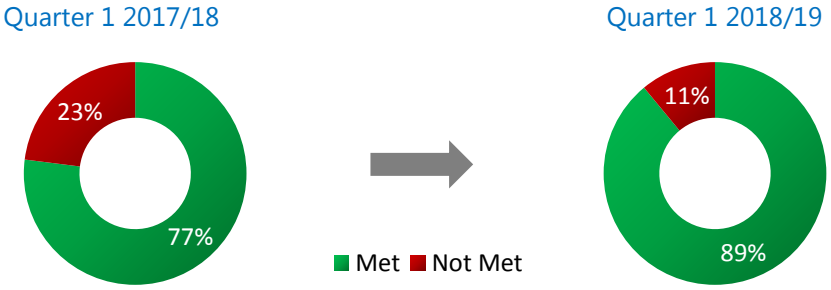
At the end of quarter 1 there were 9 Business Objectives which were considered amber, 2 of which are outlined below:

Adults Portsmouth – The Transformation Manager for the Long Term Conditions hub has now commenced and a detailed project plan has been developed. The project group has been reconvened and the work is being divided across relevant sub groups. The timescales to complete work on the critical path for the pilot are being assessed to determine whether the project timelines of developing a business case by the end of October 2018 and implementing the pilot from quarter 4 of 2018/19 can be met.

Primary Care Services – The service have been working closely with Commercial colleagues in order to resolve the organisations Diagnostic contracting issues for 2018-20. Although diagnostic cost pressures have in part been mitigated for Fareham and Gosport and South East Hampshire CCGs, following increased funding of £275k for 2018/19, unresolved issues remain within the Portsmouth and Southampton contracts due to the cost pressure created by the growth in demand. In addition to this the SWASH consortia has given notice to Solent on its service provision for the storage and access of images. Solent are now seeking other options to this which include a cloud based PACS solution. All options however are likely to create further cost pressure to MSK services and result in further negotiations being required with all CCGs.

2.4 Milestone Progress

At the end of quarter 1, against a target of 121 milestones, 108 were met (89%) and 13 milestones were outstanding (11%). This is an improvement of 12% compared to quarter 1 in 2017/18:



N.B. These percentages have been calculated against total milestones due for quarter 1 only.

There were 13 milestones not met at the end of quarter 1 for 2018/19. These milestones were on projects that at the planning stage were in their infancy; these projects have now revisited their timelines and believe that the completion of the project in the original timescale is still on track. The CPMO team will continue to work with Service Line Operational Directors to reduce this number by ensuring that Verto is maintained and up to date and/or milestones are allocated more realistic dates now work on the objectives has begun.

3. Additional 2018/19 Projects

3.1 Integrated Care Partnership

The CPMO is assisting the Integrated Care Partnership work which covers the Portsmouth area. This work brings joint working across local NHS organisations including, NHS Portsmouth CCG, NHS South Eastern Hampshire CCG, NHS Fareham and Gosport CCG, Southern Health NHS Foundation Trust, Portsmouth Hospitals NHS Trust, NHS South, Central and West CSU, South Central Ambulance Service NHS Foundation Trust and Solent NHS Trust. The Solent CPMO involvement will be to specifically provide PMO support to the Mental Health Programme and its contributing Projects.

This work is still in the early stages, but will continue to develop working partnerships across the above organisations to improve pathways and services in Urgent Care, Elective Care, Community Health and Care, Children's Services and Mental Health.

4. Next Quarter

4.1 Verto Project Gateways

2018/19 will see the continuation of the Verto Project Management System implementation. Business Objectives and Action Tracking is now live in the system and can be monitored and managed within it. Project Management functionality development is almost complete and is expected to roll out during quarter 2 with ICT and Estates departments as early adopters. This will allow Verto to be used across departments that have a high turnover of projects with often complex planning involved. Once these two departments have helped the CPMO understand what works well and what needs further development then it will be rolled out across the Trust.

Automated reporting and report subscriptions for managers will be a key feature and output of Verto and is currently being refined by the CPMO team and TMI Systems who develop Verto reports.

4.2 Quality Impact Assessments (QIA)

The CPMO will continue to work with the Chief Nurse to simplify and rationalise the QIA process. One solution to ensuring that every Project and Cost Improvement Plan is QIA'd is to place the QIA form into Verto. This will then allow Projects to be linked within the system ensuring greater transparency and governance of the process.

2.1 Solent NHS Trust Performance Report - Operations August 2018/19

Activity

			Same Period 2017/18
14,538	New Referrals in month*		15,238
58,652	Attended Contacts in month*		55,606
3,227	DNA'd Appointments in month*	4.2%	4.0%
26	Delayed Patients in month (DTOCs)		25
413	Delayed Days in month		402
15,452	Discharges in month*		13,842

Key Performance Indicators

214	KPIs due in month
153	KPIs achieved in-month

CQUIN Schemes

15	CQUIN schemes
7	Milestones due YTD
7	Milestone Achieved YTD

2	Contract Performance Notices (CPN) open

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

Hotspots

- Contract Performance Notice - Southampton Domiciliary Phlebotomy service
- Contract Performance Notice - Southampton Behavioural Change Service
- Results of the patient-Led Assessments of the Care Environment (PLACE)
- CAMHs Waiting List and Vacancy Pressures
- MH OOA Placement Days
- Hampshire Section 136 Suite
- Children's Dental GA - increasing waiting list and capacity concerns
- Medicines reconciliation performance
- MCA training compliance
- Community insulin injections
- Primary Care Workforce Mitigations
- COAST Closure
- Pressure Ulcer Incidences

2.2 Chief Operating Officer Commentaries – August 2018/19

Portsmouth System

- Inter-agency mapping of all of the transformation programmes being developed/implemented within Portsmouth is progressing and will help inform collaborative business planning for 2019/20.
- Roll out of Portsmouth MSK telephone triage service to Portsmouth GP practices is ongoing and to plan. Now offering 52 week cover. 71% of available MSK telephone triage slots in July were used by primary care. Work being done within primary care to continue to promote the service to maximise uptake. Return visits are being arranged with all surgeries 3 months post-service implementation to maintain strong working relationships, resolve any issues arising and to gain valuable feedback from the teams regarding the MSK Triage service, the training provided and the overall implementation process.
- Results of the 'study and analysis' phase of the Integrated Community Team programme have been presented to the MCP team. The 'experimental design' phase of the programme has now commenced and is likely to last 8 weeks. Learning from this pilot phase will form the basis of implementing the Neighbourhood Model from April 2019.
- Work is commencing to review the current Frailty pathway within the city and identify opportunities to improve the ability of our health and care services to respond to urgent demand from the frail older population in order to avoid presentations to the acute trust.

Portsmouth Care Group Hotspots

- Results of the Patient-Led Assessments of the Care Environment (PLACE) that assess the quality of the patient environment have been published. Action plans are being implemented where appropriate to resolve any identified issues.
- MCA training compliance continues to be a concern for certain services, despite some recent improvements. The option of scenario based training is being implemented for any non-compliant staff.
- Assurances are not forthcoming from Commissioners concerning the 136 Suite. A next stage meeting is planned for the end of September when further escalation might be necessary.
- Ongoing ligature mitigation and remediation work continues across all mental health units. A ligature works tracker is maintained by the estates team, reviewed weekly by services and overseen six weekly at a ligature meeting. 130 individual ligature points (45 high-risk) will be addressed before end December 2018.
- CAMHS East's longest waiters continue to reduce, although there has been an increase in the total numbers on the list in August. The service continues in its attempt to recruit to hard-to-fill vacancies.
- The current 52 week wait for neurodevelopmental intervention in CAMHS reflects 107 young people waiting (it should be noted that waiting times are for urgent and routine assessments). The service plans to run clinics which would have the capacity to see 4 families at once and enable the young people to be seen in a group to eliminate the need for school observations on all young people. The feedback would be given to families on the same day so that they have the outcome of the assessment which would be followed up with a report. The service aim to offer 32 assessments a month which would reduce the numbers waiting by the end of January 2018.
- For Looked after Children (LAC), initial health assessments statistics are improving month on month, but issues still continue with those children/young persons placed out of area. Whilst huge improvements have been made in requesting timely health assessments for children placed out of area, the offer of appointments within statutory timeframes remains out of our control. A LAC action plan is in place and is being implemented.
- Medicines reconciliation performance is not at the required standard due to capacity and demand problems which are impacting other elements of medicines management in the trust. The issue is recorded comprehensively on the risk register and investment has been put in but further Executive level discussion is underway to determine the best approach.
- Vacancies in Adults Portsmouth continue to require agency cover - work continues to develop both recruitment and retention plans and a new look at skill mix.
- The issue of Hampshire Section 136 breaches were considered at Mental Health Act Scrutiny – they will be helped by Maples reopening but issues of Hampshire system responsiveness were discussed and need further escalation.

- The first 4 months of 2018/19 have shown an increase in Grade 4 PUs acquired in Solent Care, with 10 reported in July alone although this did reduce to 3 in August (further details are in the Quality section of this report). This is the highest level recorded over the past 3 years; although patient contacts are at a higher level over the same time period. Pressure Ulcer rates are also lower per 1000 patients than the average for similar Community Nursing services in the national benchmarking group; so the raw data in itself does not generate direct cause for concern. The service is keen to learn from detailed analysis of avoidable PUs acquired in Solent Care. The "deep dive" in Pressure Ulcer SIs in July, led to a change in practice in Community Nursing to ensure that first assessment visits are always undertaken by a Community Nurse. The quality team will also begin to report data for "avoidable, acquired in Solent Care per 1000 contacts", so that rates can be compared irrespective of activity. The impact of environmental factors in July is also being considered.

Southampton System

- Steady progress continues in the Southampton system under the Better Care Southampton programme. With revised, streamlined governance and a full time programme manager in place.
- At the July 2018 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. In order to achieve this, a system workshop was planned for early September, albeit this had to be postponed due to the unfortunate sickness of the programme manager. This important event will be re-programmed for October.
- Early discussions with our key council partners have begun in order to explore the next practical steps we can take to drive forward system integration.
- Several of our system CEOs joined the September Steering Group and were briefed on the progress made and envisaged next steps.

Southampton & County Wide Care Groups Hotspots

- There has been a significant increase in the requirement for insulin injections within the community setting requiring an increase in Band 3 trained HCA's to administer due to a change in University Hospitals Southampton NHS Foundation Trust (UHS) provision.
- Waiting times remain a concern with the number of patients waiting for dental 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.
- Innovative options, in close collaboration with UHS, 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.
- Solent continues to work under the Contract Performance Notice for the Behaviour Change service.
- A contract Performance Notice continues to be in place for Adults Southampton Domiciliary Phlebotomy service. The service continues to engage fully with Southampton CCG with the production of an agreed action plan.
- We have seen a regrettable rise in Pressure Ulcers acquired amongst Adult patients in the community recently. Each have, or are being, investigated, and changes in clinical leadership, additional training and support, as well as specialist advice from our Tissue Viability team have all been put in place to manage this issue (further information is in the Quality section of the report also).
- Workforce issues regarding GP and Associate Nurse Practitioners (ANPs) within our Primary Care Services over the summer have been mitigated, in part thanks to support from our system partners in Southampton Primary Care Limited.
- Notwithstanding a number of technical investigations and interventions, and despite improvement, we continue to experience a small number of failed calls when patients endeavour to contact our GP surgery. We have recently established a centralised call management and administration cell which has improved our capability to answer calls and manage appointments across our three branch sites.
- As a result of some concerns voiced by our staff within the Podiatry service in the east, we have instigated a number of changes to provide more time, support and management support to our people in order to respond appropriately.

- We continue to experience 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.
- The previously reported issue of demand outstripping capacity in our CAMHS West continues. However, a combination of Demand and Capacity remodelling, improved recruitment and an agreement with Commissioners that if clients do not attend appointments, the wait time metric for those individuals is paused until they re-engage with the service, is starting to show evidence of performance improvement.

3.1 - Quality Performance — August 2018/19

Serious Incidents

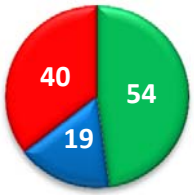
3	Serious incidents occurred in month
11	more year to date than 17/18
0	YTD Healthcare Infections / Cdiff / MRSA
0	YTD Safety compliance breaches

Pressure Ulcers in Solent Care

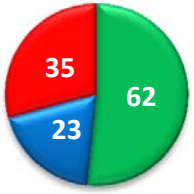
21 Occurred in month

2 More than same month 17/18

2017 / 18 YTD



2018/ 19 YTD



Grade 2
Grade 3
Grade 4

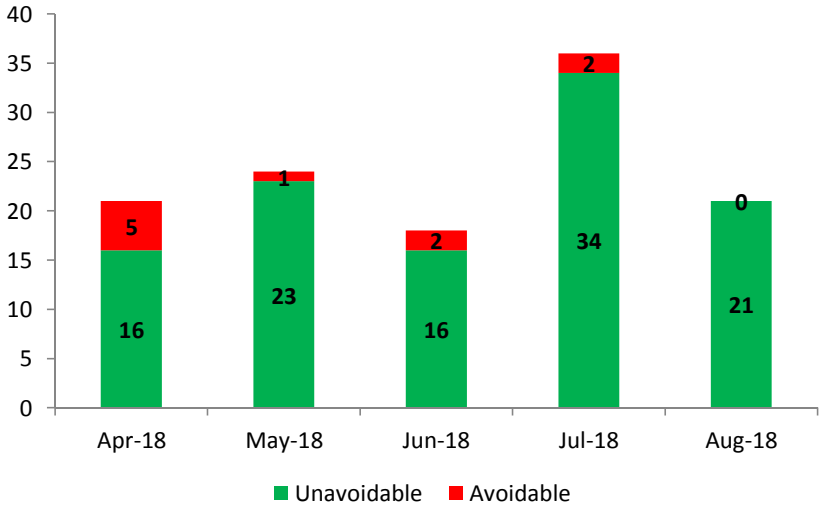
Friends and Family Test

2806	Responses received
1099	more than same month 17/18
96%	Positive ratings %
2%	Negative ratings %

Formal Complaints

17	Complaints received in month
19	Required response in month
5	Breaches in month

Avoidable Pressure Ulcers



3.2 Chief Nurse Commentary – August 2018

Events to Note

Patient-Led Assessments of the Care Environment (PLACE) results were published in August. Services are reviewing areas for improvement and further feedback will be provided. The results showed a decrease in Solent's scores on 2017. Please note that this is feedback relating to one visit only and the services are currently reviewing these reports and updates are awaited regarding planned actions. Upon review, we have identified that the 2018 PLACE Review differed from previous years in some aspects and this has likely led to the variability in scoring and the lower number of assessors. We are re-auditing the reviews to understand the extent of this impact. In addition, a number of areas that scored adversely are operated by NHS Property Services and despite our attempts at engaging them for resolution, progress has been limited in some areas.

A planned event for feedback to assessors will be held with service representatives. The purpose of this will be to share actions and progress on areas noted as requiring improvement during the 2018 visits.

We welcome Bal Johal to the Quality and Professional Standards Team as interim Associate Director for Quality and Governance.

The Head of Risk and Litigation advert closed and interviews are scheduled for early October.

Friends & Family Test (FFT)

In August 2018, the Trust received the highest number of FFT responses in a month ever with 2,806. This is the third time this year that the Trust has broken our record. However, the previous highest before August was 2,101. The Trust is on course to surpass previous years' totals.

The main increase in August is from our Sexual Health Services who amassed an impressive 1,224 themselves. Adults Southampton has also achieved their highest numbers all year. These improvements show the targeted work and dedication to patient engagement the Trust prioritises.

Safer Staffing

The Trust continues to work with services to ensure staffing levels are appropriate to meet the identified needs of patient/service users. The Chief Nurse meets on a two weekly basis with all service lines and each meeting has a focus on specific areas.

Across the Trust there continues to be challenges with recruitment to some key roles with community nursing and mental health services being a particular challenge. Specialist nursing roles in children's services is also of concern. Work is underway with the matrons to understand the variance in delivery models and to explore the implementation of a locally developed capacity and demand tool to support delivery of safe care and to be able to take a proactive approach to managing the demand. The services are working closely with workforce teams to use innovative approaches to recruitment and early indications are positive. Safe staffing is maintained using bank and agency staff and where appropriate covering with additional support workers. The safe staffing meetings have also resulted in establishment reviews and where indicated additional staff posts have been agreed.

Incident Updates

Pressure Ulcers (PU)

- The Trust's Tissue Viability leads with the Chief Nurse and Associate Director for Professional Standards and Regulation, are currently reviewing the national guidance for grading PU's. A revision will also be undertaken of the content of the current training to ensure that the most up to date guidance and standards are implemented across the Trust.
- Portsmouth presented to the Portsmouth commissioners the work that has been undertaken following PU incidents and subsequent SI's and the learning that has been implemented to improve patient outcomes following this. Positive feedback has been received directly from the Commissioners who are now assured and a robust plan to continue this improvement is in place and will routinely be shared with the CCG.

The Quality Dashboard now includes the split of Pressure Ulcers acquired in our care that were avoidable and unavoidable. The service lines have been undertaking in-depth reviews of pressure ulcers for learning and quality assurance and have identified that the numbers of avoidable PUs remain low and in fact, there weren't any avoidable PUs in August.

The number of PUs overall in August has decreased to within normal variations at 21 after high numbers in July due to the impact of significant heatwave on patients' wound care.

Medicine related incidents:

- None of the incidents reported relating to medicines resulted in moderate or above harm to patients. The majority were recorded as near misses by intervention which enables the teams to investigate further and identify any areas requiring improvements to avoid future incident repletion where able.
- In Portsmouth, on review there are no clear identifiable themes or trends. In Southampton it is noted that incidents reported from other organisations documentation account for a high number of these incidents.

Gosport War Memorial

The Solent End of Life steering group had a focussed discussion on the findings of the Gosport report specifically considering the likelihood of similar issues occurring within clinical services today. No immediate risks were identified; however, to provide robust internal assurance it was agreed to establish a task and finish group, including support from the Research and Improvement team to review the recommendations in detail and develop an audit tool for application across all relevant services. An audit will be undertaken across all relevant services, findings will be reported through QIR in December 2018.

End of Life Framework

Locality multi professional groups are being established to support the delivery of the End of Life Framework and Strategy which will reflect our agreed approach to community engagement.

SI Updates

The SI panel agreed to change the reporting timeframe to improve both the quality of reports produced at panel and to ensure submission is completed as per 60 day deadline. This was commenced in August and will continue to be monitored and reviewed by the Quality and Safety team.

There were a total of 5 SI breaches in August. 3 of these were in Portsmouth and 2 in Southampton. These investigations breached due to the complexity of the incidents and delays in completion of amendments post SI panel. The 1 exception was in Adults Southampton and related to an ongoing Police investigation that caused delays to the review.

Complaints Updates

Complaints reported remain within existing parameters. On review, no recurring or significant themes or trends have been identified.

The Complaints and PALS team continue to work with service lines to ensure that the complainant receives the requested feedback within the agreed timeframe. Where this is not achieved the complainant is kept updated.

Wheelchairs Update

Discussion is on-going with our wheelchair provider and the CCG and joint communication arrangements with patients are underway. The CCG has commissioned a psychological harm review. Locally waiting lists continue to be impacted and are monitored continuously to prevent patient risks; regular meetings are held by clinical leads to resolve any patient specific issues.

4.1 - Financial Performance

August 2018/19

Performance

£1k Deficit in Month
£93k Favourable to plan

£734k Deficit YTD
£140k Favourable to plan

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

Purchase Orders and Debts

Eligible invoices raised in month 968

961 Purchase orders raised in month

Purchase orders raised in month against eligible invoices 99%

£6,057,744 Total debt month end

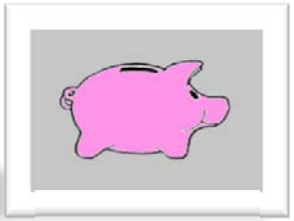
£1,428,224 Total debt over 90 days month end 24%

Savings

£2,493,000 Savings Target YTD

£2,380,000 Savings Delivered YTD

£1,559,000 QIA Savings Delivered YTD

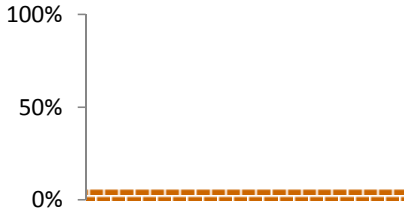


95% Savings Achieved

Capital Finance Summary

£775,000 YTD Spend

£12,713,000 Year end plan



6.1% Spend against year end plan

4.2 Finance Commentary

Month 5 Results

The Trust is reporting an in month adjusted surplus of £1k for month 5, £93k favourable to plan and a year to date adjusted deficit of £734k, £140k favourable to plan. The Trust is broadly on plan and has recognised £109k Provider Support Funding (PSF) in month and £459k YTD.

The favourable in month variance is due to the ability to invoice for additional Kite income (following assistance from the CCGs in the PSEH system) and higher occupancy in Kite and Snowdon. Discussions are to be had at the Finance Committee regarding particular services being behind plan; particular pressures lie in Southampton and Portsmouth Care Groups as well as ICT. The Trust is in the process of agreeing activity management schemes with commissioners for Sexual Health and securing additional income for Dental GA's to reflect the increase in theatre costs.

The Trust has an unchanged FOT of £971k deficit (ie as the submitted plan) including £1,620k PSF. Discussions are ongoing at Finance Committee regarding the current run-rates and the risks and opportunities in delivering the FOT.

The Trust are engaging in active conversations with lead commissioners regarding funding and future saving schemes, with the aim to jointly agree 30 September letters. The aim is to consider how both us and the commissioners can produce balanced plans over the medium term, enabling all parties to close the recognised financial gaps.

CIPs

CIP delivery in month 5 was £371k, £177k adverse to plan. YTD the adverse variance is £113k due to under delivery in pay and non-pay schemes. It is recognised that delivery of CIPs is difficult in the current climate; extra effort is being applied to put all CIP schemes through the QIA process. Significant schemes have been approved and all other schemes are expected to be presented at the next QIA with the majority already submitted awaiting the QIA meeting.

Capital and Cash

Month 5 capital expenditure is £106k. Projects totalling £4.2m have been approved and in most cases are in progress; however £1m of this spend has been deferred into 2019-20.

The Trust is also budgeted to receive £5.5m PDC funding for Phase 2 project at St Marys and St James hospitals, £235K of which has been spent YTD.

The cash balance at 31 August 2018 was £13.1m.

Aged debt

Debt over 90 days overdue has increased £152k month on month due to additional CCG debt becoming 91+days overdue. The Deputy Director of Finance is in discussions with CCGs and has been assured payments will be made. The Trust are working closely with SBS, setting priorities of debt to chase (generally highest value) and finance are working with services to clear queries/provide further backup where required.

5.1 - Workforce Performance — August 2018/19

There were **2,912.4** FTE in post this month, which equates to **3,529** staff in post.

A decrease of **2.7** since last month

89% YTD mandatory training compliance

80% YTD information governance training completed

69% YTD appraisals completed

Bank and Agency

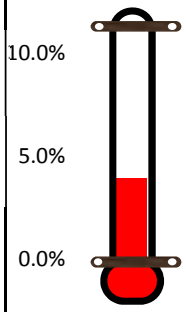
30,781 Hours requested in month

20,295 Hours filled by bank in month **£494,884**

7,374 Hours filled by agency in month **£372,149**

3,112 Hours requested not filled

In month, Solent are above agency ceiling by **£97,149**



3.9%

Sickness & absence in month

Last month, the rate was **4.0%**

94.6% *budgeted establishment (FTE) worked in month*

5.4% *vacancy factor*

FTE Posts **166.9**

12 month rolling turnover is **14.0%**

38 (32.5FTE) new starters in month

55 (41.9 FTE) leavers in month

5.2 - Workforce Commentary

Sustainable Workforce

Our vacancy factor for August as a Trust continues at circa 5% with an average annual staff turnover of 14%, the same as the previous month. The number of staff in post for August decreased by 2.7 FTE; this also includes 15 FTE who were set to leave the Trust on the last day of the month.

New recruitment methods are being deployed and we recently trialled a very successful digital campaign for mental health. The Retention Programme also continues and has yielded a reduction in nursing turnover from 21% at its peak to 17.4%.

There was an increase in employee relations cases in August, most notably in relation to sickness as part of an ongoing focus on attendance management across the Trust as part of our safe and sustainable staffing strategy. There was a slight decrease in the monthly sickness absence rate from 4% to 3.9% in August.

Temporary staffing - agency costs for August increased by a further £18,349 on the previous month which is a reflection of the number of posts currently vacant, combined with acuity and holiday cover. This is currently £97,149 over the Trust's monthly agency cap compared to £78,800 in July. The number of agency hours worked reduced in August by circa 17% on the previous month, which should see a reduction in agency spend reflected in September. As part of the workforce planning process and safe & sustainable staffing collaborative, regular reviews take place of: rosters, bank staffing, newly qualified recruitment, skills mixing, competency development and clinical education pathway solutions to address job vacancy related agency spend. Significant system constraints (referenced below) are also escalated and actioned via the HIOW Local Workforce Action Board and HIOW Sustainability and Transformation Partnership.

The following issues continue in regard to workforce capacity and planning:

- An over-reliance on agency staff (particularly off framework suppliers)
- High competition for talent with local system partners
- Preventing skills loss due to an ageing workforce
- Delays in the national implementation of apprenticeship standards for specialist roles (e.g. therapies)

These actions are being taken:

- Recruitment of additional bank co-ordinator dedicated to Portsmouth to increase recruitment of nurses in the community, in preparation for winter pressures
- Deployment of a Safe Staffing Programme Lead working in conjunction with Chief Nurse and Roster team to lead the improvement in the Safe Staffing agenda and maximise the Allocate system functionality, with a link to improved Rostering and improved contingency planning
- Budgetary incentive for services that support Nurse Degree Apprenticeships in the first year of their training.

Additional considerations for action in Q3 and Q4:

- Framework for managing flexibility in our workforce
- Trust-wide Data Quality programme: efficient management of hierarchies across all systems, including workforce reporting and rostering
- Deeper and longer term succession planning for critical positions
- Integrated working with system partners to enable Local Care Partnerships, Clusters/locality team initiatives
- Clearer signposting for learning, education and career pathways (e.g. Nursing Associate and Assistant Practitioners)

Learning & Development

The annual statutory and mandatory training compliance rate is 89% for August against a target of 90% and we are pleased to note the increase. People are still raising complaints around ease of use of the online learning system; significant investment is being made into teaching people how to use the system effectively.

Both Information Governance (IG) and Performance Appraisal (PA) compliance are reset to 0% on 1 April at the start of each financial year. The IG compliance rate for August is 80% rising from 74% in July. The PA completion rate has increased from 55% last month to 69% in August. A change to the appraisal deadline to 1 September was agreed this year to allow time for more meaningful career conversations, proactive follow-up will now begin to ensure compliance is accurately recorded.

Specific issues and actions in relation to statutory and mandatory training compliance are:

- Mental Capacity Act (MCA) training – both compliance and consistent transfer of learning into practice. Additional investment to recruit a dedicated MCA trainer has been approved, recruitment will begin in September. A Trust wide training plan is in development to include simulation and testing of competencies in practice.
- Safeguarding Adults – whilst the compliance has increased in recent months, achieving the 90% target remains a challenge. A review of the recently published intercollegiate guidance for safeguarding adults is underway with a revised training programme to meet required standards. A Head of Safeguarding has been recruited and commences on 1 October, an immediate priority will be to review training and develop a sustainable programme of training which supports excellent safeguarding practice across the Trust.
- Bank staffing – the 90% compliance target for our bank staff is challenging due to the nature of the bank staffing working patterns. An improvement plan for Bank staffing is in place to restrict shift availability of those who are non-compliant until compliance is achieved. Availability of bank staff to fill shifts will be reduced until compliance is achieved, which is likely to result in increased agency usage.

A number of new apprenticeship programmes have been procured which strengthens our career development offering and enables us to maximise our investment in the levy. The Registered Nurse Degree Apprenticeship scheme with Solent University will commence in September. We are pleased that 9 members of our existing Healthcare Assistant workforce from Adults, Sexual Health and Primary Care services have been accepted on the programme. We are preparing our clinical leaders to act as mentors over the 4 year programme. We are also preparing 2 members staff in our Mental Health services to commence the Mental Health Degree Nurse Apprenticeship programme with the Open University, and recruitment will start in September for two additional Mental Health Nurse Apprentices. Leadership and Management Apprenticeships have now become available, and 3 new degree apprenticeship programmes have been procured with local providers.

Leadership, Culture & Values

Review of our senior leadership succession and development plans took place with Executive Directors and investment in our senior leadership programme continues to develop a pipeline for future leadership candidates. An alumni of our Releasing and Maximising Potential Leadership Programmes (middle managers) has also been created to engage our leaders in the future of our Talent and Leadership strategy, the first meeting will be held in September.

The Equality, Diversity and Inclusion Sub-Committee was held in August and we were pleased to note the increased representation. Members supported local PRIDE events taking place in Portsmouth, Southampton and Eastleigh, where we received very positive feedback from those attending the events. We submitted our application to join the Stonewall organisation, a lesbian,

gay, bisexual and transgender rights charity. We will be adding some of their bite-size training modules to our learning curriculum.

We are also participating in the NHS Partners programme and will be specifically tailoring our Equality action plan toward BME community engagement so that we can build cultural awareness in our organisation. A story from one of our Diabetes Nurse Specialists will launch our Diversity Included campaign, which will fully integrate into our Quality Improvement work with Patients Included and Side by Side.

We have successfully renewed our accreditation as a Mindful Employer. In order to achieve this accreditation we have evidenced that we are positive about mental health and our OWLES (mental health staff network) play a pivotal role in creating a supportive and open culture.

Communication & Engagement

We continue to empower people to communicate and share their stories to: 'be proud, be passionate, be honest, be yourself'. In August, we launched CuriosiTea; events aimed at promoting pride and celebration within the organisation. The events gave the opportunity for people to connect with the Solent Story, our strategic narrative, and provided the space for people to connect with their own story of how they make a difference. Two events were held in August and more events have been arranged.

Noticeboards remain a key communication tool for our employees as we are based in well over 100 locations. To aid with the cascade of information, we have created a noticeboard library and clear guidance to support managers.

In August, we commenced our preparation for the 2018 NHS Staff Survey. Senior Team meetings were used as a vehicle to share our communications strategy and discuss ways that local teams could be prepare for the survey, and take steps to encourage a high response rate. In addition to regular communication and updates, managers will be provided with comprehensive guidance based on real examples and feedback from our teams following the completion of the 2017 Staff Survey.

Planning for our AGM in September, the AGM will feature a marketplace style showcase of innovation across our services, and will have a theme of accessibility, partnership and community involvement.

6.1 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 continuing to meet the Trust target. The Use of Resources score has improved to a level 2, primarily due to a reduction in the Capital service capacity and I&E Margin scores which are now at level 2. Operationally, against the framework, the Trust has only not met 3 indicators in the Quality and Operational metrics – including the Mental Health Scores from Friends and Family Tests, which has shown a slight decrease in month to 86%. As a consequence of the events on Maples in May, bed availability has reduced by 6 with a total of 116 bed days in August being out of area placements. It is expected once Maples capacity returns to normal levels in Q3, OOA placements should return to minimal levels.

The overall performance against the Single Oversight Framework is positive.

Quality of Care Indicators

Organisational Health

Internal aspirational thresholds are highlighted in grey

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Staff sickness (in month)	4%	4.8%	4.6%	4.9%	5.2%	5.1%	5.2%	4.3%	4.2%	4.2%	3.7%	3.6%	3.7%	3.7%
Staff turnover (rolling 12 months)	12%	14.8%	14.5%	14.2%	14.3%	14.4%	14.1%	14.4%	14.2%	14.2%	13.9%	13.9%	14.0%	14.1%
NHS Staff FFT	40%	..	64.1%	..	..	..	..	..	69.0%	..	..	..	..	..
Proportion of Temporary Staff (in month)	6%	6.4%	5.8%	5.7%	6.0%	6.1%	6.0%	5.9%	6.0%	5.6%	4.9%	5.7%	5.9%	5.9%

Caring

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Written Complaints		16	17	11	19	16	18	22	20	19	27	17	19	17
Staff Friends and Family Test Percentage Recommended - Care	80%	..	82.3%	..	..	..	..	..	84.0%	..	..	84.0%	..	..
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Scores from Friends and Family Test - % positive	95%	95.2%	95.0%	96.0%	97.0%	96.6%	96.2%	96.2%	95.9%	95.4%	96.4%	96.4%	95.4%	96.1%
Mental Health Scores from Friends and Family Test - % positive	95%	90.5%	83.3%	85.4%	91.3%	83.3%	95.6%	84.3%	80.5%	74.7%	71.2%	88.3%	86.5%	85.7%

Effective

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	92%	100%	98%	100%	100%	100%	100%	100%	100%	97%	98%
% clients in settled accommodation		70%	72%	72%	71%	71%	71%	70%	71%	74%	75%	80%	79%	79%
% clients in employment	5.0%	5.0%	5.0%	6.0%	6.0%	5.0%	5.0%	5.0%	5.2%	4.4%	5.0%	5.8%	6.0%	5.9%

Safe

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

Operational Performance Indicators

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	99.8%	99.5%	99.7%	99.6%	99.7%	99.4%	99.4%	99.7%	99.5%	99.8%	99.4%	99.7%	99.1%
Maximum 6-week wait for diagnostic procedures	99%	100%	100%	100%	100%	100%	100%	100%	100%	99%	99%	100%	100%	100%
Inappropriate out-of-area placements for adult mental health - services Number of Bed Days	0	-	-	0	0	0	0	0	0	0	21	71	122	116
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	67.0%	83.0%	80.0%	88.0%	50.0%	40.0%	83.0%	100.0%	75.0%	100.0%	100.0%	60.0%	100.0%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%	-	97.4%	-	-	97.4%	-	-	86.2%	-	-	-	-	-
Improving Access to Psychological Therapies (IAPT) / Talking Therapies		-	-	-	-	-	-	-	-	-	-	-	-	-
- Proportion of people completing treatment who move to recovery	50%	56.5%	61.1%	60.4%	57.8%	53.4%	57.8%	57.6%	58.2%	51.1%	56.1%	60.4%	61.9%	54.0%
- Waiting time to begin treatment - within 6 weeks	75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	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%	100.0%

Use of Resources 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		Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Capital service capacity	Financial Sustainability	2	2	2	2	2	2	2	2	2	1	0	1.2	1.4
Score		*3*	*3*	*3*	*3*	*2*	*3*	*2*	*2*	*2*	*4*	*4*	*4*	*3*
Liquidity (days)	Financial Sustainability	-12.9	-13.3	-12.7	-14.4	-15.4	-14.7	-10.7	-6.7	-6.2	-6.7	-6.8	-6.5	-5.9
Score		*3*	*3*	*3*	*4*	*4*	*4*	*3*	*2*	*2*	*2*	*2*	*2*	*2*
I&E Margin	Financial Efficiency	1.1%	0.9%	1.0%	-1.0%	-1.0%	-0.9%	-0.7%	0.4%	-0.9%	-1.3%	-1.4%	-1.2%	-1.0%
Score		*2*	*2*	*2*	*4*	*3*	*3*	*3*	*2*	*3*	*4*	*4*	*4*	*3*
Distance from financial plan	Financial Efficiency	0.2%	0.3%	0.1%	0.0%	0.1%	0.1%	0.2%	1.3%	0.3%	0.2%	0.1%	0.1%	0.1%
Score		*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Agency spend	Financial Controls	47%	40%	38%	38%	42%	42%	43%	38%	24%	37%	34%	35%	38%
Score		*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*2*	*3*	*3*	*3*	*3*

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Use of Resources Score	2	2	2	3	3	3	2	2	2	3	3	3	2
RAG	G	G	G	R	R	R	G	G	G	R	R	R	G

6.2 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, including that issued by NHSI.	
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.	
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	Tithe 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 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.	

Becoming a great place to work

Solent NHS Trust

A values-based and people-centred organisation in which people can thrive and are liberated do their best work.

Solent NHS Trust:
Great care at the heart of our community

Presentation to	X In Public Board Meeting	☐ Confidential Board Meeting	
Title of Paper	**Quality Framework**		
Author(s)	Julie Jones, Bank Project Manager	**Executive Sponsor**	Jackie Ardley, Chief Nuse
Date of Paper	September 2018	**Committees presented**	QIR – 3rd September TMT – 19TH September
Link to CQC Key Lines of Enquiry (KLoE)	X Safe ☐ Effective ☐ Caring ☐ Responsive X Well Led		

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

Action requested of the Board	☐ **To receive**	X **For decision**

- The new Quality Framework has been developed to replace the Quality Improvement Strategic Framework (Chief Nurse, June 2016).
- The purpose of the Framework is to bring together in a single document how the Trust delivers *Great Care* in a way that is clear to patients, staff and our stakeholders
- The Framework is based around a simple formula designed to be easy for patients and staff to remember and relate to: **SEE (Safe, Effective, Experience)**
- It sets out:
    - what quality means to Solent, its patients and staff in terms of Safe, Effective and Experience (SEE)
    - the pivotal role our staff play and how we support them to deliver *Great Care*
    - how we check the quality and standards of care in our services
    - how we use innovation, research and organisational learning to continually improve
    - governance, risk management and leadership arrangements for quality
    - how we talk about quality at all levels of the Trust
- The Framework also describes how the Trust develops its annual quality priorities which are published in the Quality Account, and which guide our key quality improvement work programmes and business plan objectives throughout the year
- The Framework is provided in a staff-friendly PowerPoint slide deck and in more detail in the document attached.
- Once approved the Framework will become part of the Solent Story and promoted via our website and SolNet

Recommendation

The Board is asked to approve the Quality Framework

Item 13.2

NHS Solent NHS Trust

Quality Framework

Our ambition to deliver great care to more people

Version 6: 01 August 2018

Quality Matters

Our patients, and communities are at the heart of everything we do, and our ambition is to care for more people in, or close to, their homes. Our focus on delivering high quality, great care will help us achieve this.

Great Care is about high quality standards; standards which improve the experience for patients and staff. These combined will help us continue to innovate, and shape our future care plans. So, high quality standards begin with our staff. It is thinking about quality every day, and using their ideas, and experience to help create and deliver the quality improvements that will deliver our ambition.

This is our quality framework which will help guide and support us to continue to provide high quality, great care.

It begins with our Story, who we are and why we are here

At Solent NHS Trust we all share an ambitious vision, to make a difference by keeping more people healthy, safe and independent in, or close to their own homes.

People, values and culture drive us. The best people, doing their best work, in pursuit of our vision. People dedicated to giving great care to our service users, and great value to our partners.

We aspire to be the partner of choice for other service providers. With them we will reach even more people, and care for them through even more stages of their lives. Ultimately it is the people we care for who will tell us if we are successful, and who will help shape our future care.

This means that to continue to deliver great care, our ambition is to:

- maintaining the right balance between delivering great care and providing value for money
- make engagement a priority by further enhancing the way we listen and work with our patients, our staff, people who live within our communities and with local organisations and stakeholders
- make quality improvement everyone's business at Solent by continuing to develop and support our staff and making quality core to our conversations with staff; starting with when people first begin working with us, and continuing in their day to day routines, as part of regular supervision and one to one conversations, and formally as part of annual performance reviews
- strengthen our reputation as a learning organisation, delivering real and measureable change that makes a difference to people we care for and treat. We will do this by actively utilising positive and negative events and feedback to facilitate change and improvement.
- build on the many areas of outstanding practice across the Trust and excellent multidisciplinary teamwork by spreading excellence and sharing best practice
- continue to help vulnerable people in our communities live safer lives by supporting our staff to further build their expertise, skills and capabilities

Our Quality Framework

Our formula for Great Care is as simple as 1, 2, 3

1. **S**afety is paramount
2. **E**ffectiveness is measured
3. **E**xperiences of patients and staff guide us

SEE our formula for great care!

1. Safe

We treat thousands of patients every day and patient safety means working proactively to minimise the chance that things could go wrong; if they do we are open and honest with patients and their families about what's happened and we take steps to reduce the chance the same thing could happen again. Being safe means we will:

Workplace	•Treat patients in clean, safe surroundings •Ensure equipment is tested, accurate, and working properly •Be proactive where safety is concerned
Care	•Make sure tests are appropriate and timely •Give medicines at the right time, and in the right dose •Act quickly to rectify problems if things go wrong
Everyone	•Ensure safe care is not just relevant to front line staff, but everyone •Speak up, especially if it could impact patients •Identify ways to improve safety for and with our colleagues

2. Effective

Clinical effectiveness means providing the right care for each individual patient. It means our staff are constantly thinking about what they do and questioning whether it is having the desired result for each patient and if not, making a change. We will:

Innovate	•Be ambitious but follow our service line quality goals •Innovate, use our experience, and look for incremental improvements •Tap into programs like academy for research and Dragons Den
Collaborate	•Share our stories and value how we all make a difference •Recognise we may not have the answers but our colleagues might •Collaborate with colleagues, teams, partners
Everyone	•Share our ideas for improvement, everyone has them •Measure improvements to ensure effectiveness •Be inclusive and hear everyone's voice

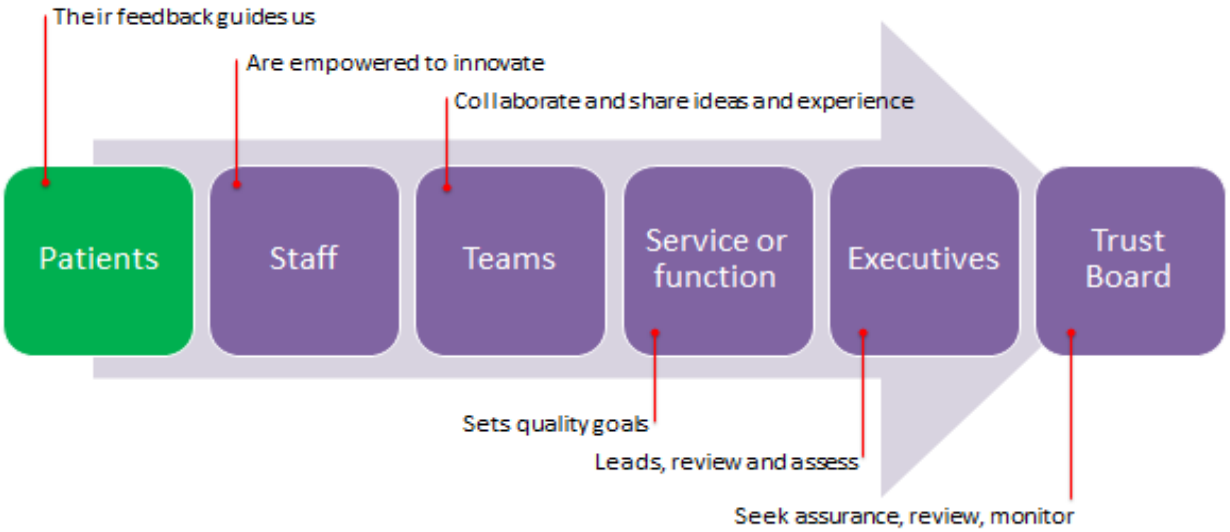
3. Experience of our Patients and Staff

Our patients are at the centre of everything we do. By listening to patients and asking them about their experience, we can check that they and their families and carers are receiving care that is respectful of and responsive to individual patient preferences, needs and values. We will:

Feedback	•Ensure Friends and Family Test results are our navigation •Action Compliments and Complaints •Empower staff to innovate and share ideas for improvements
Experience	•Let patients guide us. If it can be done better, do it •Check we are changing for patient reasons. If not we will question it •Make our ideas make a difference. Experience equals innovation.
Everyone	•Ensure patient centred care is not just for front line, it's everyone •Understand how what we each do impacts on patient experience •Use patient feedback to help everyone make improvements

Quality throughout the organisation

At every level of the organisation Great Care is a priority and we have established a supportive infrastructure to enable individuals and teams to focus on quality.



Our people are the key to Great Care

Everyone at Solent is responsible for quality and our staff take pride in their work and in the care they provide to patients.

We are committed to having the right numbers and types of staff to deliver safe services, ensuring that roles and responsibilities are clear and our values and behaviours are upheld to deliver compassionate care. We make sure our people are properly inducted, trained and qualified; have the required knowledge and skills to do the jobs the service needs whilst working effectively in a team. It means we have a strong focus on:

- Recruiting, retaining and developing staff to meet our current and future needs
- Using technology to help us enable staff to work more efficiently
- Supporting people to be their best through supervision, training and personal development
- Investing in our buildings so they are great places to work and receive care and treatment
- Making sure that people who lead teams at all levels promote a safety culture and good practice as the norm
- Providing flexible working opportunities

Everyone at Solent, including those directly and indirectly employed staff, volunteers, agency staff and contractors, plays a part in providing ***Great Care,*** and regardless of whether they have direct contact with patients on a daily basis.

Executive Team	•Are ultimately responsible for quality and should provide the resources, systems, and processes to ensure that staff are empowered to deliver high quality care
Clinical Services	•The clinical services are responsible for creating a culture of high quality care by providing the management, support and empowerment to staff to drive quality care and improvements
Corporate Services	•Corporate services support everyone in the management and delivery of high quality care through the effective delivery of systems, processes, and administration of quality efforts

Individually each of us is responsible for ensuring patient safety, patient safety and the effectiveness of our clinical services improves year by year and we also:

- understand and work within our professional duty of care and the responsibilities and accountabilities of our individual roles
- raise concerns we may have about quality as soon as they arise
- seek to learn from others to help us improve
- work in line with Solent policies and procedures and national requirements and standards
- seek out and respond to feedback about our services and use this to help us improve

Leading for Quality

Great Care is delivered by great teams and great teams are supported by great leaders. From clinical team leaders to the Trust Board, all of our leaders recognise the importance of proving high quality safe care and a positive experience to our patients.

We recognise how important it is to build a culture in which supports high quality care and innovation. Our Trust Board is responsible for setting the culture of the organisation and does this by:

- Ensuring quality is core to the Trust's vision and values
- Giving quality priority on Board agenda's
- Investing resources in quality improvement and innovation initiatives such as our Quality Improvement Programme and Dragon's Den
- Building quality goals into all business development and delivery plans
- Including patient feedback and other quality measures in key performance indicators
- Carrying out regular Board quality visits to frontline services
- Providing visible board leadership for specific quality initiatives

We constantly challenge ourselves to ensure our leadership is aligned to national best practice standards of being a well-led organisation. This means we regularly test ourselves against national best practice frameworks such the NHS Improvement Well Led Framework, to identify how we can improve.

Quality Goals & Priorities

Continuous improvement is a fundamental to our approach to Great Care and to providing staff with the support they need to develop and improve their services

Each year the Trust sets its annual objectives and this includes agreeing our shared priorities for quality improvement.

Our priorities are linked to our story, which sets out who we are and why we exist; our priorities set out our ambitions to help us deliver our vision in relation to quality

These are based on feedback from staff, patients and our stakeholders and from findings from our quality surveillance, local and national priorities and

We set out our quality priorities in our Annual Quality Account which is published on the NHS Choices website

Our clinical services devise their own plans and initiative's to help us achieve our priorities and we check how we are doing against these priorities throughout the year

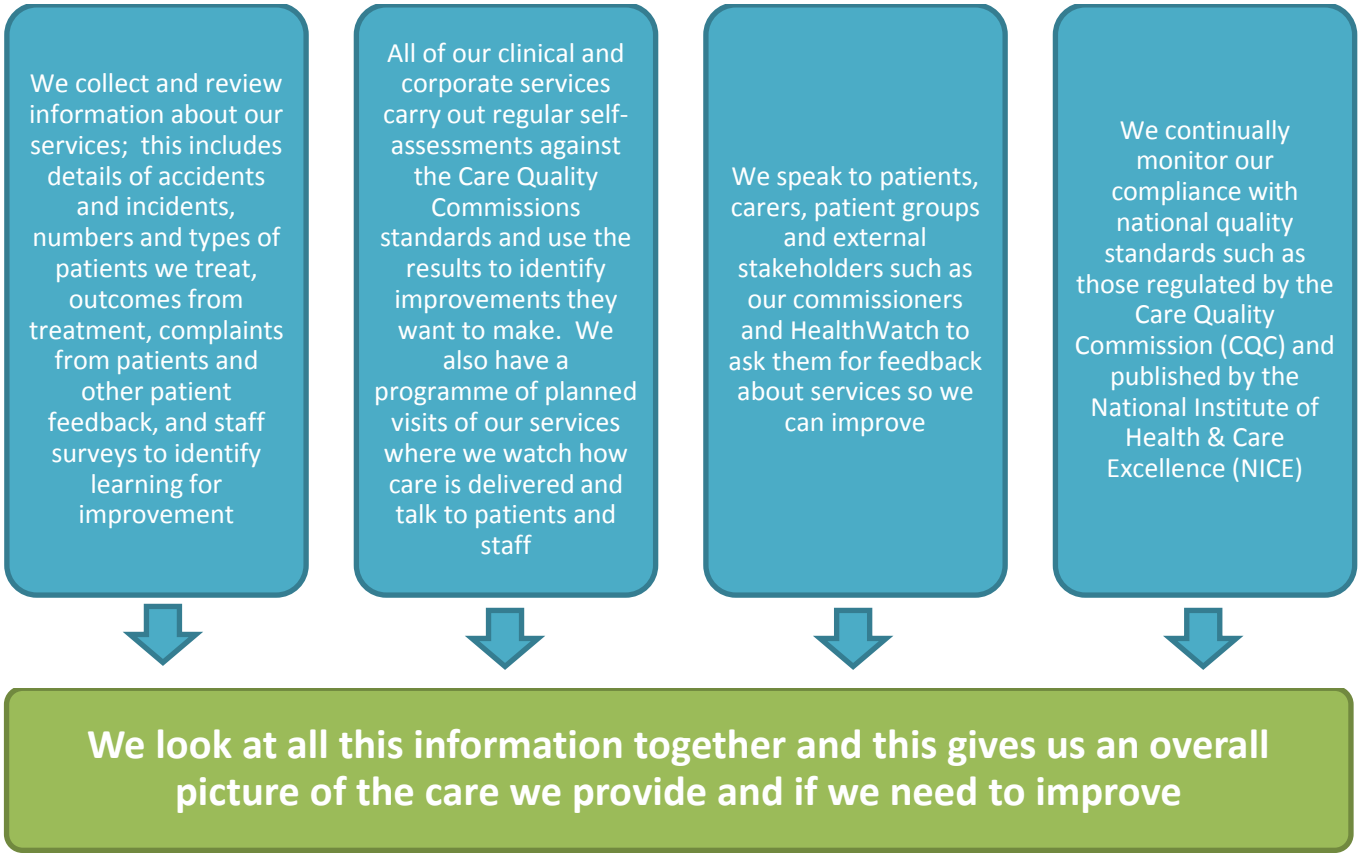
Empowered to innovate

We support staff to be ambitious and to use their own experiences to innovate to make incremental improvements in line with their service line goals:

- We have a team of research clinicians who work with our services to recruit patients into clinical research studies and deliver clinical trials. We can also provide development grants to support research projects
- Our Quality Improvement (QI) Programme equips staff with the confidence and skills to deliver improvements in their clinical areas and show how these have made a different to patients
- The Solent Dragons' Den is another way we encourage innovation and improvement. Any member of staff, team or patient can put forward ideas that will improve or enhance care and patient experience and small grants of up to £10,000 can be awarded to help put these ideas into practice.
- We use service evaluations to critically think about whether an individual service has achieved what it should. We asks questions like - "has this service been a success?" or "how satisfied are patients with the service being provided?"
- We support the use clinical audit to review clinical care against local and national standards; this gives us confidence that care is to the standards we expect but also helps us identify areas for improvement
- We use our Organisational Learning Framework to ensure we identify lessons and share learning across the Trust to help us improve safety, care and experience

Assessing Quality

We constantly monitor our services to ensure we're meeting the high standards of safety, care and experience we and our patients expect:



Managing and monitoring quality

We've put in place a comprehensive clinical structure, systems and processes and have clear roles and responsibilities to ensure we deliver *Great Care* and these are summarised below:

- Our clinical services are organised around the types of health care services they provide; each service line has strong clinical leadership and the autonomy to design and deliver services that are right for their patients

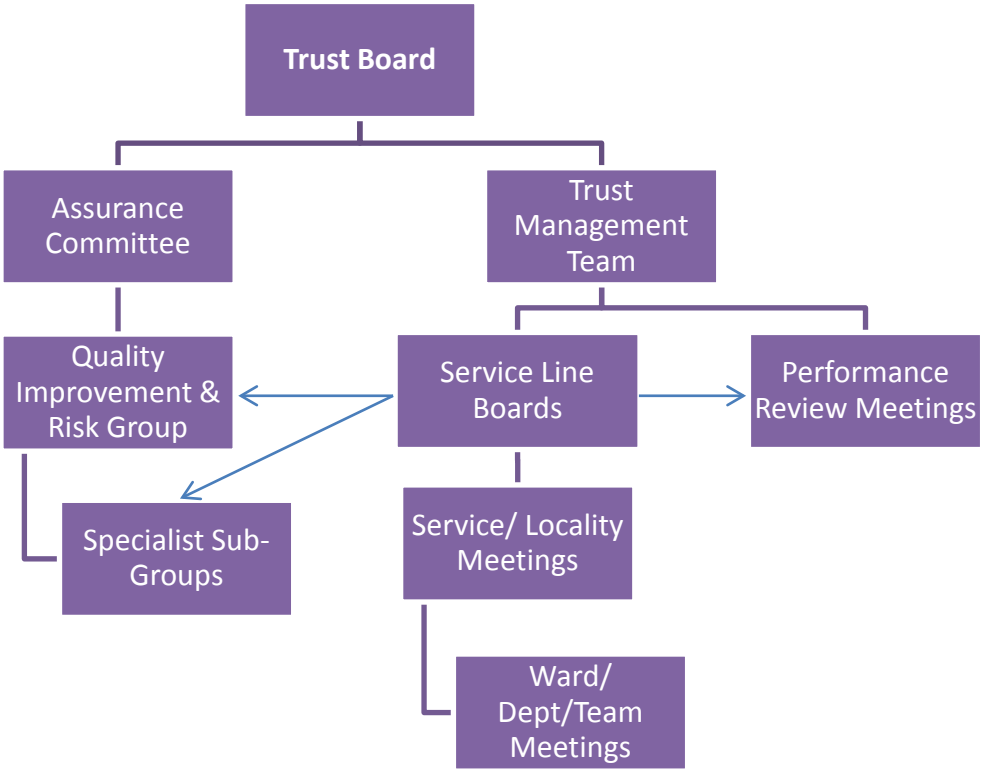
- We have a clear meeting structure (summarised below) which enables us talk about quality at every level from front line clinical teams to the Board and provides our Board with a clear line of sight down to ward and team level

- In our meetings we review and triangulate many different types of information such as performance data, staff and patient feedback and findings from service visits, to give us an overall picture of quality across all of our services

- If improvements are needed we put robust plans in place that are regularly monitored to ensure they are on track and have the desired impact on care

- We use internal audit to check that the quality systems and processes we have put in place are working effectively and often commission external reviews to give us an independent perspective

- We make sure all our staff understand their role in quality and they receive the support they need to be able to deliver Great Care



Managing risk

Risk is a part of everyday life. Delivering *Great Care* includes anticipating risks that might impact on quality and preventing or managing those risks:

- Our Risk Management Framework sets out how we anticipate and manage all types of risk, including risks to quality and patient care. It provides a clear process to ensure we understand what risks we face and minimise these as much as possible

- Any risks we do identify are collated in our Risk Register (operational quality risks) or Board Assurance Framework (strategic quality risks) and this helps us monitor the risk and make sure appropriate action is being taken

- When we make changes to services and introduce new services we carry out a Quality Impact Assessment to check that quality will not be adversely affected

- We have policies & procedures in place which staff follow and which include our standards and the systems and processes within which staff must work. Policies include Safeguarding, Infection Prevention & Control, Medicines Management, Medical devices, Health & Safety, Clinical Supervision, the Mental Health Act and Learning from Deaths, to name but a few

- If something goes wrong we carry out an investigation to find out what happened; we use the findings and learning to improve services and reduce the chance of the same thing happening again

- We conduct regular environmental risk assessments to ensure we provide safe environments for staff, patients, visitors and the public

So that's our formula for Great Care

Is as simple as 1.2.3.

1. **S**afety is paramount
2. **E**ffectiveness is measured
3. **E**xperiences of patients and staff guide us

Item 14

REPORT

NHS Solent NHS Trust

Presentation to	Trust Board							
Title of Paper	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annual Board Report and Statement of Compliance							
Author(s)	Sally Cordall, Business Manager		**Executive Sponsor**		Dan Meron, Chief Medical Officer			
Date of Paper	16th July 2018		**Committees presented**		None			
Well Led KLoEs	**W1** Leadership Capacity & Capability	X	**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	X
	W5 Risks and Performance		**W6** Information	X	**W7** Engagement		**W8** Learning, Improvt & innovation	

Executive Summary

NHS England has developed The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA). The purpose of the framework is to support designated bodies and responsible officers in providing assurance that systems and processes are in place, identifying areas in which development will be required over the coming year and engaging Boards and management teams.

Every year, all Responsible Officers are asked by NHS England to present an annual report to their Board. Following this, a statement of compliance should then be signed off by the Chairman or Chief Executive Officer of the designated body's Board and submitted to the Higher-Level Responsible Officer by 28th September 2018.

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

Key Decisions/ Action(s) requested

The Board is requested to receive the Annual Board Report and the Chairman or Chief Executive is required to sign the Statement of Compliance. The Medical Directorate Business Manager will return the Statement of Compliance to NHS England by 28th September 2018.

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D - Annual Board Report Template

1. Executive summary

As at the end of March 2018, Solent NHS Trust had 86 doctors with a prescribed connection to this designated body and 83 who have completed their appraisals. The circumstances for the remaining 3, the Responsible Officer has accepted as reasonable. As per the Revalidation and Appraisals policy, medics' appraisals are carried out April-September each year.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers (RO) in discharging their duties under the Responsible Officer Regulations and it is expected that boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3. Governance Arrangements

GMC Connect is the system we use for the management of an accurate list of prescribed connections. This system details the individual doctor's submission date and allows the RO to electronically revalidate the individual following review of their appraisal portfolio. This system is managed by the Medical Directorate Business Manager.

As new doctors are employed, they are able to add themselves to the Solent list via their GMC login. The Business Manager and RO are also able to add and remove doctors. The list is monitored monthly to ensure it is up to date and correct.

In March 2016, the Trust commissioned a revalidation dashboard which allows appraisal documents to be uploaded directly, highlights those doctors who are due for revalidation and flag any missing documentation. The system also offers patient and colleague feedback surveys for all doctors for whom Solent is their designated body.

a. Policy and Guidance

The Medical Appraisal and Revalidation policy details Solent's guidance for medical staff and directs its readers to national documentation namely 'The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012' .

4. Medical Appraisal

a. Appraisal and Revalidation Performance Data as at 31 March 2017

Detailed activity levels of appraisal outputs:

- 86 doctors
- 83 completed appraisals

For details of exceptions i.e. missed appraisals and reasons, incomplete appraisals etc. (See **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

Solent NHS Trust has 23 appraisers.

New appraisers are required to attend an external training course and are then assessed by the Appraisal Lead, to ensure they are ready to appraise. Appraisers should undertake a minimum of 2 and max of 5 appraisals yearly.

We have recruited two new candidates who will be trained at the end of 2018 so they can become trust approved appraisers in 2019.

Our Appraisal Lead organises an Appraiser Support Group on a regular basis. This aims to support the quality and practice of medical appraisals. It is a requirement for all appraisers to attend at least one of these groups per year to ensure appraisal practice is up to date and high quality.

c. Quality Assurance

Outline of quality assurance processes:

The DMG;

- Reviews the appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate,
- Reviews the appraisal folder to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard using the PROGRESS tool,
- Reviews the appraisal output to provide assurance that any key items identified pre-appraisal, as needing discussion during the appraisal, are included in the appraisal outputs.

The Business Manager, for the organisation manages;

- A list of trust approved appraisers,
- A list of allocated appraisers and who they are appraising,

- A record of appraisals and when completed,
- Feedback forms on the appraisers.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, Security and Confidentiality

Appraisal folders for each doctor and all revalidation submissions are securely stored on the R drive accessibly only by the RO and the Medical Directorate Business Manager. All Patient Identifiable data found in appraisal portfolios is obscured.

Both Solent NHS Trust and the appraisee will need to retain copies of the appraisal documentation over a five year period.

5. Revalidation Recommendations

Number of recommendations made between 01/04/17 – 31/03/18: 6

Recommendations completed on time: 6

Positive recommendations: 4

Deferrals requests: 2 (1 doctor left our employment, 1 doctor external)

Non engagement notifications: **0**

Reasons for all missed or late recommendations: **N/A**

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

6. Recruitment and engagement background checks

When a doctor moves to a new designated body, information needs to be available to the new responsible officer regarding that doctor as soon as possible. This formal request is made by the Human Resources team via a Transfer of Information form for information to be forwarded from the previous designated body.

See **Annual Report Template Appendix D;** Audit of recruitment and engagement background

7. Monitoring Performance

The process re managing performance is described in the Solent NHS Trust Policy, HR17 Managing Performance of Medical and Dental Staff.

8. Recommendations

The Board is asked to approve this report and the Chair or Chief Executive is required by NHS England to sign a statement of compliance. The Medical Directorate Business Manager will return the signed statement to NHS England by 28th September 2018.

9. Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**3**
Maternity leave during the majority of the 'appraisal due window'	*1*
Sickness absence during the majority of the 'appraisal due window'	*1*
Prolonged leave during the majority of the 'appraisal due window'	*1*
Suspension during the majority of the 'appraisal due window'	*0*
New starter within 3 month of appraisal due date	*0*
New starter more than 3 months from appraisal due date	*0*
Postponed due to incomplete portfolio/insufficient supporting information	*0*
Appraisal outputs not signed off by doctor within 28 days	*0*
Lack of time of doctor	*0*
Lack of engagement of doctor	*0*
Other doctor factors	*0*
Appraiser factors	**0**
Unplanned absence of appraiser	*0*
Appraisal outputs not signed off by appraiser within 28 days	*0*
Lack of time of appraiser	*0*
Other appraiser factors (describe)	*0*
Organisational factors	**0**
Administration or management factors	*0*
Failure of electronic information systems	*0*
Insufficient numbers of trained appraisers	*0*
Other organisational factors (describe)	*0*

10. Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed	83
	Appraisers are trained to only accept Medical Appraisal Guide (MAG) forms which are complete with all inputs. Where MAGs are not 100%, they are returned to the appraisee and the appraisal will not go ahead until complete. The standards for the selection, training and QA of the Appraisers are set out in the Solent Appraisal Policy and is overseen by the Appraisal Lead and the Responsible Officer. The Solent Appraisal policy conforms with the standards set by the Revalidation Support Team, NHS England Appraisal Policy and the GMC. The QA system PROGRESS has been developed nationally and addressed in Appraisal Lead networks. The Appraisers will only accept patient and colleague feedback from Trust approved systems. All pre-revalidation appraisals consider the doctors feedback and reflection as a compulsory part of the portfolio included in every MAG form prior to appraisal. The doctors have a point of contact with Quality and Professional Standards team where they can check all significant events/clinical incidents/SUIs they have been named in.
Appraisal Inputs	
Scope of work: Has a full scope of practice been described?	
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	
Patient feedback exercise: Has a patient feedback exercise been completed?	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	
Review of complaints: Have all complaints been included?	
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	
Is there sufficient supporting information from all the doctor's roles and places of work?	
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	
Appraisal Outputs	
Appraisal Summary	
Appraiser Statements	
Personal Development Plan (PDP)	

11. Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	0	0	3	3
Capability concerns (as the primary category) in the last 12 months	0	0	1	1
Conduct concerns (as the primary category) in the last 12 months	0	0	0	0
Health concerns (as the primary category) in the last 12 months	0	0	2	2
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2018 who have undergone formal remediation between 1 April 2017 and 31 March 2018. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows,				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	0
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	
Number of NCAS assessments performed	0

12. Annual Report Template Appendix C – Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	6
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	6
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	0
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	0
TOTAL [sum of (late) + (missed)]	0

13. Annual Report Template Appendix D – Audit of recruitment and engagement background checks

(1 April 2017 to 31 March 2018)

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	4
Temporary employed doctors	0
Locums brought in to the designated body through a locum agency	5
Locums brought in to the designated body through 'Staff Bank' arrangements	1
Doctors on Performers Lists	1
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	
TOTAL	11

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	BDS	3 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	4	4	4	4	4	4	4	4	0	0	4	4	4	0	0	0
Temporary employed doctors																
Locums brought in to the designated body through																

a locum **agency**																
Locums brought in to the designated body through **'Staff Bank'** arrangements																
Doctors on Performers Lists	1	1	1	1	1	1	1	1	0	0	1	1	1	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)																
Total (these cells will sum automatically)																

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

1. Designated Body Statement of Compliance

The board of Solent NHS Trust can confirm that;

- an Annual Organisational Audit has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes, on GMC Connect IT system

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes and a process of recruitment in place

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent);

   Yes, through our Appraisal Lead and Appraiser Support Group

5. All licensed medical practitioners[3] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes, recorded by the Medical Directorate Business Manager

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Yes

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[4]

Yes, Solent uses the national Medical Practice Information Transfer form (MPIT)

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[5] have qualifications and experience appropriate to the work performed;

Yes, completed by HR

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Solent NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

REPORT

Item 15

Presentation to	**Trust Board**		
Title of Paper	**Freedom to Speak Up Self-Assessment**		
Author(s)	Mandy Sambrook, FTSU Lead Guardian	**Executive Sponsor**	Jackie Ardley, Chief Nurse
Date of Paper	13th September	**Committees presented**	Previously discussed and presented at Board Workshop

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 Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led. Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

Context

The lead guardian attended a board seminar to review the FTSU guidance self-review tool – the key findings and themes are summarised.

The current guardianship is good and is now embedded within the organisation; the ambition is to be outstanding. To enable the vision is to develop the guardianship will continue to develop to be "Independent but not in Isolation".

Our Leaders are clear about their role and responsibilities

The Trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their roles and responsibility. They meet monthly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required.

Our Leaders receive assurance in a variety of forms

- The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:
- Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- Speak up issues that raise immediate patient safety concerns are quickly escalated
- Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- Lessons learnt are shared widely both within relevant service areas and across the trust
- The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented

- FTSU policies and procedures are reviewed and improved using feedback from workers.

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

Although the current FTSU Lead guarding is leaving; there are no known risks and there is business continuity plan in place prior to a substantive appointment being made.

Key Decisions/ Action(s) requested

The Board is asked to agree with the key findings from the self-assessment and support the following key developmental areas;

Recruitment Independent Guardian

Recruit an independent lead guardian within the organisation to develop and enhance the model, allowing ring fenced time to ensure the national guidance and network commitment are fulfilled.

Embedding within the organisational development strategy

The review of the self-assessment has also highlighted the need to develop the strategy further for Freedom to Speak Up. This will not be achieved in isolation and will be part of the organisational development programme. This will be achieved through developing the reporting structure. The current steering group will invite attendees from HR and work force to enable planning and development within this area. This will include the Chief Nurse in setting the vision; this will be developed and promoted when the independent lead guardian is appointed.

Item: 16.1

Board Report

Presentation to	X	In Public Board Meeting		Confidential Board Meeting					
Title of Paper	Compliance with the NHS Constitution								
Author(s)	Jayne Jenney, Assistant Company Secretary and Corporate Support Manager		**Executive Sponsor**		Rachel Cheal, Associate Director of Corporate Affairs and Company Secretary				
Date of Paper	September 2018		**Committees presented**		n/a				
Link to CQC Key Lines of Enquiry (KLoE)		Safe		Effective		Caring		Responsive	X Well Led
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	X	
	W5 Risks and Performance	X	**W6** Information	X	**W7** Engagement		**W8** Learning, Improvt & innovation		
Action requested of the Board	X	**To receive**		**For decision**					

The purpose of this paper is to provide assurance to the Board that Solent NHS Trust has continued to assess itself against the pledges and rights of the NHS Constitution. Solent's ability to demonstrate compliance against the constitutions principles and pledges has been reviewed by the relevant executive lead and their teams.

One of the primary aims is to set out clearly what patients, the public and staff can expect from the NHS and what the NHS expects in return. All NHS organisations are legally required to take account of the NHS Constitution in performing their NHS functions.

A summary status against the key areas is illustrated below;

Compliance with principles:

Principle	Compliant/ Non-Compliant	Exceptions
Comprehensive, available to all	✓ Compliant	Not applicable
Access based on clinical need	✓ Compliant	Not applicable
Aspires to highest quality standards	✓ Compliant	Not applicable
Patients are at the heart	✓ Compliant	Not applicable
Working across boundaries and with partners	✓ Compliant	Not applicable
Value for money	✓ Compliant	Not applicable
Accountable to public, community and patients	✓ Compliant	Not applicable

Compliance with pledges:

Focus	Key Area	Compliant/ Non-Compliant	Exceptions
Patient & Public	Access to services	✓ Compliant	Not applicable
	Quality of care and environment	✓ Compliant	Not applicable
	Nationally approved treatment, drugs and programmes	✓ Compliant	Not applicable
	Respect, consent and confidentiality	✓ Compliant	Not applicable
	Informed choice	✓ Compliant	Not applicable
	Involvement in your healthcare and in the NHS	✓ Compliant	Not applicable

	Complaints and redress	✓ Compliant	Not applicable
Staff	Rights/pledges	✓ Compliant	Not applicable

A copy of the full report is available separately for information.

Board Recommendation

The Board is asked to note the content of this report as assurance that the Trust is compliant with the legal requirement to take account of the NHS Constitution in provision of its NHS services.

Compliance with the 2015 NHS Constitution –September 2018

RAG key | Green = full assurance | Amber = part assurance | Red = not compliant/ no assurance

THE NHS CONSTITUTION
the NHS belongs to us all

Item 16.1

Seven Principles	Exec Leads	Compliant / Non-Compliant	RAG status	How do we demonstrate compliance?	Exceptions to compliance
1. The Trust provides a **comprehensive service, available to all**	DN / SA	Compliant	Green	All patients eligible for treatment	
2. **Access to services is based on clinical need**, not an individual's ability to pay	DN / SA	Compliant	Green	Services are free at the point of delivery	
3. The Trust **aspires to the highest standards of excellence and professionalism (Quality)**	JA	Compliant	Green	• Community Engagement strategy in development • Quality improvement programme and cohorts A Framework of Quality Assurance for Responsible Officers and Revalidation Annual Board Report and Statement of Compliance (September 2018) • Quality Assurance Framework revised - presentation to September 2018 Assurance Committee • Quarterly monitoring through the Quality Report including CQC essential standards • Quarterly Patient Experience Forum • Quality Account • Quarterly complaints scrutiny panel • Quality Improvement and Risk Group • Annual Clinical Audit Programme • Annual staff survey • Professional Advisory Group • Competency Scrutiny Panel	
4. The **patient will be at the heart** of everything the NHS does	JA/SA /DN	Compliant	Green	▪ Solent 'story' linked to strategy ▪ "Your voice counts" leaflets ▪ "Your view, your say, your service" leaflets ▪ Patient Experience Strategy ▪ Service user feedback is encouraged through the use of social networking sites (e.g. Facebook, NHS Choices, Twitter, Patient Choices) ▪ Service User Support Groups ▪ Family and Friends monitoring of numbers and narrative ▪ Patient Experience and Patient Involvement Committee ▪ Community Engagement strategy in development Everyone counts – Duty of Candour approach ▪ Volunteer strategy 2017 ▪ The Academy of Research & Improvement	
5. The NHS works **across organisational boundaries and in partnership** with other organisations in the interest of patients, local communities and the wider population.	DN / SA	Compliant	Green	• Active participant and partner in the Hampshire & IOW Sustainability and Transformation Partnership (STP) and developing Integrated Care System and Integrated Care Partnerships - for example; o In Portsmouth & South East Hampshire (PSEH) system: Medically Fit for Discharge programme , MCP programme o In Southampton: Better Care • Strategic exchanges with partner organisation boards and exec teams • Membership of multi organisational programme boards • Health and social care teams in the localities • Acute community multi disciplinary teams for frail elderly • Working in partnership for individual care pathways including COPD, diabetes, stroke, heart failure • A range of partnerships through sub contracts with third sector organisations •	
6. The Trust is committed to providing **best value for taxpayers' money & the most effective**, fair & sustainable use of finite resources.	AS	Non-compliant	Green	• External Audit VFM opinion for 17/18 was an unqualified opinion on the Trust's financial statements. • Financial Strategy	
7. The Trust is **accountable to the public, communities and patients** it services	RC	Compliant	Green	• Annual Report • In Public Board Meeting papers and minutes available via the public website • Community Engagement strategy in development • Membership Attendance at health watch, scrutiny panels	

Access to Services			Executive Lead = David Noyes Sarah Austin	
The NHS commits to			**How do we demonstrate compliance?**	**Exceptions to compliance**
•to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge); • to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge); and • to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them (pledge).			• Activity against waiting times recorded within performance report and monitored in more detail through performance sub committees. • Board In Public papers • Solent NHS Trust works with its partners to ensure smooth transitions along care pathways and between providers	**None**
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right to receive NHS services **free of charge**, apart from certain limited exceptions sanctioned by Parliament.	Compliant	Green	Services are free at the point of delivery	
You have the right to **access NHS services**. You will not be refused access on unreasonable grounds.	Compliant	Green	All patients eligible for treatment and access is available using a range of options including, GP referral, direct access, Referral criteria on web site	
You have the right to expect your local NHS to **assess the health requirements of the local community** and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.	Not applicable		Duty rests with commissioners ; • Commissioning plans in place to commission services from Solent NHS Trust. • Solent NHS Trust plans are aligned with commissioners and wider STP plans	
You have the right, in certain circumstances, to **go to other European Economic Area countries or Switzerland** for treatment which would be available to you through your NHS commissioner.	Not applicable		Duty rests with commissioners	
You have the right **not to be unlawfully discriminated against** in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status	Compliant	Green	• Equality & Diversity & Human Rights Steering Group • Equality Impact Assessments	
You have the right to **access** certain services commissioned by NHS bodies **within maximum waiting times**, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution	Compliant	Green	• Performance report • 18 wk national targets achievement monitored • 6 week diagnostic targets achievement monitored • Delayed transfers of care targets achievement monitored • Solent NHS Trust works with its partners to ensure smooth transitions along care pathways and between providers • Waiting list reports • Solent NHS Trust meets constitutional standards whilst acknowledging unacceptable therapy secondary waits	

Quality of care & environment			**Executive Lead = Jackie Ardley**	
The NHS also commits			**How do we demonstrate compliance?**	**Exceptions to compliance**
• to identify and share best practice in quality of care and treatments (pledge).			• PLACE inspection results • Ad-hoc infection control inspections. • Board to Floor visits • Quarterly monitoring through the Quality Report • CQC registration maintained without conditions • Complaints feedback • Patient Survey feedback • Single Sex Accommodation monitoring • Friends and Family feedback	**None**
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right to be **treated with a professional standard of care**, **by appropriately qualified and experienced staff**, in a properly approved or registered organisation that meets required levels of safety and quality.	Compliant	Green	• Implementation of the Patient Experience Strategy • Quarterly patient FFT • Annual Quality Account • Quality Improvement Programme • Annual Clinical Audit Programme • Complaints and concerns process • Staff training in customer care	
You have the right to be cared for in a **clean, safe, secure and suitable environment**	Compliant	Green	• PLACE assessments • IPC Audit Programme • IPC Training • Ligature Risk Assessments • Environmental Audits • H&S Statement of Intent	
You have the right to receive **suitable and nutritious food** and **hydration** to sustain good health and wellbeing	Compliant	Green	• PLACE assessments • Nutrition and Hydration Steering Group • Risk assessments and Care planning	
You have the right to **expect NHS bodies to monitor, and make efforts to improve** continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	Compliant	Green	• Quality goals and Annual Quality Priorities • Quarterly patient and carer experience • Quality Account • Performance and governance committee structure from Board to service • Quality Improvement Programme • Research and • Quality Performance Reporting and monitoring via performance governance infrastructure including service line governance groups, QIR, Performance SubCommittees. • Annual Clinical Audit Programme • PLACE inspection results • infection control inspections. • Board to Floor visits	

Nationally approved treatment, drugs and programmes			**Executive Lead = Dan Meron**	
Pledges			**How do we demonstrate Compliance**	**Exceptions to compliance**
• to provide screening programmes as recommended by the UK National Screening Committee (pledge).			• Chlamydia Screening • Newborn Screening	
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right to **drugs and treatments** that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.	Compliant	Green	• NICE compliance is part of the annual clinical audit plan (national and local). Report to QIR and Assurance Committee. Also monitored via Medicines Management Committee • Medicines Management & Safety Policy • Medicines Management Committee	None

You have the right to **expect local decisions on funding of other drugs and treatments** to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.	Not applicable	N/A	Duty rest with commissioners	N/A
You have the right **to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends** that you should receive under an NHS-provided national immunisation programme.	Not applicable	N/A	Duty rest with commissioners • HPV Vaccination programme • Child Immunisation Programme	N/A

Respect, consent and confidentiality			**Executive Lead = Jackie Ardley**	
The NHS also commits to:			**How do we demonstrate compliance?**	**Exceptions to compliance**
• ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively (pledge); • that if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution (pledge); • to anonymise the information collected during the course of your treatment and use it to support research and improve care for others (pledge); • where identifiable information has to be used, to give you the chance to object wherever possible (pledge); • to inform you of research studies in which you may be eligible to participate (pledge); and • to share with you any correspondence sent between clinicians about your care (pledge)			• Waiting times • Leaflet availability • Complaints feedback • Caldicott Guardian • Information Governance adherence • Records review and audit • Research Strategy • All clinicians have access to the summary care record • All patient records now electronic.	Where it is not deemed in the best interest of the client or family to share data
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right to be treated with **dignity and respect**, in accordance with your human rights.	Compliant	Green	• Our values • Dignity at Work Policy (Bullying & Harrassment) Quarterly essence of care benchmarking on Dignity and respect • Quarterly survey of patient and carer experience • Complaints process and quarterly monitoring of themes and trends. • DOLS audits • Monitoring of compliance with the new Care Act 2014 within the Safeguarding Adult framework • Policies subject to impact assessments • Monitoring of compliance with mixed sex accommodation • Chaperone Policy • Interpreter service available • Monitoring of compliance with EDS2 • Data Encryption Policy • Monitoring of compliance with Accessible Information Standards	None
You have the right to be **protected from abuse** and **neglect**, and care and treatment that is degrading.	Compliant	Green	• Level 1- 3 Safeguarding training for Children and Adults • Safeguarding referral in place • Safeguarding Audits • Safeguarding Supervision • Participation in MASH and MARAC • Safeguarding Committee • Safeguarding Policy for Children and Adults • Compliance with MHA, and review through committee	
You have the right to **accept or refuse treatment** that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests	Compliant	Green	• Consent to Examination and Treatment policy and consent audits • Safeguarding policies • Care Programme Approach (CPA) Standard Care Policy • Information Leaflets • DoLs and MCA • Training on DoLs and MCA • Advocacy Service and MHA advocates • Compliance with MHA, and review through committee	None
You have the right to **be given information about the test and treatment options** available to you, what they involve and their risks and benefits.	Compliant	Green	• Service Information leaflets • Initial and Pre-operative assessments • Consent to Examination and Treatment Policy	None
You have **the right of access to your own health records** and to have any factual inaccuracies corrected.	Compliant	Green	• Access to Health Records Policy/Subject Access Requests • Information Sharing Protocols • Information Governance Policy & Strategy • Caldicott Principles, • Confidentiality Policy & Data Protection Act • SIRO and Caldicott positions held at Board level • IG Toolkit Level 2	None
You have the **right to privacy and confidentiality** and to expect the NHS to keep your confidential information safe and secure.	Compliant	Green	• Patient feedback • IG Toolkit Level2 • Access to Health Records Policy/Subject Access Requests • Information Sharing Protocols • Information Governance Policy & Strategy • Caldicott Principles, • Data Protection, Caldicott & Confidentiality Policy • SIRO and Caldicott positions held at Board level	None

You have **the right to be informed about how your information is used.**	Compliant	Green	• Patient feedback – complaints and incidents • Access to Health Records Policy/Subject Access Requests • Information Sharing Protocols • Information Governance Policy & Strategy • Caldicott Principles, • Data Protection, Caldicott & Confidentiality Policy • SIRO and Caldicott positions held at Board level	None
You have the **right to request that your confidential information is not used beyond your own care** and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.	Compliant	Green	• Patient feedback – complaints and incidents • Access to Health Records Policy/Subject Access Requests • Information Sharing Protocols • Information Governance Policy & Strategy • Caldicott Principles, • Data Protection, Caldicott & Confidentiality Policy • SIRO and Caldicott positions held at Board level • Process and Information leaflets for patients who wish to opt out of their information being shared	None

Informed Choice			Executive Lead = David Noyes / Sarah Austin	
The NHS also commits:			**How do we demonstrate compliance?**	**Exceptions to compliance**
• to inform you about the healthcare services available to you, locally and nationally (pledge); and • to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. • This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge)			• Detail of services available on the public website • Service leaflets • Performance Reports including quality data • Quality Account	**None**
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right **to choose your GP practice**, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	Compliant	Green	Commissioning responsibility GP practices run by Solent welcome all patients.	
You have the right **to express a preference for using a particular doctor** within your GP practice, and for the practice to try to comply.		Green	Commissioning responsibility GP practices run by Solent allow patients to express a preference for a particular doctor.	
You have the right to **transparent, accessible and comparable data** on the quality of local healthcare providers, and on outcomes, as compared to others nationally		Green	Reported through performance reports presented at In Public Board and the Annual Report. Also the responsibility of commissioners	
You have the right **to make choices about your NHS care and to information to support these choices.** The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.	Compliant	Green	• Service Information • Patient Information Policy and patient leaflets - leaflets available in alternative formats, such as large print, Braille, alternative languages and audio • CQC ratings • Detail of services available on the public website	

Involvement in your healthcare and in the NHS			**Executive Lead = David Noyes /Sarah Austin**	
The NHS also commits:			**How do we demonstrate compliance?**	**Exceptions to compliance**
• provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge); • to work in partnership with you, your family, carers and representatives (pledge); • to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); • and to encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).			• Board In Public papers • Service users are involved in planning many services • Focus groups • Consultation groups with patient/public involvement • Community Engagement strategy in development	**None**
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right to be **involved in planning and making decisions** about your health and care with your care provider or providers, including your **end of life care,** and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.	Complaint	Green	• Core question asked in the quarterly patient experience survey programme • Consent to Examination and Treatment Policy • Policy annual audit of compliance • Patient information leaflets • Complaints/concerns process • Key element of Solent Values • Involvement in care planning and having a copy of care plan	
You have the right to an **open and transparent relationship** with the organisation providing your care. You must be told about any **safety incident** relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	Complaint	Green	• Duty of Candour • SIRI policy • Complaints policy • Emphasis on timely local resolution of complaints and concerns	
You have the right to be **involved, directly or through representatives**, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	Complaint	Green	• Service users are involved in planning many services • Focus groups • Consultation groups with patient/public involvement • Community Engagement strategy in development	

Complaints and Redress			**Executive Lead = Jackie Ardley**	
The NHS also commits			**How do we demonstrate compliance?**	**Exceptions to compliance**
• to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment • to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again; and • to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services			• The Trust has an open and honest approach to complaints and is willing to accept when standards have not been at a level they would expect. Apology is always made in these circumstances and the complainant will be informed of what actions are to be taken to resolve the problem. • The Trust has a continuous improvement plan to ensure learning is implemented. • All complaints are reported to our Trust Board on a quarterly basis. Details of all complaints, in particular those which have required improvements to be made are recorded and shared with Senior Managers and discussed at monthly Divisional Governance Meetings in an effort to provide assurance that actions are completed but also to allow other teams to share in the lessons learned. • Whistleblowing policy, grievance policy, Staff friends and family. , IMPACT groups.	**None**
Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
You have the right to **have any complaint you make about NHS services dealt with efficiently** and to have it properly investigated.	Compliant	Green	• Managing Concerns & Complaints Policy and Procedure • Emphasis on early and appropriate local resolution • Complaints Report • The Trust has implemented a policy in relation to Duty of Candour, and staff are informing patients/service users who may have suffered harm of their ability to raise a complaint. • The Trust welcomes all feedback from our service users and sees complaints as an opportunity to review and improve the standard of care we are providing. All complaints are thoroughly investigated by a senior member of staff and responses scrutinised by members of our Executive Team prior to being sent. • The CEO reviews all formal complaints responses prior to release • Duty of Candour • Quarterly Complaints Scrutiny Panel	
You have the **right to discuss the manner in which the complaint is to be handled,** and to know the period within which the investigation is likely to be completed and the response sent.	Compliant	Green	• The Trust's Patient Experience Service make contact within 3 working days with anyone who has made a complaint. • Once a complaint has been responded to a satisfaction questionnaire is sent to the complainant to ask if they feel they have been discriminated in any way because of having made a complaint. • A meeting with the Service involved is always offered and Patient Experience staff will attend to support the complainant. • Details of the Independent Complaints Advocacy Service are also included in the Trust's acknowledgement letters and complaints leaflet	
You have the **right to be kept informed of progress and to know the outcome of any investigation** into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.	Compliant	Green	• Where there is an unavoidable delay to the response due to either the complexity of the issue or service delays the organisation will contact the complainant either by phone, email or letter to explain. • Complainants can also meet with service and corporate leads to understand the outcomes in more detail and to be assured of lessons learnt and changes made. • The trust follows the guidance of the Duty of Candour Policy as best practice in relation to informing complainants of the progress/outcome of an investigation.	
You have the right to **take your complaint to the independent Health Service Ombudsman**, if you are not satisfied with the way your complaint has been dealt with by the NHS.	Compliant	Green	• In every formal response letter the Trust provides information on the right to refer a complaint to the 2nd stage of the NHS complaints process, the Ombudsman. Contact details for the Ombudsman's office are also included in our complaints leaflet and Trust website	
You have the right to **make a claim for judicial review** if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.	Compliant	Green	• All complainants are informed of their rights to progress the complaint further if they are dissatisfied with the organisational response	None
You have the **right to compensation where you have been harmed by negligent treatment.**	Compliant	Green	• NHSL Resolution Risk Pooling membership • Litigation Process .	None

Staff			**Executive Lead = Helen Ives**	
The NHS commits:			**How do we demonstrate compliance?**	**Exceptions to compliance**
• to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability (pledge); • to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge); • to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential (pledge); to provide support and opportunities for staff to maintain their health, wellbeing and safety (pledge); • to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge); •to have a process for staff to raise an internal grievance (pledge); and •to encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996 (pledge)			• All staff have job descriptions and all staff should have an annual appraisal • PDPs are in place linking personal development plans with appraisal.	**None**
Staff Rights	**Compliant / Non-Compliant**	**RAG status**	**How do we demonstrate compliance?**	**Exceptions to compliance**
have a **good working environment** with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;	Compliant	Green	• Flexible Working practices • Occupational Health and Wellbeing Service • Counselling Service and Employee assistance programme (24/7 confidential line) • Special Leave Policy	None
have a **fair pay** and contract framework;	Compliant	Green	• Agenda for change pay scales embedded • Committed to Living Wage pledge	None
can **be involved and represented** in the workplace;	Compliant	Green	• Staff Side partnership working • Joint Consultative Committee & Doctors & Dentist Negotiating Committee • Focus Groups • Engagement Programme • Staff Survey • People & OD Committee • Workforce Planning sub-committee • Employee Engagement sub-committee • Communications Champions • Solent Awards – staff recognition & appreciation programme	None
have **healthy and safe working conditions** and an environment free from harassment, bullying or violence;	Compliant	Green	• Investors in People Health & Wellbeing accreditation • SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation • Health & Safety Committee & Policy • Joint Consultative & Negotiating Committee • Health & Wellbeing Strategy and Working Group • Optimising Wellbeing & the Lived Experience of Staff Group • Dignity at Work Policy (Bullying & Harassment) • Staff Survey • Freedom to speak up guardians • Communications Champions	None
are **treated fairly, equally and free from discrimination**;	Compliant	Green	• Equality & Diversity & Human Rights Steering Group • Equality & Diversity & Human Rights Strategy • Equality & Diversity & Human Rights Policy • Freedom to Speak up Policy	None
can in certain **circumstances take a complaint about their employer to an Employment Tribunal;**	Compliant	Green	• Grievance Policy • Disciplinary Policy	None
can **raise any concern** with their employer, whether it is about safety, malpractice or other risk, in the public interest.	Compliant	Green	• Freedom to Speak Up Policy • Incident reporting system • Freedom to speak up guardians	None

Item 17.1

Exception and recommendation report

Committee /Subgroup name	Audit & Risk Committee	**Date of meeting**	2nd August 2018
Chair	Jon Pittam, Non-Executive Director	**Report to**	Board

Key issues to be escalated

A summary of the key business transacted at the meeting is as follows:

- The Committee received an update regarding Single Tender Wavers (STW), presented by the Director of Finance, who confirmed that there were no contentious issues associated with STWs
- The Committee received the Annual Audit Letter (Year ending 31 March 2018) from the Trust's external auditors, Ernst & Young, confirming that an unqualified opinion on the Trust's accounts was issued. The committee were informed of the generally smooth audit process and positive engagement with the Trust; however additional audit fees were incurred as a result of the final closing stages of the audit.
- External Audit also presented the latest quarterly 'Health audit committee briefing' – including the recommendation of completing the Audit Committee effectiveness toolkit, developed by EY, however it was acknowledged that the audit committee has proactively conducted a self-evaluation. Key questions were posed within the Briefing; which the Committee considered. An additional briefing on Artificial Intelligence was presented by EY and the Committee considered the relevance of AI technology for the organisation; key questions were posed for consideration.
- Internal Auditors, PriceWaterhouse Coopers (PWC) presented their 'Internal Audit Progress Report' – confirming the identification of external sponsors for each planned review during the year ahead and that the draft Terms of Reference have been drafted and scoping reviews held for the forthcoming audits; Data Security and Protection Toolkit, Risk Management (Child & Family Service Line) and Learning's Review. It was confirmed that the fieldwork to the Risk review has been delayed to October 2018, post impending CQC inspection. A summary of the status of audits planned for the year ahead is as follows;

Review to be undertaken	Target ARC Reporting Date	Identification of key contact	Scoping meeting(s) held	Terms of reference approved
Data Security and Protection Toolkit	January 2019	Completed	Completed	In progress
Risk Management – Child and Family Service Line	January 2019*	Completed	Completed	In progress
Key Financial Systems	January 2019	Completed	In progress	
Business Continuity Planning and IT Disaster Recovery	March 2019	Completed	In progress	
Demand and Capacity Review	March 2019	Completed	In progress	
Learnings Review	January 2019	Completed	Completed	In progress
Mental Health Scrutiny Committee Review	January 2019	Completed	In progress	

- The Committee was informed that PWC have recently been appointed to assist with CQC preparation; however it was confirmed that there is conflict of interest arising from this support in relation to the Trust's audit programme.
- The Trusts' Local Counter Fraud Specialist presented the 'Fraud, Bribery and Corruption Work Plan and Risk Assessment Quarter 1 Update' – the Committee were informed of the work programme and associated planned promotion via the Communication Team. The Committee were also briefed on the recommendations made and subsequent actions taken concerning fraud deterrence cases including 'Operation Alpha' (regarding credit card controls). It was noted

that there were no specific cases of fraud reported through the Freedom to Speak up route.

- The Chief Nurse briefed the Committee on the CQC Provider Information Request (PIR) process
- A deep dive report was presented concerning progress made in relation to the Risk Management Framework implementation and previous recommendations made by Internal Auditors. The Committee were briefed on actions taken and changes to the Quality Team structure in support of risk management arrangements. (The report is appended to this summary).
- The Committee reflected on the results of a recently completed Audit Committee Self-assessment and auditors commented on the positive attendance by executive team members at meetings.
- An update was provided in relation to the Freedom to Speak up Board Self- Assessment and it was confirmed that a further briefing is scheduled at the August Board Seminar. The Committee Chair provided assurance in relation to the FTSU process.
- The Committee were also briefed of potential contentious issues by the executive.

Decisions made at the meeting

None to report

Recommendations

The Board is asked to formally note the above business transacted. The Risk Management Deep dive paper is provided as an appendix.

Other risks to highlight (not previously mentioned)

There are no risks to highlight.

Item 17.2

NHS Solent NHS Trust

Report presented to:	Audit and Risk Committee							
Title of Paper:	Progress on implementation of Risk Management Framework and previous Internal Audit Recommendations			**Author(s):**	Julie Jones, Interim Head of Risk			
Executive Lead:	Jackie Ardley, Chief Nurse			**Date of Paper:**	2nd August 2018			
Committees presented:	Not applicable							
Well Led KLoEs	**W1** Leadership Capacity & Capability	X	**W2** Vision & Strategy		**W3** Culture	x	**W4** Roles & Responsibilities	x
	W5 Risks and Performance	x	**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	

Executive Summary

The Trust's risk management governance has been reviewed a number of times since June 2016:

- Solent NHS Trust Quality Report - Care Quality Commission, November 2016
- Internal Audit Report 2016/17 – Risk Management - PwC, February 2017
- Internal Audit Report 2017/18 – Review of the Assurance Committee – PwC, April 2018

In 2016 CQC made a recommendation for the Trust to *" … ensure governance arrangements are effective and identify, assess, monitor and manage risk and quality issues appropriately."* **Appendix 1** provides a more detailed breakdown of the status of each internal audit recommendation and below is a summary of progress to date:

- As part of a review of the wider Quality & Governance function, funding was agreed in May for a new *Head of Risk* to provide leadership, expertise and capacity and the post is currently out to advert. An Interim Head of Risk has been appointed to progress key areas of work until November 2018. A new Quality Information Analysis and Quality Systems Officer to support the risk management function and Ulysses analysis and maintenance are currently being recruited.
- The *Risk Management Framework* was approved by the Trust Board on 28 March 2018 and launched on 20th June 2018. It is now available to download from the risk management page on SolNet.
- A new *Risk Management Process – Step by Step Guide for Staff* has also been produced. It was also launched on 20th June and is available for staff to download from SolNet. It is being promoted in the new risk management training.
- A new 20 minute *Introduction to Risk Management* e-learning course has been developed and went live on ESR on 16th July. It is compulsory for all existing staff who must complete it within 3 months and it will be completed by all new staff on induction. The course must be repeated by all staff every 3 years. Additional face to face training is being targeted at key staff groups in Service Lines. Training for managers who use the online Risk Register (Ulysses) has been reviewed, updated and re-launched. Courses are now offered monthly throughout the year and staff are not able to access the system until they have completed the training.
- A schedule of regular risk management reports has been established to ensure appropriate escalation and ward to board visibility of risk; it includes:
  - In August 2018 the quarterly Comprehensive Risk Report will be presented to QIR and will include a detailed analysis of the Risk Register and the Trust's top scoring risks
  - In September 2018 (and at every meeting thereafter) TMT will receive details of all risks scoring

15+ to review and receive assurance that action plans are in place and being delivered
    - The quarterly Comprehensive Risk Report will be presented to QIR, Assurance Committee and Audit and Risk Committee following QIR
    - The risk management section of the CEO Report has been reviewed to ensure that risks identified for escalation at Assurance Committee and Audit and Risk Committee are included
- Ulysses – the risk management system has now been aligned with the hierarchical structure of Trust.
- SolNet risk management pages have been brought up to date and include a range of documents, tools and guidance which staff and managers can download. These resources are being promoted in the risk management training and via the communications plan (below).

The following additional work is planned in the coming months:

- Work has begun on the triangulation of risks to identify themes which cross-cut several services and which when viewed collectively, may represent a more significant risk than single risks alone; early themes identified include capacity to deliver services due to rising demand, risks associated with the wheelchair contract, and risks associated with partnership working and sub-contracting. Detailed review and analysis of these risks will be included in quarterly Comprehensive Risk Reports from August 2018.
- The Interim Head of Risk is meeting with Professional Leads individually to review all *significant service line risks (12+)* and ensure the highest scoring risks in particular are appropriately represented in the Risk Register. This will be completed by the end of July 2018.
- The Trust needs to clearly articulate and raise an awareness of its *top operational risks*. The highest scoring risks on the Risk Register are not necessarily an accurate reflection of the top risks. The work will the Professional Leads will improve the reliability of the Risk Register and the Executive Directors will be asked to agree the Trusts top operational risks in August.
- New processes for quality assuring and formally approving all risks in future will be implemented within the next 4 weeks.
- A *Risk Communication plan* has been developed to ensure information about Trust risks and risk management processes are communicated regularly, consistently and effectively across the organisation in order to raise the profile of risk and build a culture of every day good risk management practice
-

Risks identified in relation to this report

- E-learning is the most efficient and cost effective way of rapidly delivering training to the workforce however completion rates can be affected by workforce capacity, annual leave, access to IT systems (ESR), etc. To mitigate this, training will be heavily promoted throughout the summer and face to face training will be delivered to key staff groups in each Service Line (such as at clinical governance meetings and operational business meetings which large numbers of staff attend).

Key Decisions/ Action(s) requested

The Audit and Risk Committee is asked to note the progress made and further actions planned.

Appendix 1 – Status of Internal Audit Recommendations

Internal Audit Report 2016/17: Risk management

Audit recommendation	Rating	Action already taken	Further action to be taken
1. Improve understanding and awareness of what constitutes risk	Medium	• Risk Management Framework developed and launched with provides clear definition of a risk and differentiates this from an operational issue • Risk management e-learning compulsory for all staff from 16th July with 3 yearly refresher. Training includes risk identification and the difference between incidents, risks and issues. Face to face sessions being targeted at specific groups over the summer 2018. • SolNet pages updated with resources and guidance for staff	• Launch of short risk management PowerPoint to be used by local managers at team meetings to facilitate discussion and identify local risks
2. Improve the dissemination of risk information	Medium	• Risk Framework and Risk Process include details of the Trust's Risk Appetite. Risk appetite and tolerance levels have been aligned to the Trust escalation and oversight arrangements and these are included in the risk management training. • Risk Management Framework, Process and the risk management training explain how to articulate and risk and differentiate between the risk and its impact • Staff are now able to run and download their own reports directly from the system.	• New committee reporting schedule (commencing August 2018) will provide detailed analysis of the Risk Register and aid dissemination of risk information • Communication Plan includes the regular publication across the organisation and on SolNet of analysis and themes from the Risk Register – such as the Trusts top risks and top risks in each Service Line.
3. Ensure processes around the Risk Register are followed consistently	Medium	• Risk Management Framework and Risk Process clearly articulate what constitutes a risk (as opposed to an incident or issue) • One-page Risk Assessment Process flowchart has been introduced, is available on SolNet • Risk Management training explains the process and signposts staff to guidance documents • One-to-on meetings with each Professional Lead taking place to review individual risks scoring 12+ and identify where additional information is needed such as controls and action plans adding and risks reviewing • Ulysses now sends automatic reminders to relevant staff when risks are overdue for review or require action	• Quality control checklist has been developed and is to be launched for all new and existing risks within the next 4 weeks; the checklist includes ensuring the risk is appropriately described, initial, current and target scores entered, controls and full action plans entered and review dates set. • Any risk which does not meet the quality criteria will be returned to the Risk Assessor and Responsible Manager for review.
4. Improve the use of Risk Register procedures	Low	• The new Risk Management Process has been disseminated by email to the senior leadership team for cascade	

Audit recommendation	Rating	Action already taken	Further action to be taken
		• Face to face Online Risk Register training has been reviewed, updated and re-launched. All staff who use the online register must attend the training before being given access to the system. • Staff are signposted and refer to the Online Risk Register Guide during the Risk Register training • The new e-learning training also signposts staff to the Online Risk Register Guide and other resources available on SolNet.	
5. Improve Risk Register completeness	Low	• One-to-on meetings with each Professional Lead are taking place to review individual risks scoring 12+ and identify where additional information is needed and the quality/ completeness of entries needs to be improved • Online Risk Register Training and Risk Management e-learning is now in place.	• Quality control checklist has been developed and is to be launched for all new and existing risks within the next 4 weeks; any risk which does not meet the quality criteria will be returned to the Risk Assessor and Responsible Manager for review. • New process for formally approving risks is to be implemented within the next 4-6 weeks; the approver is based on the current score with risks 15+ to be approved by the relevant Executive Director
6. Share BAF Action Plan as good practice (format)	Advisory	• The default template for a report from the Risk Register has been revised, the layout improved and content expanded. The report for each risk now includes details of all actions, progress against actions and dates when the risk has been reviewed to enable a clear understanding of the risk and its status. • For consistency, Service Lines are being asked to use this as the default report for presenting risks to Performance Review and other meetings.	

Internal Audit Report 2017/18: Review of the Assurance Committee

Audit recommendation	Rating	Action already taken	Further action to be taken
8. Risk Management – reporting and escalation of risks from Board to Ward	Advisory	A new committee reporting schedule has been agreed for risk management which will enable greater visibility and escalation of risks from services to the Trust Board: • Significant risks reported monthly by exception to QIR by service	

Audit recommendation	Rating	Action already taken	Further action to be taken
		lines • Monthly summary of BAF and Risk Register in CEO Report to Public Board • Quarterly Comprehensive Risk Management Report including analysis of Risk Register to QIR, Assurance Committee, Audit & Risk Committee from August • Risks scoring 15+ to each TMT meeting for review from September	

Item 18.1

Exception and recommendation report
Learning from Deaths (LfD) Quarter 1 (April to June) 2018

Committee /Subgroup name	*Quality Improvement and Risk*				**Date of meeting**		*September 2018*	
Chair	*Jackie Ardley*				**Report to**		*Assurance Committee*	
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		**W8** Learning, improvement & innovation	**X**

Key issues to be escalated

The committee is asked to note that this report is a summary of Quarter 1 information.

It follows on from the previous report to the assurance committee for Quarter ending April 2018.

- We are continuing the development of the LfD dashboard to provide better visibility of our review and decision making processes. A recent review of quality of data and dashboard format has been completed, and relevant processes updated.
- We have continued to provide clinical judgement tool (CJT) training across the Trust which is used when reviewing a death and further supports the learning process.
- The employment of a Family Liaison Manager will help to further improve the involvement of families and provide support to them at a time when they are most vulnerable. This person will start in the Trust on the 22nd October. This is a new role to the Trust.
- There have been no recommendations or actions requested by the Coroners court over the last quarter.

Decisions made at the meeting

Service lines reviewed all data to improve data quality. We made a decision to review the dashboard from April onwards and ensure that data fields were completed correctly**.** This is now reported in the updated dashboard below.

Recommendations

We are asking the Assurance Committee to note the actions that we have taken to further improve and develop the Trust's processes for Learning from Deaths and to recognise the continued work undertaken by all service lines.

Other risks to highlight (not previously mentioned)

Development work continues to improve the accuracy of the data provided by improving the cross referencing system with the national database where deaths are recorded.

Please note the following dashboard does not contain data for Special care dentistry or Sexual health services.

Trust-wide Mortality Report, Q1 2018

YTD Count of Deaths Considered for Review via CJT*

Considered for Review via CJT
383

Monthly Count of Deaths Considered for Review via CJT*

monthname	Considered for Review via CJT
April	130
May	140
June	113

Monthly Count of Deaths Reviewed via CJT*

monthname	Reviewed via CJT
April	68
May	73
June	76

Monthly Count of Deaths SI / HRI Raised

monthname	SI
April	2
May	3
June	1

Monthly Count of Deaths of Learning Disability Patients

quarter
1

Reporting terminology:
Considered for review = reviewed by service to decide whether an in-depth mortality review is indicated

Reviewed = in-depth review via clinical judgement tool or death subject to root cause analysis

*CJT = Clinical Judgement Tool

Data sources:
Dates of death and patients extracted from SystmOne (as per Service Line definitions), confirmed against Spine, confirmed by Service Lines

HRI, SI data provided by Quality Team (inclusion = date of death within reporting period)

Learning Disability data provided by Learning Disability Team (inclusion =

Author:
Data Warehouse Team
Process: Mortality Reporting
ProcessFlow v01

Main categories of deaths not reviewed via CJT by Service Lines:
Adults Portsmouth: 1. Specialist Palliative Care deaths in the community 2. Some deaths in QAH

Adults Southampton: 1. Palliative care & EoL pathway deaths in the community 2. Some deaths in UHS

General Practice: Deaths in UHS are reviewed in UHS and the learning is shared with Solent

Q1 Deaths Considered for Review via CJT* by Service Line

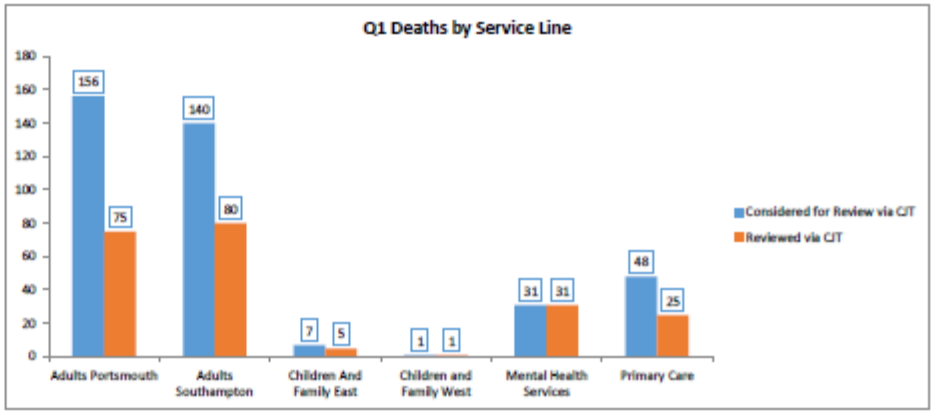
service line	Considered for Review via CJT	Reviewed via CJT
Adults Portsmouth	156	75
Adults Southampton	140	80
Children And Family East	7	5
Children and Family West	1	1
Mental Health Services	31	31
Primary Care	48	25

Learning Disabilities

Considered for Review via CJT
1

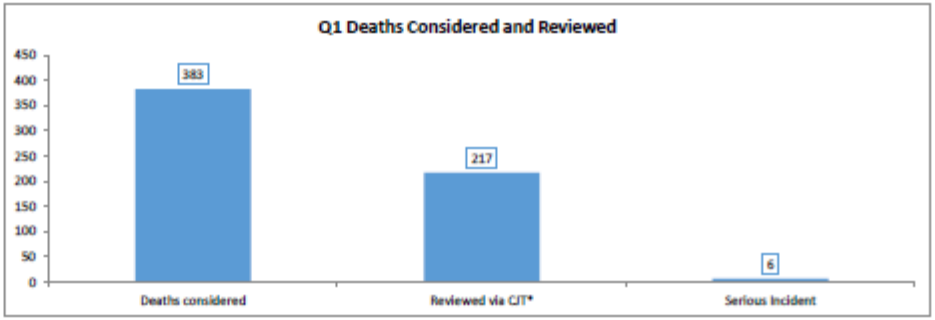
Primary Care Services

service	Considered for Review via CJT
GP Surgery	11
Podiatry	37



Quarterly Deaths Considered and Reviewed

Category	Count
Deaths considered	383
Reviewed via CJT*	217
Serious Incident	6



Learning from Coroner's inquests

In Quarter 1 there have been a total of 5 inquests; 2 for Adults Portsmouth and 3 for Adult Mental Health. No actions or requests have been made by the Coroner when concluding the proceedings. Where SI reports have been provided, the Coroner has been satisfied with the Trust's response and any actions undertaken as a consequence of learning noted (please note that this learning did not indicate that the outcome would have been different).

What has changed as a result of Learning from Deaths during Quarter 1

We are developing a greater understanding of the importance of writing SI reports in a sensitive manner which families will find more appropriate. A review of the serious incident (SI) process has resulted in further improvements to the template used and this continues to be reviewed and amended as required. Families are now actively invited to provide questions and queries to the investigator at the beginning of the investigation which can then be taken into consideration. After the completion of SI reports, families are invited to meet with the Professional lead of the service to discuss the report and any learning that has been identified.

We developed the learning database as a tool to capture learning that we identify as an area that requires prompt change that will make a significant difference for patients, families, and/or staff. This can be learning from positive or adverse events/feedback. In this quarter, the following areas for improvement have been noted:

- Following the death of an adult with mental health problems who died after being referred to the Crisis team. It was agreed that on receipt of referrals from a team who have already completed an assessment, the Crisis team need to accept and review patients for at least 72 hours. Guidance (in the form of a standard operating procedure) will be completed and shared with the teams and will be presented to panel on completion in quarter 2.
- A child received excellent end of life care as a result of good working relationships between all providers of care; this resulted in the wishes of the child and family being met at an extremely difficult time. It was highlighted that these close partnerships are not available across all geographical areas. The importance of sharing positive practice and learning was highlighted and the service is developing a partnership model with the local hospice to enable community outreach for care at home for children with end of life care packages.
- Following the death of a baby, it was noted that there are differences in the safe sleeping messages provided by services. The service is developing a standardised package of communication including leaflets. New guidance (in the form of a standard operating procedure) regarding health promotion is to be shared and implemented with all their teams and presented at panel in quarter 2.
- A patient with complex physical health needs was in receipt of care from multiple providers in the period leading up to her death. On review of this person's history, the provision of care was further complicated by challenging behaviours and responses to the different care providers. A standard operating procedure is being developed to provide further guidance to ensure best practice is maintained with consideration of both physical and psychological needs.

Report completed September 2018

Exception and recommendation report

Item 22

NHS Solent NHS Trust

Committee /Subgroup name	**Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee**	**Date of meeting**	13th September 2018
Chair	**Mick Tutt**	**Report to**	Trust Board

Key issues to be escalated

This was a meeting originally scheduled for August '18, but delayed because of the non-availability of some, key, participants

The most significant item discussed was that related to a **Review of the Operation of the s136 suite**, at the Orchards – following the reduction in the time allowed for assessment under s135 & 136, as a consequence of the Policing & Crime Act 2017. The substantive report is appended to this exception report – and I would wish to commend its clear indication of robust planning and partnership working arrangements. These have led to a position where compliance with the reduced time threshold has only been exceeded on three occasions (two following the production of this report)
The occasion within the reporting period for the report has been considered by the committee – who are satisfied with the explanation related to the circumstances. The other two occasions are subject to investigation processes and will be considered at our November '18 meeting

Although we were not joined, on this occasion, by colleagues from Solent MIND who act as both **Independent Mental Capacity Act (IMCA) and Independent Mental Health Act (IMHA) advocates** for people detained in both Solent and Portsmouth Hospitals Trust they had met with the Operations Manager – who was able to reflect on their feedback during the meeting. They provide a much-valued 'proxy' for the views and wishes of people we detain

We received up-dates on the situation with regard to **Maples ward**, and its **re-opening** following the incident which led to its temporary closure

We received reports of **management scrutiny into the use of the Mental Capacity and Mental Health Acts, including those related to the restrictive practices of restraint and seclusion**. We noted that use, generally, met with the expectations of the Acts and associated Codes of Practice – and, where exceptions occurred, we received explanations or assurance of action taken. There were no matters which we felt it necessary to escalate here – although I agreed to liaise with both our (mental health law) solicitors and the Court of Protection Practitioner Association regarding issues discussed

Part B of the committee was our usual **annual training session for Associate Hospital Managers** (AHM), regarding **compliance with Information Governance expectations**

Decisions made at the meeting

We confirmed the desirability to recruit additional AHM, and a forthcoming interview for a person with experience elsewhere

Recommendations to the Trust Board

- the Board are asked to note the issues set out above

Other risks to highlight (not previously mentioned)

None of note

Item 22.2

Solent NHS Trust

Report for Mental Health Act Scrutiny Committee on S136 operations following changes to length of detention in December 2017

Introduction

This paper has been written at the request of Solent NHS Trusts Mental Health Act Scrutiny Committee. Its purpose is to provide assurance regarding the operations and governance of the Trusts Section 136 process following changes to the length of time a person may be detained under this Section in December 2017. These changes are set out in the Policing and Crime Act 2017 and propose that the length of time a person may be detained under a Section 136 or Section 135 would reduce from 72 hours to 24 hours. The option of extending this timeframe by 12 hours was reserved for medical staff if they were of the view that the assessment could not be completed in the 24 hour period due to the clinical condition of the person. These changes were approved by parliament and became lawful practice from 11th December 2017.

This paper will set out:

1) The work taken prior to the law change to ensure staff/systems and processes were prepared for the change
2) The activity within the suite since the law changed
3) Key Learning Messages

Work taken prior to the law change

Solent NHS Trust were (and continue to be) active partners alongside key stakeholders in both commissioning and other providers in the preparation phase for the law change. This included regular attendance at the county wide crisis care concordat as well as a monthly S136 governance meetings. These forums enabled a pan Hampshire, collaborative approach with regard to maximising the throughput of S136 admissions and discharges to ensure that the new time frame could be adhered to. Several documents were produced as a result of this work as included below:

A Pan-Hampshire Policy in relation to Section 136 has been produced and updated regularly over the last 18 months with changes in custom and practice and accounting for the law change in December 2017. The most up to date version is included here. *Please note, this policy has not yet been through the Solent policy ratification process. The Operations Manager will lead on this task later once the governance group/concordat agree it is ready for ratification the individual stakeholders*	See item 9.2
A Solent specific escalation protocol was produced by the service and the MHA Lead to outline to front line staff the actions that were to be taken should the length of time the patient is detained on a S136 begin to increase without a foreseeable resolution being available	See item 9.3
The Operations Manager produced a guide for Solent on call managers and directors that could be added to the suite of documents available for on call staff to help support them should they encounter issues (particularly out of hours) with the S136 process	See item 9.4

Further preparation was also conducted by the Operations Manager through 2 main forums:

1) The monthly MHA monitoring meeting – this is attended by key service personnel and is the forum used to discuss use of MHA across the mental health services (inpatient, community, S136) and this was used in the months leading up to the change to plan and problem solve any issues that might arise from the law change
2) The monthly contract review meetings with the S136 suite staffing service which Solent contracted directly at the time of the change. As above, this was used as a forum to share with our subcontractors how we would manage the change in law and what our expectations were from them with regard to supporting timely patient assessments

Activity within the suite since the law change

The following tables present an overview of the use of the Orchards S136 suite since 11th December 2017 until 30th June 2018. Please note, the suite was closed for essential maintenance improvements between 29th January 2018 and 5th March 2018. This report will not duplicate data that has already been reported to the committee via the routine quarterly report prepared by the MHA Lead. However, activity data for this paper is as follows:

The service can confirm that there were no breaches of the 24 hour timeframe since the law changed on 11th December 2017. Only one assessment went past this timeframe but this was authorised by the responsible doctor on the grounds of the clinical condition of the patient

Information to be gathered	Results
Total number of assessments in the Solent suite in the reporting period above	54 assessments
Assessments split by males and females	44% Males/56% Females
Patients split by responsible CCG	Portsmouth 33% Hampshire (including Southampton) 61% Other CCG 6%
Number of times an assessment was extended past 24 hours due to the clinical condition of the patient	1 – This was an assessment in March 2018 and was due to the patient being under the influence of alcohol to a level that prevented an objective assessment of their mental state. The decision was made to allow the patient to sleep/rest and then to undertake the assessment once they were no longer intoxicated. The total length of time that the patient was detained under S136 was 24 hours and 15 minutes
Average Length of stay in the suite broken down by month	December 2017 – 18.5 hours January 2018 – 14 hours February 2018 – Closed for maintenance March 2018 – 15.5 hours April 2018 – 12.5 hours May 2018 – 12.5 hours June 2018 – 10.5 hours (excluding 1 assessment)

Number of assessments which took between 20 hours and 23 hours 59 minutes to complete	7
Average Length of time taken between letting the AMHP know that a S136 assessment was required and the assessment starting broken down by month	December 2017 – 8 hours January 2018 – 10.5 hours February 2018 – Closed for maintenance March 2018 – 10.5 hours April 2018 – 8.5 hours May 2018 – 7 hours June 2018 – 7 hours (excluding 1 assessment)

Key Learning Messages

Prior to the law change in December 2017, there were 2 main concerns that were raised by key stakeholders that if unaddressed would pose increased risks to Trusts breaching the 24 hour detention period for S136. These were:

a) Access to an inpatient bed if the person was liable to be detained and admitted to hospital following their assessment. This is most pertinent to none Portsmouth residents who may be within the Solent suite
b) The response times of the assessing team (AMHPs and Drs) being insufficient to enable the assessment to begin and conclude at the earliest possible juncture

The preparation work prior to the law change focussed on how the system across the county could address these issues to prevent them from occurring and this is laid out in the documents on page 1 of this report. To summarise:

a) The escalation plan was widely shared with all staff who work within the suite as well as on call managers to support them in how to raise concerns
b) Our neighbouring Trust, Southern Health Foundation Trust, committed to ensuring that if a bed was required for a detained patient that they would source a bed within a hour of it being requested
c) Solent NHS Trust have agreed that in order to prevent a breach of the 24 hour timescale from occurring in our suite, then we would admit the patient to one of our wards at The Orchards as a last resort
d) Whilst the Hampshire care concordat have requested that assessments within the suites occur within 3 hours of the person arriving, Portsmouth AMHP team have maintained their position that they will undertake the assessment when it is in the persons best interests. This may mean that the person is allowed to sleep if they arrive at the suite during the night or that they will delay the assessment if it means that the persons own clinical team can undertake the assessment the following day

The activity within the suite since 11th December 2017 appear to support that the issues above have been well managed so as not to cause a breach in the time period. Below are some key learning messages:

- 7 of the 54 assessments went over 20 hours in the suite (13%). 1 of these related to the assessment which was extended in March 2018. Of the remaining 6 assessments, 4 of these were during December 2017 and January 2018 shortly after the law changed. This shows a significant downward trend in the length of time people are detained under a S136
- The above is supported further by the mean figures shown in the table on page 2 of this report (18.5 hours in December 2017 to 10.5 hours in June 2018)
- Likewise, the activity data shows that even though Portsmouth AMHP team co-ordinate the patient assessment in line with their assessment of when is the best time for the patient to receive it (rather than doing it as quickly as possible without acknowledgement of the patients best interests), their attendance is still within the first 7-10 hours (on average) of the person arriving in the suite – thus enabling time to find a bed for the person if required
- Over the 6 assessments that did take over 20 hours, there is evidence in 4 of them that the S136 facilitator escalated the risks as per the escalation protocol. The 2 that weren't were following the law changing (1 during December and 1 during January) and were possibly due to the facilitators not being fully aware of the protocol. On each occasion, the risk of the person breaching was identified by the matron/ward manager who then did escalate appropriately and the opportunity to remind all staff of the escalation protocol was taken
- Each of the assessments that took over 20 hours had evidence to suggest that the finding of a bed to transfer the person to contributed to the length of time the person was in the suite

Conclusion

Since the law changed in December 2017, Solent NHS Trust has not had any S136 detentions within its S136 suite that have breached the 24 hour timeframe. It has had one assessment that was extended due to the clinical condition of the patient. The escalation protocol, advice for staff (including on call managers/directors) and monthly monitoring of activity within the suite indicates that the Trust has robust procedures and reporting mechanisms in place to ensure that staff are supported to enable people to receive a timely assessment and conclusion of their detention under S136

Richard Brown

Operations Manager – Mental Health Services

11th July 2018

Solent NHS Trust

Item 24

Scheme of Reservation and Delegation

Version	Approved by	Date	Date of next review
7	Chairs action (March 3RD 2016) – and noted at March 2016 Board Amendment pg29+30 re: financial sign off thresholds concerning business cases prior to presentation to the Finance Committee		March 2017
8	Board	November 2016	November 2018
9	Board	September 2017 – amendments made to section 7, financial thresholds as recommended by the Finance Committee	November 2018
10	Board	Nov 2017 – amendments made as recommended by the Commercial Team	November 2019
11	Board	September 2018 – amendments made as recommended by the Commercial Team and approved via Finance & Commercial Team and Finance Committee, July 2018	November 2019

Section One - Decisions reserved to the Board of Directors

Reference to the 'Board of Directors' should also be read as the 'Trust Board'.

Decisions reserved to the Board
General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, it wishes, in full session within its statutory powers
Regulations and Control 1.1 Approve Standing Orders (SOs) (the Constitution), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 1.2 Suspend Standing Orders. 1.3 Vary or amend the Standing Orders. 1.4 Ratify any urgent decisions taken by the Chairman and Chief Executive in the next formal public session in accordance with the Standing Orders (section 5.2). 1.5 Approve a scheme of delegation of powers from the Board of Directors to committees of the Board of Directors. 1.6 Require and receive the declaration of members of the Board of Director's interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 1.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust. 1.8 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 1.9 There is a requirement placed on the Trust by external agencies such as the NHS Litigation Authority that some policies are formally approved by the Board and this may not be delegated (for example Risk Management Policy). The Board shall also approve policies with significant public interest or where enactment requires a significant change in the way the Trust operates. Policies presented to the Board for approval should first have been considered and agreed at the Assurance Committee. 1.10 Confirm or if necessary amend the recommendations of Committees of the Board of Directors where the Committees do not have executive powers. 1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held in trust. 1.12 Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 1.13 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 1.14 Authorise use of the Trust seal. 1.15 Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with the Standing Orders.

1.16 Discipline members of the Board of Directors or employees who are in breach of statutory requirements or Standing Orders.

1.17 Undertake a formal review of its own performance and of its committees on an annual basis.

Appointments/ Dismissal

2.1 Appoint and remove the Deputy Chairman of the Board as required.

2.2 Appoint and dismiss committees (and individual members) that are directly accountable to the Board of Directors.

2.3 Confirm appointment of members of any committee of the Board of Directors as representatives on outside bodies.

2.4 Approve proposals of the Remuneration Committee;

2.5 Appointment and removal, (subject to law and their contract) of the Chief Executive and executive directors;

2.6 Ensure that appropriate succession planning is carried out for the Board and senior management team.

2.7 Appointment and removal of the Trust Secretary or equivalent

Strategy, Plans and Budgets

3.1 Define the Trust's mission, vision and strategic objectives. To set the strategic direction to be pursued by the Trust

3.2 Ensure that a Board development and organisational development plans are in place to support the Trust's delivery of the strategic direction.

3.3 Approve annual operating plans and budgets.

3.4 Deliver the control total agreed with NHS Improvement

3.5 Approve plans for material service changes and efficiencies;

3.6 Define the Trust's values and standards of conduct.

3.7 Approve proposals for ensuring the safety and quality of services and safety and quality governance for services provided by the Trust, having regard to any guidance issued by the Secretary of State;

3.8 Approve the Trust's policies and procedures for the management of risk;

3.9 Approve Outline and Final Business Cases for Capital Investment above and beyond the Finance Committee's delegated limits;

3.10 Approve proposals for acquisition, disposal or change of use of land and/or buildings;

3.11 Approve Private Finance Initiative proposals (if any);

3.12 Approve the opening of bank accounts;

3.13 Approve proposals on individual contracts (other than NHS clinical contracts) of a capital or revenue nature amounting to, or likely to amount to over £3,000,000 regardless of the length of the contract;

3.14 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance & Performance (for losses and special payments)

previously approved by the Board;

3.15 Approve individual compensation payments;

3.16 Approve proposals for action on litigation against or on behalf of the Trust

3.17 Approve use of NHS Resolution (formally known as NHSLA) risk pooling schemes (including CNST).

3.18 Responsible for overseeing the development and implementation of a workforce strategy, ensuring the workforce meets the needs of the organisation and is fit for purpose.

Audit

4.1 Approve the appointment (and where necessary the dismissal) of external auditors.

4.2 Notify the external auditor of any problems relating to the service.

4.3 Approve the appointment (and where necessary the dismissal) of internal auditors.

4.4 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit and Risk Committee.

4.5 Approve the remuneration of the external and internal auditors.

Annual Reports and Accounts

5.1 Approve the Annual Accounts, Annual Report and Quality Account and receive a statement of assurance from the Audit and Risk Committee that the Committee has made appropriate enquiries before recommending the documents for approval by the Board.

5.2 Hold an Annual General Meeting at which the report and accounts will be laid and approve any resolutions to be presented to the AGM.

Monitoring

6.1 Receive such reports as the Board of Directors sees fit from Committees in respect of their exercise of powers delegated.

6.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health, NHS Improvements and the Charity Commission shall be reported, at least in summary, to the Board.

6.3 Ensure maintenance of a sound system of internal control and risk management which holds the organisation to account for the delivery of the strategy and seeks assurance that systems of internal control are robust and reliable.

6.4 Ensure that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives and periodically review management performance, including through reports from the Director of Finance & Performance on financial performance against budget and contracts agreed with commissioners.

Clinical standards and Patient Safety

7.1 Ensure compliance with all legal and regulatory requirements and clinical guidance monitoring performance against the Care Quality Commission requirements and ensuring that effective systems operate for the dissemination of National Guidance and directives

7.2 Oversee the risk management strategy implementation of Solent NHS Trust, and ensure appropriate action in relation to adverse events that occur

7.3 Ensure a focus on quality at strategic and operational levels including patient safety (including Healthcare Associated Infections), effectiveness and patient experience as well as the promotion of health and wellbeing

Section Two - Matters delegated to Board Committees

Committee	Matters delegated by the Board of Directors to Committees
Audit and Risk Committee	In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee. The Committee is a non-executive Committee of the Board and has no Committee executive powers, other than those specifically delegated by the Board in the Terms of Reference. The overall purpose of which is to: 1. seek assurance that the Trust's activities are efficient, effective and represent value for money; 2. review the establishment and maintenance of an effective system of corporate governance, internal control and risk management across the whole of the Trust's activities that supports the achievement of the Trust's objectives; 3. monitor the integrity of the financial statements of the Trust; 4. monitor the independent auditor's qualifications, independence and performance; 5. monitor the performance of the Trust's internal audit function ; 6. monitor compliance by the Trust with legal and regulatory requirements; 7. review the findings of other significant assurance functions, including counter fraud, to the organisation, and consider the implications to the governance of the organisation.
Remuneration Committee	In accordance with Standing Orders the Board shall establish a Remuneration Committee with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. The Remuneration Committee makes decisions on behalf of Solent NHS Trust Board about appropriate remuneration, allowances and terms of service for the Chief Executive and other executive directors, to include:- • Salary; • Performance related pay; • Provision of other contractual terms and benefits; • Approval of settlement agreements/severance pay or other occasional payments to individuals and out of court settlements, taking account of national guidance; • Receive and note decisions of the Clinical Excellence Awards (CEA) panel; • Within the constraints of national frameworks the Committee will agree the remuneration package, allowances and terms of service of the Trust's executive directors. No executive director shall be involved in any decisions as to his/her own remuneration; • Monitor and oversee the evaluation of the performance of the Chief Executive and other individual executive directors; • Approve participation in any performance related pay schemes, where operated by the Trust, and approve the total annual payments made under such schemes; • Ensure that contractual terms on termination, and any payments made, are fair to the individual and the NHS, aligned with the interests of the patients, that

	failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate; • Be responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the committee, and to obtain reliable, up-to-date information about remuneration in other trusts.
Assurance Committee	In accordance with Standing Orders, the Board shall formally establish an Assurance Committee. The Committee is chaired by a Non-Executive Director and has no executive powers, other than those specifically delegated by the Board in the Terms of Reference. The Assurance Committee seeks assurance on all aspects of Quality (including patient safety & experience, infection control, health and safety, safeguarding, risk management, research & development, clinical effectiveness and audit) as well as Regulatory Compliance. The Committee will seek assurance and scrutinise exception reporting from its reporting groups being: • **The Quality Improvement & Risk Group** who seek assurance from: • **The Service Line Clinical Governance Groups** (who seek assurance from the following groups; Serious Incidents Requiring Investigation Group, Clinical Audit & Effectiveness Group, Patient Experience & Public Involvement Group and the Complaints Panel. The Service Line Clinical Governance Subcommittees will also report on the following standing items; Service Risks including Quality Impact Assessments) • **Research & Development Group** • **Emergency Planning & Resilience Group** • **Medicines Management Group** • **Health & Safety Group** • **Infection Prevention & Control Group** • **Dignity & Safeguarding Group** • The **IT Group** – will be required to provide assurance reports on Information Governance matters. The committee has delegated authority for the approval of policies, other than for policies where approval is required by law to be given by the Board.
Mental Health Act Scrutiny & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee	The Mental Health Act Scrutiny & Deprivation of Liberty Safeguards (DoLs) Committee [hereby referred to as the MHA&DoLSC] has been established and constituted to oversee the implementation of the Mental Health Act 1983 and DoLS functions within Solent NHS Trust. The Scrutiny Committee has primary responsibility for seeing that the requirements of the Act and the Code of Practice regarding DoLS are followed within the Trust. In particular, to seek assurance that patients are detained only as the Mental Health Act 1983 or the DoLS Code of Practice allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights. In addition, the remit of the MHA&DoLSSC has been expanded during 2016 to include oversight and scrutiny of training for practitioners; to enable them to, competently, discharge their relevant responsibilities.
Charitable Funds Committee	In line with its role as a Corporate Trustee for any funds held in Trust, either as charitable or non-charitable funds, the Board of Directors will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charity Commission. The provisions of this paragraph must be read in conjunction with paragraph 2.12 above and Standing Financial Instruction 18.

	The Charitable Funds Committee has delegated powers to approve the Charity Accounts on behalf of the Board.
Governance and Nominations Committee	A Governance & Nominations Committee will be established and constituted to lead on the identification, nomination and recommendation of appointments (in accordance with their Terms of Reference) to the Board. The Committee will also keep under review the corporate governance arrangements for the Trust including Committee Structure, membership and Terms of Reference, making appropriate proposals and recommendations to the Board as appropriate.
Finance Committee	A Finance Committee will be established and constituted to ensure appropriate financial frameworks are in place to drive the financial strategy, and provide assurance to the Board on financial matters as directed. Specifically the Committee will make recommendations to the Board in relation to its duties of: • strategic financial planning • annual budget setting and monitoring • treasury management, • business management and may on request from the Board review specific aspects of financial performance where the Board requires additional scrutiny and assurance. The Finance and Commercial Group is a subgroup of the Finance Committee and is responsible for overseeing the Trust's Capital Programme.

The Trust's Operational Management is lead by the Chief Executive, as the Accountable Officer and executed via the Executive Management Team.

Section Three - Scheme of delegation derived from Accountable Officer Memorandum

Ref	Delegated to	Duties delegated
3	**CEO**	Responsible for the propriety and regularity of public finances in the NHS; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the efficient and effective use of all the resources in my charge.
7	**CEO**	Accountable to the board as NHS Accountable Officer to Parliament for stewardship of Trust resources
9	**CEO and DOF**	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	**CEO**	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Through the Annual Governance Statement acknowledge responsibilities for maintaining a sound system of internal control and describe the risk management framework
12, 13	**CEO**	Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
12	**Chairman of the Board of Directors (and Members Council)**	Implement requirements of corporate governance.
13	**CEO**	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO).
14	**CEO**	Provide such information as is requested by the NAO and co-operate with external auditors in any enquiries into the use your trust has made of public funds. Provide information on any points raised by external auditors which generate public or Parliamentary interest. Ensure internal audit arrangements comply with those described in the NHS Internal Audit Manual and ensure prompt action is taken in response to concerns raised by both external and internal audit.
15	**DOF**	Operational responsibility for effective and sound financial management and information.
15	**CEO**	Primary duty to see that the Director of Finance & Performance discharges this function. Ensure the continuing financial viability of the Trust, in particular to ensure that

		expenditure is contained within available levels of income, and to achieve any other financial objectives set by the Secretary of State for Health with the consent of the Treasury, as appropriate. Ensure that the assets of the Trust are properly safeguarded.
16	**CEO**	Ensuring that expenditure by the Trust complies with Parliamentary requirements. Including: • Drawing to the attention of Parliament to losses or special payments by appropriate notation of the statutory accounts; • Obtaining sanction from the NHS Executive for any expenditure which exceeds the limit delegated to the Trust; this includes any novel, contentious or repercussive expenditure, which is by definition outside your delegation; • Ensuring that all items of expenditure, including payments to staff, fall within the legal powers of the Trust, exercised responsibly and with due regard to probity and value for money; • Complying with guidance issued by the NHS Executive on classes of payments which you should authorise personally, such as termination payments to general and senior managers.
17	**CEO**	Promote their observance by all staff OF THE Trusts Code of Conduct and Accountability
18	**CEO and DOF**	Chief Executive, supported by the Director of Finance & Performance, to ensure appropriate advice is given to the Board of Directors on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	**CEO**	If Chief Executive considers the Board of Directors or Chairman of Board of Directors is doing something that might infringe probity or regularity, (s)he should set this out in writing to the Chairman of the Board of Directors and the Board of Directors. If the matter is unresolved, (s)he should ask the Audit and Risk Committee to inquire and, if necessary, and the relevant Regulatory Body.
20	**CEO**	Inform the NHS Executive, if possible before the Board takes its decision or in any event before the decision is implemented so that the Executive can if necessary intervene with the Board and inform the Treasury.
21	**CEO**	If the Board of Directors is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board of Directors. If the outcome is that the Chief Executive is overruled it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the Department of Health. In such cases, and in those described in paragraph 21, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

Section Four - Scheme of delegation derived from the Codes of Conduct and Accountability

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
BOARD	Approve procedure for declaration of hospitality and sponsorship.
BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to Code of Conduct.
BOARD	Board members share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health for the discharge of those responsibilities.
BOARD	The role of an NHS board is to: - be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs - provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed - set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance - set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.
CHAIRMAN	It is the Chairman's role to: - Provide leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda; - ensure the provision of accurate, timely and clear information to directors; - ensure effective communication with staff, patients and the public; - arrange the regular evaluation of the performance of the board, its committees and individual directors; and - facilitate the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by NHS Improvements to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community. The duties of the non-Executive Directors are to: constructively challenge and contribute to the development of strategy; - scrutinise the performance of management in meeting agreed goals and objectives and

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	monitor the reporting of performance; - satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible; - determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and - ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.
CHAIR AND ALL DIRECTORS	Declaration of conflict of interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Section Five - Scheme of Delegation from Standing Orders

SO Ref	Delegated to	Duties delegated
Section 1-definitions	**Chairman of the Board of Directors**	Final authority in interpretation of Standing Orders (SOs).
1.3	**Board of Directors**	Powers to "make arrangements for the exercise, on its behalf, of any of its functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit (or as the Secretary of State may direct). Delegated powers and Schemes of Delegation are available separately.
2.4	**Board of Directors**	Appointment (and removal) of Deputy Chairman.
2.5.2	**Board of Directors**	Joint responsibility for every decision of the Board regardless of their individual skills or status.
2.5.4	**Chief Executive**	Responsible for the overall performance of the executive functions of the Trust
2.5.5	**Director of Finance**	Responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems
3.1.2	**Chairman of the Board of Directors**	The Chairman of the Trust may call a meeting of the Board of Directors at any time.
3.9	**Chairman of the Board of Directors**	At any meeting of the Trust Board the Chairman, if present, shall preside
3.10	**Chairman of the Board of Directors**	The decision of the Chairman presiding at the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.
3.12.1	**Chairman of the Board of Directors**	In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote).
3.13.1	**Board of Directors**	Suspend Standing Orders, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (at least 8 including at least one member who is an executive member and one member who is a non-executive member) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the minutes of the meeting.
3.13.4	**Audit and Risk Committee**	The Audit and Risk Committee shall be advised of and review every decision to suspend Standing Orders.
3.14	**Board of Directors**	Vary or amend the Standing Orders if two thirds of the Board members are present at the meeting (i.e 8 members) where the variation or amendment is being discussed, and that at least one half of the Trust's non-executive members vote in favour of the amendment;.
4.1	**Board of Directors**	The Board of Directors may appoint committees of the Board of Directors. The Board of Directors shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires to, receive and consider

		reports of such committees.
4.2	**Board of Directors**	Joint Committees may be appointed by the Board of Directors by joining together with one or more other Trusts consisting of, wholly or partly of the Chairman and members of the Board of Directors or other health service bodies, or wholly of persons who are not members of the Board of Directors or other health bodies in question.
4.6	**Board of Directors**	The Board of Directors shall approve the appointments to each of the committees which it has formally constituted.
4.7	**Board of Directors**	Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board of Directors, such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.
5.2	**Chairman of the Board of Directors and CEO**	The powers which the Board of Directors has reserved to itself within these Standing Orders (see paragraph 2.8 of the Standing Orders) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman. A proposal will be recommended by the Chief Executive and approved under 'Chairs action' and noted at the next formal meeting of the Board of Directors in public session.
5.4.2	**CEO**	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board of Directors subject to any amendment agreed during the discussion.
5.6	**All Staff**	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1.1	**Board of Directors**	Declare relevant and material interests.
7.2.1	**Chief Executive**	Ensure a register of interests is maintained
7.4.1	**All Staff**	Comply with national guidance contained in HSG 1993/5 *Standards of Business Conduct for NHS Staff* and the Trust's Conflict of Interest Policy. The Board of Directors and all employees must comply with the Trust's Code of Conduct.
7.4.2 **7.4.4**	All Staff	Any executive member of the Board of Directors or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he or any person connected with him (as defined in paragraph 7.3 above) has any pecuniary interest, direct or indirect, the Officer shall declare their interest.An executive director other than the Chief Executive or a senior employee should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. On appointment, non-executive members of the Board of Directors, and in the case of executive members of the Board Directors, prior to appointment, should disclose to the Board of Directors whether they are related to any other member or holder of any office in the Trust.
8.1/8.3	**CEO**	Keep seal in safe place and maintain a register of sealing.
8.4	**CEO and Executive Directors**	Approve and sign all documents which will be necessary in legal proceedings.

Section Six - Scheme of Delegation from Standing Financial Instructions

SFI Ref	Delegated to	Duties delegated
1.2.1	**Board**	(i)Formulating the financial strategy (ii)Requiring the submission and approval of budgets within approved allocations/overall income; (iii)Defining and approving essential features in respect of important procedures and financial systems, including the need to obtain value for money; (iv)Defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Scheme of Delegation document.
1.2.3	**CEO & DOF**	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.2.3	**CEO**	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
1.2.3	**CEO**	To ensure all members of the Board of Directors and employees, present and future, are notified of, and understand, Standing Financial Instructions.
1.2.4	**DOF**	Responsible for: (i) implementing the Trust's financial policies and co-ordinating corrective action; (ii) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; (iii) ensuring that sufficient records are maintained to explain the Trust's transactions and financial position; (iv) providing financial advice to members of the Board of Directors and staff; (v) maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
1.2.5	**All members of the Board of Directors and employees**	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures. Have a duty to disclose any non-compliance with Standing Financial Instructions to the Director of Finance & Performance as soon as possible.
1.2.6	**CEO**	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
2.1	**Audit & Risk Committee**	(i)Oversee Internal and External Audit services; (ii)review financial and information systems and monitor the integrity of the financial statements and review significant financial reporting judgments; (iii)review the establishment and maintenance of an effective system of corporate governance, internal control and risk management across the whole of the Trust's activities that supports the achievement of the Trust's objectives; (iv)monitor the integrity of the financial statements of the Trust; (v)monitor the independent auditors' qualifications, independence and performance; (vi)monitor the performance of the Trust's Internal Audit function; and

		(vii)monitor compliance by the Trust with legal and regulatory requirements (viii)review the findings of other significant assurance functions, including counter fraud, both internal and external to the organisation, and consider the implications to the governance of the organisation
2.1.2	**Chairman of the Audit & Risk Committee**	Raise the matter at the Board of Directors meeting where Audit & Risk Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3 & 2.2.1	**DOF**	Ensure that an adequate internal audit service, for which (s)he is accountable, is provided and involve the Audit & Risk Committee in the selection process when/if an internal audit service provider is changed. Internal audit should report to the Audit & Risk Committee; role of DoF is to assist the committee in the selection process.
2.2.1	**DOF**	(i) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function; (ii) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards; (iii) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; (iv) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee
2.3	**Head of Internal Audit**	Internal Audit will review, appraise and report upon: (i) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures; (ii) the adequacy and application of financial and other related management controls; (iii) the suitability of financial and other related management data; (iv) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from: (a) fraud and other offences; (b) waste, extravagance, inefficient administration; (c) poor value for money or other causes. (v) the economic acquisition and the efficient use of resources (vi) efficient operation of systems and departments (vii) the adequacy of follow up action to audit reports (viii) other matters as requested by directors and senior managers and agreed by the Head of Internal Audit, or considered appropriate by the Head of Internal (ix) Internal Audit shall also independently verify the assurance statements in accordance with guidance from the Department of Health The Head of Internal Audit will attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairman of the Board of Directors and Chief Executive. The Head of Internal Audit shall be accountable to the Director of Finance & Performance.
2.4	**Audit and Risk Committee**	Ensure a cost-effective external and internal audit service.
2.5.1	**CEO & DOF**	Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.

2.5.2	**Board of Directors**	Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.
2.6	**CEO**	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
2.6.2	**Board of Directors**	Nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. Nominate a non-executive member to be responsible to the Board of Directors for NHS security management.
3.1.1	**CEO**	Compile and submit to the Board an annual operating plan which takes into account financial targets and forecast limits of available resources. The plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.
3.1.2 & 3.1.3	**DOF**	Prepare and submit budgets to the Board of Directors for approval, following presentation at the Finance Committee. Monitor performance against budget; submit to the Board of Directors financial estimates and forecasts.
3.1.6	**DOF**	Ensure adequate training is delivered on an ongoing basis to budget holders.
3.2	**All budget holders**	Must provide information as required by the Director of Finance & Performance to enable budgets to be compiled. All budget holders will sign up to their allocated budgets at the commencement of each financial year. Must make themselves aware of relevant Trust guidance, procedures and instructions on financial management Required to work within the financial limits Responsible for all expenditure against their budget and the use of Trust Resources to deliver work outlined in their local business plans and in commissioners contracts
3.3.1	**CEO**	Delegate budget to budget holders.
3.3.2	**CEO & Budget Holders**	Must not exceed the budgetary total or virement limits set by the Board of Directors.
3.4.1	**DOF**	Devise and maintain systems of budgetary control.
3.4.2	**Budget Holders**	Ensure that (i) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Board of Directors; (ii) approved budget is not used for any other than specified purpose subject to rules of virement; (iii) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and approved budgeted manpower establishment.

3.4.3	**CEO**	Identify and implement cost improvements and income generation activities in line with the annual operating plan.
3.6	**CEO**	Submit monitoring returns.
4.1	**DOF**	Preparation and submission of annual accounts and reports.
5.1	**DOF**	Managing banking arrangements approved by the Board of Directors, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
5.1.2	**Board of Directors**	Approve banking arrangements
5.2	**DOF**	Responsible for: (i) bank accounts; (ii) establishing separate bank accounts for the Trust's non-exchequer funds; (iii) ensuring payments made from bank do not exceed the amount credited to the account except where arrangements have been made; (iv) reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn. (e) monitoring compliance with Department of Health guidance on the level of cleared funds.
5.3	**DOF**	• prepare detailed instructions on the operation of bank account • must advise the Trust's bankers in writing of the conditions under which each account will be operated • authorized to make payments using BACs and CHAPS to establish appropriate procedures in accordance with locally agreed arrangements. • Approve payment by direct debit mandates
5.4	**DOF**	review the commercial banking arrangements of the Trust at regular intervals
5.5.1	**Board of Directors**	• Approves overall treasury policy • Approves external funding arrangements subject to the Treasury policy • Delegates to the Finance Committee approval the Trust's treasury management detailed policies, processes and controls
5.5.2	**Finance Committee**	• Recommends to the Board the Trust's detailed treasury management policies, processes and controls • Approves relevant benchmarks for measuring performance • Reviews and monitors investment and borrowing policy and performance against the relevant benchmarks • Ensures proper safeguards are in place for security of the Trust's funds by: approving a list of permitted institutions; approving investment limits for each permitted institution; approving permitted investment types; and ensuring approved bank mandates are in place for all accounts which are updated regularly for changes in signatories and authority levels • Monitors compliance with treasury policies and procedures in particular as regards limits, approved counterparties and types of investments • Delegates responsibility for treasury operations to the Director of Finance Oversees and reviews detailed treasury reporting requirements
6.1 **6.2**	**DOF**	• responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due. • responsible for the prompt banking of all monies received. • approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by statute
6.2.3	**All employees**	Duty to inform the Director of Finance & Performance of money due from transactions which they initiate/deal with.

6.3	**DOF**	responsible for • the appropriate recovery action on all outstanding debts. • establishing and maintaining procedures for issuing credit notes and for debt write off, within delegated limits, after all reasonable steps have been taken • agreeing all write-offs of debts. A list of amounts written off shall be submitted by the Director of Finance & Performance to the Audit and Risk Committee twice yearly
6.4	**DOF**	responsible for: (i) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; (ii) ordering and securely controlling any such stationery; (iii) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; (iv) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. ensure that there is a system for recording the transfer of custody of cash, cheques and other negotiable instruments from one person to another, and in what circumstances such records should be made.
6.5	**DOF**	Director of Finance & Performance shall ensure that there are systems in place to identify all costs and revenues attributed to each income generation scheme.
7.5.3	**CEO**	Waive formal tendering procedures.
7.5.3	**CEO**	Report waivers of tendering procedures to the Audit & Risk Committee.
7.5.5	**DOF**	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.
7.6.2	**CEO**	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.3	**CEO**	Shall maintain a register to show each set of competitive tender invitations dispatched.
7.6.4	**CEO & DOF**	Where one tender is received will assess for value for money and fair price.
7.6.5	**CEO**	May consider late tenders if exceptional circumstances
7.6.6	**CEO**	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
7.6.8	**CEO**	Will appoint a manager to maintain a list of approved firms.
7.6.9	**CEO**	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
7.7.2	**Service Line Operational Director or Corporate Associate Director**	The Chief Executive or his nominee should evaluate the quotation and select the quote which gives the best value for money.
7.7.4	**CEO or DOF**	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
7.10	**CEO**	The Chief Executive shall demonstrate that the use of private finance represents

		value for money and genuinely transfers risk to the private sector.
7.10	**Board of Directors**	All Private Finance Initiative (PFI)_proposals must be agreed by the Board of Directors.
7.11	**CEO**	The Chief Executive shall nominate an employee who shall oversee and manage each contract on behalf of the Trust.
7.12	**CEO**	The Chief Executive shall nominate employees with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
7.15	**CEO**	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
7.15.5	**CEO**	The Chief Executive shall nominate an employee to oversee and manage the contract on behalf of the Trust.
8.1.1	**CEO**	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
8.3	**CEO**	As the Accountable [Accounting] Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA.
9.1.1	**Board of Directors**	Establish Remuneration Committee and any others required.
9.2.2	**CEO**	Approval of variation to funded establishment of any department.
9.3	**CEO**	Staff, including agency staff, appointments and re-grading.
9.4.1 and 9.4.2	**DOF**	Payroll: (i) specifying timetables for submission of properly authorised time records and other notifications; (ii) final determination of pay and allowances; (iii) making payments on agreed dates; (iv) agreeing method of payment; (v) issuing instructions (as listed in SFI 9.4.2).
9.4.3	**Nominated managers**	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
9.4.4	**DOF**	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.6	**Chief People Officer**	Ensure that all employees are issued with a Contract of Employment in a form approved by the Trust Management Board and which complies with employment legislation. Deal with variations to, or termination of, contracts of employment.
10.1	**CEO**	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
10.1.3	**CEO**	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.2	**DOF**	The Director of Finance & Performance is responsible for the requisition,

		ordering, receipt and payment for goods and services.
10.2.1	**Requisitioner**	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust.
10.2.2	**DOF**	Shall be responsible for the prompt payment of accounts and claims.
10.2.3	**DOF**	(i) Advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed. (ii) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds. (iii) Be responsible for the prompt payment of all properly authorised accounts and claims. (iv) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. (v) A timetable and system for submission to the Director of Finance & Performance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment. (vi) Instructions to employees regarding the handling and payment of accounts within the Finance Department. (vii) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
10.3	**Appropriate executive director**	Make a written case to support the need for a prepayment.
10.3	**DOF**	Approve proposed prepayment arrangements.
10.3	**Budget Holder**	Ensure that all items due under a prepayment contract are received and immediately inform the Director of Finance & Performance if problems are encountered.
10.4	**CEO**	Authorise who may use and be issued with official orders.
10.5	**Senior employees**	Ensure that they comply fully with the guidance and limits specified by the Director of Finance & Performance.
10.5.1	**CEO / DOF**	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the Health Building Note 00-08 (Strategic framework for the efficient management of healthcare estates and facilities). The technical audit of these contracts shall be the responsibility of the relevant Director.
10.6	**DOF**	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 256 and 257 of the NHS Act
11.1.1	**DOF**	The Director of Finance & Performance will advise the Board of Directors on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
11.1.2	**Board of Directors**	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and Director of Finance & Performance
11.1.3	**DOF**	Prepare detailed procedural instructions concerning applications for loans and

		overdrafts.
11.1.4	**CEO OR DOF**	Be on an authorising panel comprising one other member for short term borrowing approval.
11.2.2	**DOF**	Advise the Board of Directors on investments and report, periodically, on performance of same.
11.2.3	**DOF**	Prepare detailed procedural instructions on the operation of investments held.
12	**DOF**	Ensure that members of the Board of Directors are aware of the Financial Framework and ensure compliance.
13.1.1 **13.1.2**	**CEO**	Capital investment programme: (i) ensure that there is an adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; (ii) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; (iii) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; and (iv) ensure that a business case is produced for each proposal.
13.1.2	**DOF**	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
13.1.3	**CEO**	Issue procedures for management of contracts involving stage payments.
13.1.4	**DOF**	Assess the requirement for the operation of the construction industry taxation deduction scheme.
13.1.5	**DOF**	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
13.1.6	**CEO**	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
13.1.7	**DOF**	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
13.2.1	**DOF**	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
13.2.1	**Board of Directors**	Proposal to use PFI must be specifically agreed by the Board.
13.3.1	**CEO**	Maintenance of asset register, on advice from the Director of Finance & Performance.
13.3.5	**DOF**	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.3.8	**DOF**	Calculate and pay capital charges in accordance with Department of Health requirements.
13.4.1	**CEO**	Overall responsibility for fixed assets.

13.4.2	**DOF**	Approval of fixed asset control procedures.
13.4.4	**Board of Directors, executive directors and all senior staff**	Responsibility for security of Trust assets including notifying discrepancies to the Director of Finance & Performance, and reporting losses in accordance with Trust procedure.
14	**CEO**	Delegate overall responsibility for control of stores (subject to Director of Finance & Performance responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
14.2.1	**DOF**	Responsible for systems of control over stores and receipt of goods.
14.2.1	**Chief Pharmacist**	Responsible for controls of pharmaceutical stocks
14.2.1	**Designated estates manager**	Responsible for control of stocks of fuel and power supplies
14.2	**Nominated staff**	Security arrangements and custody of keys.
14.2.1	**DOF**	Set out procedures and systems to regulate the stores.
14.2.4	**DOF**	Agree stocktaking arrangements.
14.2.5	**DOF**	Approve alternative arrangements where a complete system of stores control is not justified.
14.2.6	**DOF**	Approve system for review of slow-moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.2.6	**Nominated staff**	Operate system for slow-moving and obsolete stock, and report to the DOF evidence of significant overstocking.
14.3.1	**CEO**	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
15.1.1	**DOF**	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	**DOF**	must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
15.2.2	**All Staff**	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Director of Finance & Performance.
15.2.2	**DOF**	Where a criminal offence is suspected, the Director of Finance & Performance must inform the police if theft or arson is involved. In cases of fraud and corruption the Director of Finance & Performance must inform the relevant LCFS and CFSMS Regional Team in line with Secretary of State directions.
15.2.2	**DOF**	Notify CFSMS and External Audit of all frauds.
15.2.3	**DOF**	Notify the Board of Directors and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.4	**Board of Directors**	Approve write off of losses
15.2.5	**DOF**	Authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.6	**DOF**	Consider whether any insurance claim can be made.
15.2.7	**DOF**	Maintain losses and special payments register.
16.1	**DOF**	Responsible for accuracy and security of computerised financial data.
16.1.2	**DOF**	Satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation.
16.1.3	**DOF**	Shall publish and maintain a Freedom of Information Scheme.
16.2	**DOF**	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
16.3	**All employees**	Send details of the outline design of computer systems to the Director of Infrastructure
16.4	**Director of Infrastructure**	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
16.5	**DOF**	Where computer systems have an impact on corporate financial systems satisfy themselves that: (i) systems acquisition, development and maintenance are in line with corporate policies; (ii) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; (iii) Director of Finance & Performance and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
17.2	**CEO**	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.3	**DOF**	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
17.6	**Senior Managers / Department managers**	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1	**DOF**	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
19	**DOF**	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
20	**CEO**	Retention of document procedures in accordance with Department of Health Guidelines
21.1	**CEO**	Ensure the Trust has a programme of Risk management programme.
21.1	**Board of Directors**	Approve and monitor risk management programme.
21.2	**Board of Directors**	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) or self-insure for some

		or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
21.4	**DOF**	Where the Board decides to use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) the Director of Finance & Performance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance & Performance shall ensure that documented procedures cover these arrangements. Where the Board of Directors decides not to use the risk pooling schemes administered by NHS Resolution (formally known as the NHS Litigation Authority) for any one or other of the risks covered by the schemes, the Director of Finance & Performance shall ensure that the Board of Directors is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance & Performance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
21.4	**DOF**	Ensure documented procedures cover management of claims and payments below the limit for settlement of claims (the 'deductible'.)
	CEO and DOF	Responsible for the management and allocation of reserves
	CEO and Associate DOF	Interim Revolving Working Capital Support Facility - The Chief Executive to execute the agreement. The Associate Director of Finance to manage the agreement.

Section Seven - Scheme of Delegation for capital and revenue expenditure and signatories (*financial values are over the contract lifetime)*

Capital			
Approval of capital plan	Approval by the Board (via the Finance & Commercial Group and Finance Committee)		
Allocation and virement to individual programmes within the overall agreed budgetary allocation	Finance & Commercial Group agree all allocations, report to Board as appropriate		
Business Case Approval	Approval by Board >£3m	Finance Committee Between £500k and up to £3m For cases: • ≥ £500k sign off by the DOF required prior to presentation for approval to the Finance Committee	Finance & Commercial Group Up to £500k For cases: • ≥£250k < £500k sign off by the Deputy DOF required prior to presentation for approval at the Finance & Commercial Group
Payment Approval	CEO any £value	Director of Finance any £value	Deputy Director of Finance up to £250k
NHS Improvement Approval	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH		
DH Approval	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury		

Tendering and quotations(*subject to the terms of any contract with the Integrated Supply Chain)					
Formal quotes	Between £5k and £50k				
Formal Tender	Over £50k				
OJEU	Subject to current limits				
Tender Approval					
	Chairman and CEO (and then report to Board)	**CEO**	**DoF (or nominated deputy)**	**Other Executive Directors**	**Others**
Lowest	Over £3m	Up to £3m	Up to £3m	Up to £3m	Up to 50k
Not the Lowest	Over £3m	Up to £3m	Up to £250k		
Single Tender	Over £3m (and notify Audit and Corporate Risk Committee)	Up to £3m (and notify Audit and Corporate Risk Committee)	Up to £250k (and notify Audit and Corporate Risk Committee)		Deputy DoF up to £250k(and notify Audit and Corporate Risk Committee)

<table>
<tr><th colspan="5">Revenue Expenditure</th></tr>
<tr><td>Revenue Plan</td><td colspan="4">Approval by the Board (via Finance & Commercial Group and Finance Committee)</td></tr>
<tr><td>Virement between cost centres within overall service line or corporate functional budget</td><td colspan="2">CEO
any £value</td><td>Over £250k Director of Finance / Deputy DOF approval required</td><td>Service Line Operational Directors and Corporate Associate Directors up to £50k for any one transaction (and Executive Directors for their respective areas).</td></tr>
<tr><td>Proposed changes that increase overall planned levels</td><td>Approval by Board
>£3m</td><td>CEO
any £value</td><td colspan="2">Over £250k Director of Finance / Deputy DOF approval required</td></tr>
<tr><td>Business Case Approval</td><td>Approval by Board
>£3m</td><td colspan="2">Finance Committee
Between £500k and up to £3m

For cases:
• ≥ £500k sign off by the DOF required prior to presentation for approval to the Finance Committee</td><td>Finance & Commercial Group
Up to £500k
(All business cases requiring investment to be presented)
For cases:
• ≥£250k < £500k sign off by the Deputy DOF required prior to presentation for approval at the Finance & Commercial Group</td></tr>
<tr><td>NHS Improvement Approval</td><td colspan="4">For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHSI approval in line with the delegated limits outlined below.

For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required.

(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)

• All trusts have delegated authority to approve capital investment business cases up to £15m
• £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH
• £30m to £50m - NHS Improvement Resources Committee and then DH</td></tr>
<tr><td>DH Approval</td><td colspan="4">Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury</td></tr>
</table>

New contracts/Contract Renewals/ Novations / Extensions / Terminations/ ~~Variations~~/ Leases [Annual Value] Variations (Annual Value of change) (Over £50k will have been tendered)			
Awarding /terminating contracts and signing contracts (where Solent is the commissioner) *	Approval by Board >£3m Signed by CEO / DOF	Approval >£500k to £3m by Finance Committee Signed by DOF / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by any of the Executive team~~Chair/ Deputy Chair of Group~~ (Up to £50k – approved by Operational Director of service or equivalent (i.e. Corporate Associate Director or, where nominated by the relevant executive Director, Head of Service/corporate area) ~~/ Corporate Associate Directors as appropriate~~ and signed by any of the Executive team ~~Director of Commercial~~ or Head of Commercial)
Contract Approval/ termination and signing of documents (where Solent is the provider)	Approval by Board >£3m (Signatures – CEO/ DOF)	Approval >£500k to £3m by Finance Committee Signed by DOF / any of the Executive Team	Approval >£50k to £500k by Finance & Commercial Group Signed by any of the Executive team~~Chair/ Deputy Chair of Group~~ (Up to £50k – approved by Operational Director of service or equivalent (i.e. Corporate Associate Director or, where nominated by the relevant Executive Director, Head of Service/corporate area) ~~/ Corporate Associate Directors as appropriate and~~ signed by any of the Executive team~~Director of Commercial~~ or Head of Commercial)
Contract under seal approval	(All seals report to Board via CEO Report)	CEO / DoF approval	(For capital contracts – seals must come via recommendation of Director of Infrastructure)
NHS Improvement Approval on managed service contracts	For IT, leased equipment, leased property, managed equipment and managed service schemes the delegated limits apply to the whole life costs, not just capital costs. Schemes with whole life costs in excess of NHS Trust delegated limits will require-NHSI approval in line with the delegated limits outlined below. For all business cases over £15m and up to £50m relating to IT, leased equipment, property leases, managed equipment and managed service contract business cases, Capital Investment Group approval is required. *(In accordance with NHS Improvement Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts –November 2016)* • All trusts have delegated authority to approve capital investment business cases up to £15m • £15m to £30m – NHS Improvement executive director of resources/deputy chief executive or NHS Improvement director of Finance and then DH • £30m to £50m - NHS Improvement Resources Committee and then DH		
DH Approval on managed service contracts	Approval required on cases over £50m – NHS Improvement Resources Committee, NHS Improvement Board, DH, HM Treasury		
Letter of intent	Approval by Board >£3m Signed by CEO /	Approval >£500k to £3m by Finance Committee	Approval >£50k to £500k by Finance & Commercial Group

	DOF	Signed by DOF / any of the Executive Team	Signed by Chair/ Deputy Chair of Group (Up to £50k – signed by Operational Director / Corporate Associate Directors)
Issuing contracts of employment and deployment of agency staff	CEO / DOF / Chief People Officer / Recruiting Manager		
Waiver of Tenders and quotations	CEO / DOF (Report to Audit & Risk Committee)	Deputy DoF up to £250k (Report to Audit & Risk Committee)	

*Contract variations to specification only with no tenure of value change can be signed by the Director of Strategy or in their absence any Executive Team member (no presentation at Committee required). Lease variations with no tenure or value change can be signed by the Director of Infrastructure or in their absence any Executive Team member (no presentation at Committee required).

No commitments should be made via email.

Delegated financial limits for budget holders

Level	Staff with authority	Requisitions		Invoices - limit (£000)	Credit Notes
		Purchase orders – limit (£000)	Non purchase orders – limit (£000)		
1	Chief Executive	Any amount over 250	Any amount over 250	Any amount over 250	Any amount
2	Director of Finance & Associate Director of Finance				
3	Level 1 Management Other Executive Directors, and Associate Director of Finance and Financial Controller	250	250	250	Financial Controller only – up to 250K
4	Level 2 Management Service Line Operational Directors and Corporate Associate Directors	50	50	50	Up to 50k
5	Level 3 Management senior managers, Heads of Department	20	20	20	Financial Services Manager up to 20k
6	Other budget holders	5	5	5	