# Agenda
# Solent NHS Trust In Public Board Meeting

Monday 26th November 2018 09:30am – 13.25pm
The Oasis Conference Centre, Arundel Street, Portsmouth, PO1 1NP.

| Item | Time | Dur. | Title & Recommendation | Exec Lead / Presenter | Well Led Domains |
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| 1 | 09:30 | 5mins | **Chairman's Welcome & Update**<br>• **Apologies to receive**<br>*To receive* | Chairman | - |
| | | | **Confirmation that meeting is Quorate**<br>*No business shall be transacted at meetings of the Board unless the following are present;*<br>• *a minimum of two Executive Directors*<br>• *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair* | Chairman | - |
| 2 | 09:35 | 30mins | **Joint Patient and Staff Story – Sensory Services**<br>*To receive*<br>*Jo Pinhorne and Bev Stratton to attend + patient* | Chief Nurse/Chief People Officer | W7 |
| 4 | 10:05 | 10mins | **Board reflection on patient story and staff story and discussion** | Chairman | W7 |
| 5 | 10:15 | 5 mins | ***Minutes of Last Meeting and action tracker**<br>*To agree* | Chairman | - |
| 6 | | | **Register of Interests & Declaration of Interests**<br>*To receive* | Chairman | - |
| 7 | 10:20 | 5mins | **Matters Arising** | Chairman | - |
| 8 | 10:25 | 5mins | **Any Other Business** | Chairman | - |
| 9 | 10:30 | 10mins | **Safety and Quality First and Feedback from Board to Floor Visits –** *to receive*<br>*To include:*<br>• *Board to Floor Six Monthly Summary Report* | Chief Executive / Chief Nurse | W3 |
| **Strategy & Vision** | | | | | |
| 10 | 10:40 | 30mins | **Chief Executive's Report**<br>*To receive* | Chief Executive | W1-W8 |

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| 11 | 11:10 | 30mins | **Performance Report** - *including*<br>• Business Plan Quarter 2 Report 2018/19<br>• Benchmarking In-Focus: Mental Health 2017/18<br>• Operational Performance<br>• Quality Performance<br>• Financial Performance<br>• Workforce Performance<br>• NHSI Single Oversight Framework<br>*To receive* | Executive Leads | W5, W6 |
| 12 | 11:40 | 10mins | **Emergency Planning Resilience Response Annual Report**<br>*To receive* | Chief Operating Officer, Southampton | W1,2,4,7 |
| 13 | 11:50 | 5mins | **Winter Planning and Contingencies 2018**<br>*To receive* | Chief Operating Officer, Southampton | W1,2,4,7 |
| 14 | 11:55 | 10mins | **Professional Leadership Report**<br>*To receive* | Chief Nurse | W1, W4 |
| 15 | 12:05 | 10mins | **Information Governance Briefing Paper**<br>*To receive* | Chief Operating Officer, Southampton | W6 |
| ***Reporting Committees and Governance matters** | | | | | |
| 16 | 12:15 | 10mins | ***Audit & Risk Committee**<br>*To receive exception report from November meeting including:*<br>• *Standing Orders – presented separately to approve (tracked changes highlighted)* | Committee Chair | W5 |
| 17 | 12:25 | 10mins | ***Assurance Committee**<br>*To receive exception report from October and verbal update from November meeting* | Committee Chair | W4, W5, W6, W8 |
| 18 | 12:35 | 10mins | ***People and OD Committee**<br>*To receive verbal update* | Committee Chair | W1-8 |
| 19 | 12:45 | 5mins | ***Charitable Funds Committee Minutes & Chairs update**<br>*To receive verbal update including:*<br>- Amendment to Terms of Reference *(tracked)* | Committee Chair | W4 |
| 20 | 12:50 | 5mins | ***Complaints Review Panel**<br>*To receive verbal update* | Committee Chair | W5-6 |
| 21 | 12:55 | 5mins | *** Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update**<br>*To receive exception report from November meeting* | Committee Chair | W5, W6, W8 |

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| 22 | 13:00 | 5mins | ***Governance and Nominations Committee**<br>*To receive exception report from September meeting* | Committee Chair | W4 |
| 23 | 13:05 | 5mins | **Finance Committee Chairs Update**<br>*To receive verbal update* | Committee Chair | W4 |
| **Any other business** | | | | | |
| 24 | 13:10 | 10mins | **Reflections – lessons learnt and living our values** | Chairman | - |
| 25 | 13:20 | 5mins | **Any other business & future agenda items** | Chairman | - |
| 26 | 13:25 | ------ | **Close and move to Confidential meeting**<br>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:<br>"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: 4th February 2019***

# Minutes

## Solent NHS Trust In Public Board Meeting

**Monday 24th September 2018 09:30am-13:30pm**
**Kestrel 1 & 2, Highpoint Venue, Bursledon Road, Southampton, SO19 8BR**

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| **Chair: Alistair Stokes,** Chairman (AMS) | |
| **Members:**<br>**Sue Harriman,** Chief Executive (SH)<br>**Andrew Strevens,** Director of Finance (AS)<br>**Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA)<br>**David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN)<br>**Dan Meron,** Chief Medical Officer (DM)<br>**Jackie Ardley**, Chief Nurse (JA)<br>**Helen Ives,** Chief People Officer (HI)<br>**Mick Tutt,** Non-Executive Director (MT) (from item 2.1)<br>**Jon Pittam,** Non-Executive Director (JPi)<br>**Francis Davis,** Non-Executive Director (FD)<br>**Mike Watts,** Non-Executive Director (MW) | **Attendees:**<br>**Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC)<br>**Jayne Jenney,** Corporate Support Manager and Assistant Company Secretary (JE)<br>**Claire Jeffries,** Physiotherapy Clinical Specialist, Hydrotherapy and Rheumatology (CJ) (until item 2)<br>**Laura Papineau,** Physiotherapy (LP) (until item 2)<br>**Suzie Calvert,** Portsmouth (SC) (until item 2)<br>**Sank Rajakaruna,** (SR) Integrated Service Manager (until item 3)<br>**Sarah Stephens,** (SS) CEDT (until item 3)<br>**Joanne Oakes** (JO), CEDT (until item 3)<br>**Mandy Sambrook,** Operational Director, Integrated Adults Services Portsmouth Care Group (MS) (until item xx)<br>**Apologies:**<br>**Stephanie Elsy,** Non-Executive Director (SE) |

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| **1** | **Chairman's Welcome & Update, Confirmation that meeting is Quorate** |
| 1.1 | Apologies were noted as above.<br><br>AMS welcomed the Board, staff observers and CQC representative to the meeting. The format of the meeting was explained. |
| 1.2 | The meeting was confirmed as quorate. |
| **2** | **Patient Story – Hydrotherapy and Rheumatology Service** |
| 2.1 | JA introduced Claire Jeffries, Laura Papineau and Suzie Calvert and explained the reason for the patient's absence from the meeting. It was also noted that the patient's wife had declined to attend however was agreeable to a video of the story being shared.<br><br>The Board was informed of the patient's symptoms, diagnosis and the treatment provided in the hydrotherapy pool and physiotherapy. It was noted that a detailed and comprehensive risk assessment was required prior to treatment in the pool due to significant ventilation issues.<br>*MT arrived at this point of the meeting.* |
| 2.2 | AMS asked if the patient has required further ventilation since his treatment. It was confirmed that the patient remained on a tracheotomy until a week after treatment and thereafter continued to improve. |

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| 2.3 | SA asked if children with ventilation issues are being considered for the same treatment. The potential was acknowledged however it was noted that the same treatment is not yet provided for children. |
| 2.4 | SH shared her experience of her visit to the pool and evidence witnessed of both positive physical and mental health consequences. SH suggested that other members of the Board arrange a visit.<br><br>SH also commented on the positive relationship with Portsmouth Hospitals NHS Trust (PHT) and asked how this was achieved. It was explained that a number of patients seen are known to PHT and Solent staff have established relationships with PHT practitioners, which supports effective communication. It was commented that strong partnership working is in place, with teams working to the same purpose and shared goals. |
| 2.5 | SA suggested that the patient story is shared with PHT colleagues. JA confirmed plans to share with the PHT Board. It was noted that the story has also been included in the Critical Care Journal and Chartered Society Physiotherapy Annual Conference. AMS also suggested using the story for posters at the next Research and Improvement conference. It was noted that this has been considered and welcomed. |
| 2.6 | The Team were thanked by the Board for attending the meeting and sharing the story. |
| **3** | **Staff Story – Community Emergency Department Team (CEDT)** |
| 3.1 | Sank Rajakaruna Integrated Service Manager introduced Jo Oakes and Sarah Stephens from the CEDT to the meeting.<br><br>Sarah briefed the Board on the function of the team that provides care to both Solent and Southern service users and of the overall objective to avoid admissions to the acute hospital. The team's caseload was explained and referral examples provided.<br><br>Sarah explained the process when service users are not well enough to return home following presentation to the Emergency Department at University Hospital Southampton NHS Foundation Trust (UHS). |
| 3.2 | A case study was presented and the reasons for admission of both the patient and her carer explained. The Board were briefed on the effective joint working between the CEDT, social services, and acute hospital (USH) enabling positive outcomes for both the patient and carer. |
| 3.3 | AMS asked if Solent is commissioned to provide inpatient rehab for Hampshire patients. Sarah explained challenges and delays associated with accessing Our of Hours and Hampshire beds, which are commissioned differently to that of Southampton City, and the Board were informed of the associated delays. SH confirmed that the work of the Sustainability & Transformation Programme and associated System Reform proposal will be considering the consistency of commissioning arrangements across the Hampshire and Isle of Wight geography. |
| 3.4 | JPi commented on being witness to a well-managed relationship between Fanshawe Ward and acute hospital during his Board to Floor recent visit. |

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| 3.5 | HI asked if the team had any reflections or issues that they would like to share with the Board. Sarah Stephens highlighted cross system IT issues and difficulties in communications. Challenges experienced due to being located in a busy and noisy environment were also highlighted. |
| 3.6 | SH requested more information regarding the environment of the team. Jo reported on a new Frailty Unit that will be in use from early December that is a much more suitable environment. Future plans for the unit is also to provide a community hub to be used by GPs. |
| 3.7 | DM commented on the high level of experience within the team and the support provided to UHS during times of black alert. |
| 3.8 | DN explained that CEDT are at the hub of the Southampton integrated model and highlighted the vital work undertaken by the team to ensure a smooth patient journey.<br>Sarah and Joanne were thanked for their presentation to the Board. |
| **4** | **Board reflection on patient story and staff story and discussion** |
| 4.1 | The Board reflected on the patient and staff stories received.<br><br>AMS commented on being impressed with the positive and strong integration with partner organisations of all teams presented. |
| 4.2 | SH commented on staff frustrations in relation to differing commissioning models and therefore access to services across the wider geography, but that regardless of these challenges, staff always ensure the patients' needs are central to actions taken. |
| 4.3 | JPi commented on the proudness and passion presented by staff who attended the Board and requested that this is formally provided as feedback to the teams, together with thanks from the Board. It was agreed that JA and DN send thanks in writing to the teams and include information on what the Board has learnt as a consequence. **Action: JA/DN** |
| 4.4 | Reflecting on frustrations staff shared in relation to interconnectivity of IT systems across partner organisation, AMS enquired as to why the IT risk within the Board Assurance Framework (BAF) had been downgraded. The Board were briefed on the rationale and were informed that the nature of the IT risk concerning third party assurance has increased. The Board were also informed of the aims of the wider STP Digital work-programme in relation to interconnectivity. |
| 4.5 | The Board discussed the successful relationships across services and organisations throughout the Trust. |
| 4.6 | SH provided a follow up on the patient story received at the July Board meeting regarding the poor condition of the garden at The Limes, Portsmouth. SH confirmed that the garden has been redeveloped and has been visited by the patient's wife who thanked Solent for acting on the information received. |
| **5** | **Minutes of Last Meeting and action tracker** |
| 5.1 | The minutes of the meeting were agreed as an accurate record subject to minor changes. |

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| 5.2 | Action 618<br>SA highlighted the likelihood of the Maples service user returning to Portsmouth however provided assurance of Trust preparation. SA informed the Board of immense improvements to the ward following the damage caused and of phased re-opening arrangements. It was noted that MT is to conduct a visit following a Mental Health Act hearing in the near future. |
| 5.3 | The following actions were confirmed as complete: 618, 619, 620, 621 and 622. |
| **6** | **Register of Interests & Declaration of Interest** |
| 6.1 | There were no further updates to report. |
| **7** | **Matters Arising** |
| 7.1 | MT enquired about item 19.1 regarding cultural sensitivity being considered by executives. It was confirmed that arrangements are planned for discussion at the January 2019 Board workshop meeting. |
| **8** | **Any Other Business** |
| 8.1 | No further business was requested. |
| **9** | **Safety and Quality First and Feedback from Board to Floor Visits** |
| 9.1 | Board to Floor – Brooker Ward<br>DN reported on the good practice and strong evidence of care witnessed during the visit to the ward. DN highlighted being impressed with ward standards. |
| 9.2 | Board to Floor – Musculoskeletal Service, Adelaide<br>MT informed the Board of conversations with both clinical and admin staff who demonstrated that quality improvement is ingrained in all activity. Challenges with the building and landlord issues were noted. MT commented on being impressed with the passionate staff who work across care groups and different organisations.<br>JPi endorsed MT's feedback and emphasised strong core working within the city. |
| 9.3 | Board to Floor – Fanshawe Ward<br>JPi commented on staff positivity being clearly evident and of processes in place to ensure safe staffing levels. Huge improvements in managing patient transfers and seamless working arrangements with UHS were also noted.<br><br>JPi informed the Board of evidence learning achieved with regards to capacity, goals and quality initiatives that benchmark well compared to other rehab wards across the country. The Board was informed that inpatients also spoke very highly of the care they were receiving. |
| 9.4 | AMS queried the ownership of the RSH estate. SH reported on work in progress with commissioners to consider strategic estate matters and AS informed the Board on an agreement reached at the last Southampton Chief's meeting to write a collective formal letter to the site landlords. Consequently, the Board were informed of the rationale to increase the risk associated with Third Party Contractors on the BAF. |

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| 9.5 | AMS raised concern regarding a lack of single responsibility for estate and suggested resolve through the STP. SH commented on a significant capital requirement that is not expected to be achieved at quick pace and highlighted the need to consider how to manage risk in the interim period.<br><br>The Board reflected on the recent visits and of the openness of staff. |
| 9.6 | MT briefed the Board on a visit to the Dental Service in Albany prison on the Isle of Wight, where it was apparent that Solent practitioners have minimal exposure to the infrastructure of the organisation. The positive regard for the Clinical Director and Professional Lead of the service and effective communication in place were however clear.<br>**The Board noted the recent visits undertaken.** |
| **Strategy & Vision** | |
| **10** | **Chief Executive's Report** |
| 10.1 | Solent Story<br>• SH provided a presentation reminding the Board of the approach taken by the Trust to making our strategy meaningful to our patients, staff and partners. The presentation highlighted initiatives such as the 'Making a Difference', examples of staff stories as well as the CuriosiTEA events being held (video shared).<br>• The success of the 2018 AGM was noted. |
| 10.2 | Trust Management Team Meeting – Sept 19th 2018<br>The Board was informed of time spent to consider future planning and business plans for 2020. A concept of one health and one team collaboration was discussed.<br>The BAF was reviewed and the Quality Framework and Staff Survey Communication plans shared.<br>Positive feedback was given on the new business planning process and an agreement was reached to reduce TMT meetings from 3 to 2 hours.<br><br>AS commented on planning sessions being key to ensure the involvement of service line leadership.<br>AS reported that 10 year plans are expected to be published during November 2018. |
| 10.3 | Hampshire and Isle of Wight Sustainability and Partnership Reform Proposal<br>The Board considered the System Reform proposal.<br><br>AMS highlighted the proposal to be a work in-progress and queried whether the timescales presented were achievable. It was also recognised that the proposals are constrained by national policy including counterproductive payment systems and challenges associated with mechanical transactional processes. |
| 10.4 | SH briefed the Board on executive and non-executive colleague involvement in the development of the proposals and associated work-streams/programmes supporting the STP and emerging Integrated Care Systems. |

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| 10.5 | SA commented on the need to ensure that the STP does not over-prescribe the design of, and, over-regulates the emerging clusters in recognition of the need to allow these to mature organically. However, it was acknowledged that there will be a need for ensuring consistency in outcomes and pathways across the place based geography, not just within the cities. |
| 10.6 | With regards to the principals of the System Reform Proposals, the Board endorsed the direction of travel and acknowledged the alignment with Solent's long standing strategy and vision of place based care and supporting the development of primary care. |
| 10.7 | FD commented on the need for further clarity in relation to funding flows and associated risk implications for the Trust, as well as the need to understand how cluster funding allocation will be granted aligned to social profiles/demographic needs. Variations in city and rural cluster allocations would be expected. |
| 10.8 | The Board acknowledged the lack of detail within the System Reform Proposals regarding enablers, such as workforce and digital strategies, although it was confirmed that work-streams have been implemented and Solent representation and engagement within these is active. On behalf of Stephanie Elsy, NED, SH acknowledged that the workforce plan is immature currently and that significant changes to the shape and construct of our teams across the system would be necessary. |
| 10.9 | The Board debated the relationship of Health & Wellbeing Boards (HWB) and with that of Strategic Commissioning functions and it was confirmed that further clarity would be required as well as ensuring appropriate provider representation and influence at HWBs. SA briefed the Board on the change in approach taken by the Portsmouth and South East Hampshire system in relation to the traditional '30th September' contracting letters. |
| 10.10 | DM emphasised the importance of integrating mental health provision with clusters and reinforced the role Solent has in this respect. |
| 10.11 | AS commented that the paper is not written in an 'accessible information' format and it was acknowledged that the STP would need to ensure appropriate community engagement to ensure appropriate description of patient outcomes as a result of the reforms.<br>**The Board endorsed the System Reform Proposals and agreed that points discussed and views from the Board would be fed back to the STP via SH. Action: SH** |
| 10.12 | <u>CEO Report</u><br>The Board discussed the use of theatre space for Dental and when a decision can be expected. DN reported that a date is currently unknown however, provided assurance that additional capacity has been identified within Portsmouth Hospitals Trust. SH suggested utilising existing theatre down time across Hampshire and the Isle of Wight and to escalate through the STP. It was agreed that an executive review is conducted and fed back to the Board. **Action: SH** |

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| 10.13 | It was agreed to reconsider the presentation of Appendix 2, risk analysis in future reports.<br><br>In relation to sub-scale services and the system reform proposal, JPi asked how sustainable services can be within a small cluster. SA reported that a multifaceted approach is being taken to consider where services should operate. A full report is to be presented to the Finance Committee.<br>**The Board received the CEO report, System Reform presentation and further updates.** |
| **11** | **Portsmouth & South East Hampshire Operating Plan 2018/19** |
| 11.1 | SA presented the Local Care Partnership (LCP) Operating Plan for 18/19, a single plan for Portsmouth and Hampshire with a statement of combined intent.<br><br>The Board was informed of work being undertaken by Portsmouth Councils, Solent and Primary Care on winter planning.<br><br>A target achievement to reduce the number of people in hospital that are fit to leave was noted.<br><br>SA briefed the Board on the intensions of a different approach to create the 19/20 Operating Plan. |
| 11.2 | SA briefed the Board on the Mental Health programme options including the creation of a Mental Health Assessment Unit at the Portsmouth Emergency Department, cluster work and care home input to avoid inappropriate admissions, and a maternity and children's programme. SA reported that all programmes are related to Solent transformation programmes. Work is in progress to improve governance arrangements around all programmes in Portsmouth and Hampshire.<br>MT commented on the assistance of the Lay Members and Non-Executive Directors with governance arrangements. |
| 11.3 | AMS asked if the term cluster is used in Portsmouth. SA confirmed different terminology used, including 'Neighbourhoods' however highlighted that the description is a secondary consideration. |
| 11.4 | SH suggested that the Board reflect moving forward on Southampton and South West Hampshire and link into the system reform conversations.<br>**The Board received the LCP Operating Plan for 2018/19 and further update.** |
| **12** | **Performance Report** |
| 12.1 | AS confirmed good progress made with regards to objectives and milestones. |

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| 12.2 | <u>Operational - Portsmouth</u><br>• SA highlighted an unusual high number of reported Information Governance (IG) incidents within Portsmouth however explained that incidents were in relation to staff identifying the risk of a breach rather than a breach occurring. The need to remind all staff of reporting responsibilities was noted.<br>• Since 136 suite figures reported to the Assurance Committee, SA reported there to be 2 breaches relating to delays in Hampshire. It was noted that ongoing concerns with the current secure transport provider have been raised and will be escalated to NHS England if assurances are not provided. |
| 12.3 | <u>Operational – Southampton</u><br>• DN informed the Board of an outstanding result achieved following a recent CQC inspection within the local authority area of the Urgent Response Service. DN confirmed that the Trust has passed on gratitude as a partner organisation.<br>• The procurement of a mobile theatre for Special Care Dental Services is being considered.<br>• DN reported on a reduction to the number of single chair clinics in the East Podiatry Service and increase in appointment times for more complex cases.<br>• Success in the recruitment of emotional support workers for CAMHs and numbers seen has improved. |
| 12.4 | <u>Quality</u><br>• JA reported on a recent well attended End of Life Framework Workshop that was joined by the parent of a child who died within a Solent service.<br>• It was noted that PLACE results and data on visits are to be reviewed to consider how feedback can be acted upon.<br>• The Board was informed of review of training with Tissue Viability Leads and a change made to the grade of pressure ulcers recorded following new national guidance. |
| 12.5 | <u>Finance</u><br>• AS confirmed that the Trust continues to forecast on plan.<br>• AS informed the Board of Finance Committee discussions regarding NHSi incentive schemes that allow organisations to declare better than plan. It was noted that the Committee reached a decision that the scheme was not appropriate for the Trust. |
| 12.6 | <u>Workforce</u><br>• Staffing issues continue due to national shortages of certain roles.<br>• HI reported a reduction in staff absences by 2% and a reduction in nursing turnover to 16.9%.<br>• HI informed the Board of the significant number of new nurses attending joining the Trust that will hopefully assist in developing a positive culture to encourage people to join the Trust.<br>• A 71% uptake of the flu vaccination with a target of 75% was noted.<br>• 90% of statutory training has been achieved due to team efforts across the organisation.<br>• The Trust has invested in a new trainer for the Mental Capacity Act (MCA).<br>• There are currently 63 apprenticeships within the Trust, 25 of which are clinical roles. |

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| 12.7 | <u>Leadership Programme</u><br>HI briefed the Board on the key principles of the 'Becoming a Great Place to Work' programme; being a values-based and people-centred organisation in which people can thrive and are liberated to do their best work. Support received from MW was acknowledged.<br><br>HI commented on the commitment to leadership and Board development. |
| 12.8 | MT referred to the appointment of an MCA trainer and how it will ensure practitioners continue to be competent with their assessments. It was noted that just one incident of a Deprivation of Liberty (DOL) application was not authorised, indicating Trust competence in the process. The Board discussed the training effectiveness. |
| 12.9 | Regarding the Friends and Family Test, MT requested further information on what the responses received were in addition to the numbers provided. It was confirmed that further information will be reported to the November Board. |
| 12.10 | Reflecting on the positive and innovative practice demonstrated by the Sexual Health Team at the recent Community Engagement Event RC queried whether similar technology could be applicable to other services, which would increase accessibility. It was acknowledged that where appropriate, and with commissioner support, this should be explored. |
| 12.11 | SH asked how risks associated with unavoidable pressure ulcers are managed. JA reported that the recent increase occurred during the heatwave however acknowledged the need for further improvements. |
| 12.12 | FD referred to a recent End of Life Seminar attended and the noticeable impact on staff working. |
| 12.13 | SA provided reassurance that the waiting time for first appointment to the CAMHs service is below 3 weeks. Longer waits reported are for a second visit.<br>**The Board noted the Performance Report and further update.** |
| **13** | **Quality Framework** |
| 13.1 | Presentation provided. JA provided a background on the work undertaken to create the Quality Framework and explained it to be a simplified replacement for the original Quality Improvement Framework. |
| 13.2 | MT requested changes to the description given to people who use Solent services, as opposed to clients/patients. **Action: JA**<br>MT also suggested moving the reference to the intrinsic way practitioners are working to the framework as part of their daily lives, to earlier in the document. |
| 13.3 | FD suggested that the Quality Framework and Engagement Framework be connected in the future. JA agreed.<br>**The Board approved the Quality Framework.** |
| **14** | **A Framework of Quality Assurance for Responsible Officers and Revalidation, Annual Board Report and Statement of Compliance** |

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| 14.1 | DM provided assurance that 100% of doctors have either completed a revalidation or have good reasons for not doing so. It was noted that the process with-stood external scrutiny last year and improvements in the process are continuing. |
| 14.3 | AS referred to Appendix C and queried the terminology regarding concerns associated with doctors' practices. DM provided assurance that there are no concerns to report.<br>**The Board received the Annual Board Report. The CEO agreed to sign the Statement of Compliance for sending to NHS England.** |
| **15** | **Freedom to Speak Up (F2SU) Assessment** |
| 15.1 | MS briefed the Board on the recent meeting held with SH and JPi to review how the Freedom to Speak Up process has embedded and to consider the recruitment of an independent guardian.<br><br>MS briefed the Board on the recent self-assessment and key findings.<br><br>MS reported on the need to consider the strategy going forward and ensure F2SU runs as part of the development programme and not in isolation. |
| 15.2 | JPi commented on the significant amount of time spent by MS to reach achievements to date. JPi also highlighted resource implications in providing assurance of process.<br>**The Board agreed to: The recruitment of an independent lead guardian 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.** |
| 15.3 | SH informed the Board of MS's departure from the Trust in October and thanked her on behalf of the Board for her hard work and leadership of F2SU. |
| ***Reporting Committees and Governance matters** | |
| **16** | **NHS Constitution Compliance** |
| 16.1 | Since circulation RC informed the Board of additions to be included in relation to Equality, Diversity and Inclusion evidence and suggested that the conclusion concerning 'Value for Money' be caveated acknowledging that whilst the organisation ended its year end position for 2017/18 in surplus, a Section 30 to the Secretary of State was issued by the Trust's External Auditor.<br><br>**The Board approved this approached and noted the content of the report presented as assurance that the Trust is compliant with the legal requirement to take account of the NHS Constitution in provision of its NHS services.** |
| **17** | ***Audit & Risk Committee** |
| 17.1 | JPi highlighted an amendment required on page 1 of the report that should have confirmed there to be 'no' conflict of interest arising from the support provided by PWC to assist with CQC preparation.<br><br>JPi informed the Board of a deep dive of the Risk Management Framework received and shared his confidence in improvements being embedded. |

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| 17.2 | AMS suggested that internal audits should focus on areas with a likelihood of identifying issues in order that the Trust can learn and improve.<br>**The Board noted the Audit and Risk Committee exception report and Risk Management Framework implementation update.** |
| **18** | ***Assurance Committee Chair's Update** |
| 18.1 | MT provided a verbal update of the September 2018meeting.<br>• The Committee focused on changes to the investigation process of the Learning from Deaths Quarter 1 report.<br>• The Annual Complaints Report was presented and a comparative breakdown of overall feedback received both positive and negative was shared as well as examples of service changes as a consequence of learning. The report is available on request.<br>• A quality impact due diligence assessment report of the Isle of Wight Community Dental Service was received and the committee concluded their support in relation to the mobilisation of the service. |
| 18.2 | The Committee approved the following policies:<br>• Hot Desk/Shared Desk Policy<br>• Sustainability Policy<br>• Procurement and Credit Card Policy<br>• Healthcare Workers Screening and Immunisation Policy<br>• Staff Recognition/Reward Policy<br>• Learning and Development Policy<br>• Health & Safety Policy<br>• Access & Transport Policy<br>• Drug, Alcohol and Substance Misuse Policy<br>• Lone Working Policy |
| 18.3 | AMS referred to the Learning from Deaths report, requesting more information regarding the reference to close partnerships' unavailability in some geographical areas. DM explained the issue and of the need to established a similar way of working as in the West. |
| 18.4 | SH informed the Board of a meeting on 25th September to specifically review the IOW Dental Quality Due Diligence Report and to seek assurance in relation to mitigating actions. The Board will then be informed of the CEO's perspective in relation to proceeding. **Action: SH**<br>**The Board noted the Chair's update, Learning from Deaths report and endorsed the policies approved by the Committee.** |
| **19** | ***People and OD Committee** |

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| 19.1 | • MW reported on Committee discussions regarding the retention issues and workforce plans at cluster level. Potential improvements to problem solving across organisations were highlighted.<br>• The Committee considered marketing methods and an improvement in mandatory training compliance was noted.<br>• A pleasing diversity report was received by the Committee.<br>• Given concerns of the BAF risk regarding sustainable workforce, the Committee agreed to receive a further deep dive at a future meeting. A future deep dive on the use of rostering was also agreed.<br>**The Board noted the verbal update.** |
| **20** | ***Charitable Funds Committee Minutes & Chairs update** |
| 20.1 | FD informed the Board of a joint partnership working proposal received. It was noted that more time is required to digest and understand the proposal. Slow progression in future arrangements was acknowledged. |
| **21** | ***Complaints Review Panel** |
| 21.1 | JA informed the Board on behalf of SE, that it was agreed to review of the Terms of Reference due to changes in the approach of complaint reviewing in order to ensure a balance across service lines. |
| 21.2 | AMS asked if resolutions are being sought by services rather than automatic escalation through the formal complaints process. JA confirmed an increase in the number of local resolutions achieved and of a trial in progress in Children's Services to seek agreement of complaints responses with the complainant. Further improvements to escalation numbers are expected. It was noted however that all formal complaint requests are fully respected.<br>**The Board noted the update.** |
| **22** | ***Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs Update** |
| 22.1 | MT briefed the Board on the review of S136 following a reduction in assessment time. The Board noted Richard Brown's appended report that provides a clear indication of robust planning and partnership working. MT commented on other mental health providers experiencing far more challenges and commended the work of the Solent Mental Health Team in their partnership working across Hampshire. AMS highlighted the excellent work achieved by management and clinical staff. |
| 22.2 | FD highlighted his concern regarding a possible pre-screening case raised during a recent Managers Hearing. SH shared her assumption of positive intent however agreed to make further enquiries regarding the issues raised. **Action: SH** |
| **23** | ***Governance and Nominations Committee update** |
| 23.1 | *No meeting held since last report to Board.* |
| **24** | **Finance Committee – Scheme of Delegation** |

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| 24.1 | AS informed the Board of a minor change to page 29 of the Scheme of Delegation as agreed by the Finance Committee.<br><br>RC requested further amendments of the SoD to include reference to the People and OD Committee and soon to be established Community Engagement Committee and to remove reference of the soon to be disbanded 'Members' Council'. The Board agreed that the updated document be approved via Chair's action. **Action: RC/AMS** |
| **Any other business** | |
| **25** | **Reflections – lessons learnt and living our values** |
| 25.1 | The Board reflected on the meeting and individual opinions were shared on the patient and staff stories. It was agreed that future agendas state if a Powerpoint presentation is to be provided. |
| **26** | **Governor comments and questions** |
| 26.1 | There were no Governors in attendance. |
| 26.2 | The CQC representative in attendance commented from a member of the public's perspective that the meeting was very patient focussed, transparent and was kept simple. |
| **27** | **Any other business & future agenda items** |
| 27.1 | No further business was discussed and the meeting was closed. |
| **28** | **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 |
|---|---|---|---|---|---|---|---|
| 623 | 24/09/2018 | 4.3 | Board Reflection on patient story and staff story and discussion | Jpi commented on the proudness and passion presented by staff who attended the Board and requested that this is formally provided as feedback to the teams, together with thanks for the Board. It was agreed that JA and DN send thanks in writing to the teams and include information on what the Board has learnt as a consequence. | JA/DN | | **November update:** Action complete |
| 624 | 24/09/2018 | 10.2 | CEO Report - Hampshire and IoW Sustainability and Partnership Reform Proposal | AS commented that the paper is not written in an 'accessible information' format and it was acknowledged that the STP would need to ensure appropriate community engagement to ensure appropriate description of patient outcomes as a result of the reforms. The Board endorsed the System Reform Proposals and agreed that points discussed and views from the Board would be fed back to the STP via SH | SH | | **October update**: Complete |
| 625 | 24/09/2018 | 10.13 | CEO Report - Dental Theatre Space | The Board discussed the use of theatre space for Dental and when a decision can be expected. SH suggested utilising existing theatre down time across Hampshire and the Isle of Wight and to escalate through the STP. It was agreed that an executive review is conducted and fed back to the Board. | SH | | **November update:** DN is to provide a briefing paper on the current status for sharing with the Board. |
| 626 | 24/09/2018 | 13.2 | Quality Framework | MT requested changes to the description given to people who use Solent services, as opposed to clients/patients. | JA | | **November update:** to be included in the next report. |
| 627 | 24/09/2018 | 18.4 | Assurance Committee | SH informed the Board that a meeting on 25th September to specifically review the IoW Dental Quality Due Diligence Report and to seek assurance in relation to mitigation actions. The Board will then be informed of the CEO's perspective in relation to proceeding. | SH | | **November update**: Complete |
| 628 | 24/09/2018 | 22.2 | Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee | FD highlighted his concern regarding a possible pre-screening case raised during a recent Managers Hearing. SH shared her assumption of positive intent however agreed to make further enquiries regarding the issues raised. | DM | | **November update:** Action dealt with at the Mental Health Scrutiny Committee. Complete. |
| 629 | 24/09/2018 | 24.1 | Finance Committee - Approval of the amended Scheme of Delegation | RC requested further amendments of the SoD to include reference to the People and OD Committee and soon to be established Community Engagement Committee and to remove reference of the soon to be disbanded 'Members Council'. The Board agreed that the updated document be approved via Chair's action. | RC/AMS | | **October update**: Action complete |
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## Board Report – In Public Meeting

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|---|---|---|---|---|---|---|
| **Title of Paper** | **Board to Floor Visit Update** | | | | | |
| **Author(s)** | Ellie Lindop Head of Patient Safety | | **Executive Sponsor** | | Jackie Ardley Chief Nurse | |
| **Link to strategic Objective(s)** | Improving outcomes<br>Working in partnership | x<br>x | Ensuring sustainability | x | | |
| **Link to CQC Key Lines of Enquiry (KLoE)** | Safe | x | Effective | x | Well Led | x |
| | Responsive | x | Caring | x | | |
| **Date of Paper** | November 2018 | | **Committees presented** | | | |
| **Action requested of the Board** | To receive | x | For decision | | | |

### Purpose

The purpose of this paper is to provide an overview of the Board to Floor visits.

The Board to Floor visits provide an opportunity for staff to speak with Board member's directly about their experience of working for the Trust. They also provide an opportunity for members of the Trust Board to discuss at the frontline any potential patient safety or issues of concern from staff and on some occasions patients and visitors.

From April to September there were 6 visits undertaken across the Trust.(See Appendix 1 for summary). Visits are monthly as previously agreed and all were completed as planned

For all visits undertaken, Board member feedback has highlighted that they have received a warm and friendly welcome at each visit and staff have viewed the visit as a positive experience.

### Themes of the Board to Floor Visits

The top three key themes arising from the Board to Floor Visits highlighted the following:

- A warm and welcome reception by all teams visited.
- Staff demonstrated and described their passion and commitment to providing a great service.
- The focus of all areas to improve the service provided to ensure patients receive the best care possible.

The Board visits also provide an opportunity for staff to discuss current challenges with Board members and the following themes were noted:

- Estates challenges regarding location, fit for purpose and cleanliness were highlighted.
- Car parking challenges have been noted and the impact this can have on staff morale.
- Information Technology continues to be a challenge for some services, including systems access and printer access.

Key observations and outcomes from each visit are highlighted in appendix 1 and these outcomes are shared with relevant services for any relevant actions.

A new approach to Board to Floor visits is currently being piloted and two were undertaken for Adults Southampton. The Royal South Hants wards were visited and the feedback provided was that staff were "…passionate, positive and proud". The East Sensory services and Admiral Nursing team were visited and the feedback on discussions held as follows:

- the benefits of being integrated and of being co-located with Community Matrons
- a discussion re referral sources and the need for increased awareness of our service so people are seen early on before they fall and injure themselves, or develop other problems
- a discussion re social isolation and loneliness and the impact this has on health and wellbeing, and the reduction of services out there to support people
- the cluster work and links with GPs
- the innovative work Sensory services have been doing since integration and a Rehab Support Worker described his role in working with people with visual impairment to regain their independence
- Admiral Nursing and the work they do with carers of people with dementia, and their links with Dementia UK

It is anticipated that following feedback a new style of visits would commence from January 2019.

**Conclusion**

The visits continue to be well received by the services visited and staff have provided feedback that they have enjoyed sharing the good work as well as the challenges that they are facing directly with the Board.

**Board Recommendation**

The Board is asked to receive the report and note the outcomes.

**Appendix 1**

**1.Adults Portsmouth – Learning Disabilities**

| Observations | Good Practice highlights | Challenges discussed |
|---|---|---|
| • The team are passionate and dedicated to providing an excellent service<br>• Patients truly valued throughout and involved in the development of the service.<br>• The team are innovative and consider alternative means to gain feedback and suggestions for future development | • The service has a volunteer group<br>• Positive feedback about initiatives taken in regards to training<br>• In volunteer recruitment, the volunteers lead the process.<br>• Team are leaders in co-production work and are proactive in ensuring that patients are involved in any change or service delivery | • High referrals into the service, consideration required of ways to educate the wider community and referrers to ensure referrals are appropriate and make best use of the service.<br>• How the learning from this service be transferred to others to achieve high standards, co-production, integrated working.<br>• The need to capture the full extent of work that is undertaken by the team.<br>• Printing concerns and access to G drive are longstanding issues re IT with no resolution currently in sight.<br>• Building appears not in use from the outside-cobwebs and dusty externally. The team, have raised concerns regarding cleanliness of the building in general and infection control are also aware. |

**2. Adults Southampton- Vocational Rehabilitation**

| Observations | Good Practice highlights | Challenges discussed |
|---|---|---|
| • There is also good communication networks with GP's and Crisis contacts in Southern if further referrals are required.<br>• It was highlighted that the service is unique to the surrounding area, as it is the only team who work with neurological patients who often have both cognitive as well as physical problems. The service users are diverse, but it was noted that the main caseload is male and risk taking behaviours were cited as the most common reason for this.<br>• On review of the estate, it is isolated in position and the | • The team have a service user forum and advised re the multiple agencies they also work with as part of the rehabilitation process, including the job centres and the voluntary sector. There is a Monthly psychology group in place.<br>• Two cases were highlighted as good news stories. One involved a young man who was a service user for 14 months who following traumatic injuries was unable to walk, work or see a future for himself. As a direct work that the team had undertaken, he is now working, maintaining a social life and able to see he has a future.<br>• The second story was a young man whom they visited at home initially who was in a wheelchair. The team have supported him to mobilise independently-this case has been shared via the Shine magazine. | • How to improve communication when there are issues regarding estates and maintenance which also has an impact on the delivery of service.<br>• Improve approach to reporting incidents-alongside the escalation in service. The service would also benefit from a review of current escalation process and actions taken as this appeared unclear from the discussions today.<br>• Consider how to measure outcomes-link with NICE guidelines. It was suggested that the team consider the Meridian system which is already utilised for FFT but has other capabilities.<br>• Consider /explore future opportunities for the development of the current work with acute providers and how this work could be developed for functional neurological work. |

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| general estate appears poorly maintained (Solent NHS Trust are not the landlord of this premises). | | |

**3. Adults Mental Health-Brooker Ward**

| Observations | Good Practice highlights | Challenges discussed |
|---|---|---|
| • Patient's rooms had personalised signs (developed with support of the ward occupational therapist.) Clean Rooms and some patients had tried to make it more homely and welcoming<br>• Patients, introduced and permissions always sought to enter their rooms.<br>• Developments and changes that have been implemented since the last CQC inspection, a recent review by NHSI had been undertaken as an external review and feedback had been positive to date**.**<br>• On entry to the ward, a notice board highlighted positive outcomes/practice and also identified staff to celebrate positive feedback. | • Work had been undertaken to improve the team engagement and communications and they were now working more closely with their AMH colleagues. An example of the team involvement in improvement was the recent SOP to address concerns relating to the use of the garden.<br>• Electronic care plans have been further developed with staff and are currently being piloted.<br>• Reduction in inappropriate referrals (transition) following the creation of a new document by the clinical director. A new process for screening patients before acceptance has been also been introduced.<br>• Medical cover of the unit was described as good and noted that they had 2 "excellent SPR's". This d was noted as action required following previous SI/HRI reports.<br>• Increasing number of dual registered nurses recruited over the last 3 years and the positive benefits of employing staff with multiple speciality skills.( Adult and a Learning Difficulties nurse) | • Team need to be mindful of privacy and dignity issues.<br>• To review Trust policy and guidance regarding clinical supervision on the staff.<br>• Service considering discussion with a local newsagent as to whether they would be happy to provide a few copies of papers (they usually return unsold copies to the supplier). |

| 5. Child and Family Services (West)-Looked After Children | | |
|---|---|---|
| Observations | Good Practice highlights | Challenges discussed |
| • There are approximately 530 children on the caseload. The team also provide home visits if there are additional challenges and cover the Bournemouth and New Milton area.<br><br>• When a child visits the team, they receive a medical development assessment. For older children, the team provide a Building Resilience programme which focuses on sexual health and life skills. Some patients have complex needs, so the team liaise very closely with other internal and external teams. | • There is a team member who acts as the link between Solent NHS Trust and Southampton City Council. She is based with the team for one day each week, but she will soon be leaving for maternity leave. This role is a Southampton City Council post, but is jointly funded with Solent NHS Trust. The team are committed to retaining this vital connection.<br>• SystmOne enables good communication with other teams. | • Link worker communication<br>• DNA challenges<br>• Social – paperwork in order<br>• Staffing<br>• OOA patients<br>• Breaches in the 28 day target due to patients not attending appointments (especially appointments at the end of the month) and there being little time left to reschedule.<br>• Within 28 days of a child entering care, they are seen by the team. However, the team are experiencing challenges in meeting these deadlines due to Social Workers not preparing documentation in a timely manner prior to the appointment |
| **4. Primary Care- Muscular Skeletal Service, Adelaide Health Centre** | | |
| Observations | Good Practice highlights | Challenges discussed |
| • The clinical staff reported they feel very supported by their manager and really enjoy working for the service.<br>• Portsmouth and Southampton Services are commissioned differently, with Southampton providing a service to Primary Care; Southern Parish's and post trauma patients from UHS. Portsmouth provides a post op trauma service. | • The service acknowledges there is lots of excellent work happening, but are not currently sharing this on social media.<br>• Staff have participated in the QI programmes and are allocated time to complete clinical effectiveness work which includes audits. The service has several improvement groups and staff engagement is good. | • The service has an increase of complex patients Continued IT issues.<br>• They would like support to develop their services part of Solent's external website, they feel they have a lot of information that would benefit patients to have access to and require support from Communications team to do this, they have asked for support but this has not yet been provided.<br>• The service is missing the designated HR Business Partner role.<br>• The premises are a challenge; the atrium is large and visually cold. A larger or second gym who would very beneficial as the service shares the gym with neuro, |

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| | | pulmonary rehab, COPD and the pain team. They are aware of possible changes in the future to the premises but these were put on hold a while ago. They would value an update on the future building plans.<br>• There is no security present during the day, an issue that was raised at the last Board to Floor. Staff are experiencing an increase of verbal aggression.<br>• Clinical staffing is a challenge, the service have rotational posts for band 5 Physiotherapist that are shared between PHT and Solent. Nationally there is a shortage of newly qualified physiotherapists.<br>• There are concerns about the STP plans; staff working in different care groups and the difficulty this will pose for staff cross cover. |
| **6.Sexual Health Services-Oak park** | | |
| Observations | Good Practice highlights | Challenges discussed |
| • The site, which Solent rents certain areas of, was clean and very well maintained. | • The service has their own safeguarding processes and two specialist safeguarding lead nurses – East and West. To raise an alert, staff complete a risk assessment tool on the electronic patient record system and escalate to safeguarding lead nurses.<br>• In response to a service target set by the CQC, all under 18 year old patients are risk assessed and if necessary they are referred to MASH (Multi Agency Safeguarding Hub) or the R.O.S.E Clinic (Risk of Sexual Exploitation). | • Service to liaise with SPA to ensure that phone consultations are being offered to patients who would like to discuss contraception options prior to appointment.<br>• Access of clinics and the appointment booking system via SPA<br>• Awaiting confirmation of next year's training budget |

**Item 10**

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|---|---|---|---|---|---|---|---|---|
| ***Title of Paper*** | CEO Report – November 2018 | | | | | | | |
| ***Author(s)*** | Sue Harriman, Chief Executive Officer | | | | | | | |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | X | **W2** Vision & Strategy | X | **W3** Culture | X | **W4** Roles & Responsibilities | X |
| | **W5** Risks and Performance | X | **W6** Information | X | **W7** Engagement | X | **W8** Learning, Improvt & innovation | X |
| ***Date of Paper*** | 19th November 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

### Board Succession Planning - Chair

Our Chairman, Dr. Alistair Stokes, will be retiring at the end of March 2019, which will be the natural end of his tenure. Alistair has been our Chair since the Trust was established in 2011 and prior to that in its predecessor form. In readiness for Alistair leaving we have initiated a recruitment process and will be holding an assessment centre in mid-December where key stakeholders will be invited to meet applicants, prior to interviews being held, led by NHS Improvement in early January 2019. We would like to formally thank Alistair for his support and commitment to the Trust in the last 9 years and wish him well in his future endeavours.

### Care Quality Commission, CQC

We were excited to welcome the CQC last month when they undertook both announced and unannounced core service inspections, within our Child & Family Services and Adult Community Services in both Southampton and Portsmouth during 9-11 October, and within our Primary Care and Mental Health Services during 16-17 October. Earlier this month (6-8th November) the CQC also conducted our Well Led inspection where a number of our Senior Leadership Team and Board members met with inspectors.

I would like to personally thank everyone for their efforts from across the organisation and to our partners for their support to ensure we showcased *the difference* we make. I was, and remain, incredibly proud and moved by what I heard and saw during the time CQC colleagues were with us. The inspectors heard many stories of the great work that people do to keep people safe and well in the community, and they were incredibly positive about the people who work in Solent. Thank you for making them feel so welcome.

We believe our staff were proud, passionate and honest during our inspection and we look forward to reviewing our draft report, which is expected pre-Christmas where we will undertake a factual accuracy check, prior to the report being published in January 2019.

### Visit from NHS England

On 22nd October we hosted a visit from Emma Self, Community Nursing Lead, NHS England. Emma received presentations from both our Portsmouth and Southampton community nursing teams. Emma spent the afternoon out with the Southshore Community Nursing Team. Her feedback was very positive and she said it was a real pleasure to meet and spend time with the teams. She was particularly impressed with a capacity and demand tool which is in development and has encouraged the team to share it with the 'Leading Change, Adding Value' team for inclusion in the Atlas of shared learning as a case study. The team are taking this forward currently.

## Nursing Times Award – A celebration of Nursing Achievements

I am delighted to share that at the Nursing Times award ceremony on 31st October two of our nurses were recognised for the excellent work they do and the leadership they provide.
Debbie Fudge, Tuberculosis Liaison Nurse, won the Infection Prevention and Control Award. She was nominated in this category for her pioneering work in moving tuberculosis (TB) screening into GP surgeries, helping GPs to identify and screen people at risk of latent disease. In the two years the team has screened 1,350 people. 202 of the people screened have received a positive result. Treatment for these people will mean that they are unlikely to get the active disease, and the screening should help to reduce down the rate of TB in Southampton.

Sharon Simpson, Older Person's Mental Health Research Nurse, won the Clinical Research Nursing Award. Sharon was nominated in Clinical Research Category for the work she has done in introducing research in care homes. Working in partnership with care home staff and families, the research has given a voice to those who are seldom heard. To date, 500 participants have been recruited to a number of different studies. The research in care homes supports our ambition to offer more people more opportunities to be involved in research in the community.

I am incredibly proud of Debbie and Sharon, and thrilled that they have been recognised and awarded for their dedication, passion and innovation. The awards are a real accolade and recognition of the commitment both Debbie and Sharon show to patient experience and outcomes. The awards, once again, recognise the leading role we play in community and mental health research and the innovation and passion we demonstrate in out of hospital services.

## E-prescribing update (Ref to Operational Risk Register - IT)

The Trust is committed to moving towards an e-prescribing solution across our services which will need to be compatible with the electronic patient record systems that we and our partners use, as well as with the dispensary systems that we are developing.
We are in the process of analysing our options in relation to an e-prescribing solution, particularly given the desirability of working with other providers within the Sustainability & Transformation Partnership.

## Wheelchair Update (Ref to BAF# 63)

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. Millbrook Wheelchair Service (MWS) have confirmed that the Duty of Candour letters in relation to those patients where harm has been caused should not be a joint letter and should go from MWS who are the service provider. The letter will be sent after Millbrook have met with the patients concerned (where harm was caused) and they will also write to other patients that were contacted during the trend SIRI review. The Trust is in the process of issuing a Duty of Candour letter for all patients on the waiting list, clearly identifying how to contact MWS (the leaflet provided by MWS will be included). The letter will include how we can support our patients while they wait and how they can escalate if their needs change. On-going governance and management continues, clinical leads respond to patient queries with regard to clinical care provided by Solent and liaise with MWS on a patient by patient basis.

## Southampton and County Services

### Adult Southampton (Ref to BAF# 59)

Our performance within our Domiciliary Phlebotomy Service continues to stabilise as the Contract Performance Notice actions are worked through. We are achieving 100% of urgent referrals within timescales, and an average of 91% for our routine patients. Of the 11 actions identified in the recovery action plan, 6 are now complete, 4 are on track, with one action (concerning the collection of staff & patient feedback) overdue because, although the staff feedback is now collected bi-monthly, we are still developing a process for collecting patient feedback.

### Primary Care / MPP service line

The East Podiatry Team held team building days during September and October which enabled the service to focus on key risks and issues such as the challenges associated with a highly complex case mix, patient pathways and the reporting of concerns. Despite the challenges being faced by the service, the Team are continually reviewing incidents and have no evidence of deteriorating performance. (Ref to BAF# 59)

We continue to be challenged to recruit to GPs within the GP Surgery, however, a number of applications have been received for our Associate Nurse Practitioner posts. The service held a 'future workforce workshop' on 8 November with GP colleagues to consider and identify innovative ways to ensure on-going sustainability into the future. (Ref to BAF# 55 and Operational Risk re: Workforce)

The Musculoskeletal Service (MSK) continues to experience pressures where demand, across the region, continues to outstrip projected (and contracted) activity – impacting on our performance targets. The service is also experiencing higher than anticipated diagnostic activity which is causing a cost pressure. We are engaging with commissioning colleagues to address this and to consider sustainable solutions. (Ref to BAF# 59)

We continue to experience a small number of failed telephone calls when patients contact our GP surgery despite conducting numerous 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, as well as improving patient experience. (Ref to Operational Risk Register re: IT)

### Children and Families (West)

We continue to experience estates challenges within the Eastleigh and Southern Parishes geography. 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). Options for alternative accommodation continue to be sought, with the potential for utilisation of space at Fareham Community Hospital now being explored, albeit this is not ideally located for the geography. (Ref to BAF# 27)

We remain in discussions with Commissioners regarding the potential replacement for the Child Outreach Assessment Support Team (COAST) service. Colleagues in the wider Hampshire system are expressing an interest in also participating, which is welcome.

Performance against the target set in our Child and Adolescent Mental Health Service (CAMHS) West has unfortunately deteriorated in the last reporting period, largely due to the team focusing on the current waiting list. However, we are on a recovery pathway and the team are prioritising both urgent appointments and those waiting the longest. (Ref to BAF# 59 and Operational Risk Register re: Clinical capacity)
Commissioners have also agreed additional resourcing investment over the next few months to help improve performance. Two new managers also start during December 2018.

The CAMHS team have been engaged in a number of in-reach activities with local schools including;

- Supporting World Health Day at Bitterne Park School, and
- Targeting Year 6 pupils around transition at three primary schools, via a bus

The team have also been engaging with Re:Mind (parents group) to target families on the waiting list – this partnership involves bi-monthly meetings with training and support.

### Special Care Dental Services

As a result of an options appraisal paper to seek to address the ongoing performance concerns we have with regard the number of patients on the waiting list for General Anaesthetic treatments, we are taking action to re-assess patients from the north and west of the county, and allocate space at our Poswillo site (co-located with PHT) for those suitable. We are also in negotiation with Royal Surrey about theatre capacity which could service patients in the north of the county. (Ref to BAF# 59)

We have now successfully mobilised to take responsibility for the delivery of special and occasional dentistry on the Isle of Wight.

## Portsmouth and SE Hampshire Care Group

### Portsmouth Mental health - staffing (Ref to BAF#55 and Operational Risk Register re: workforce)

The top risk in mental health services remains "staffing", as a result of nationwide shortages of qualified nurses and psychiatrists. Solent currently has 7 WTE inpatient mental health staff nurse vacancies and 5WTE Psychiatrist vacancies and we are actively engaged in recruitment activities for these positions and considering alternative staffing models where we know there are national shortages. Safety and service continuity is maintained by the use of long-term agency staff, who are trained and supervised alongside substantive colleagues. Recruitment efforts

and social media campaigns yielded some success, with the appointment of 11 WTE staff nurses to inpatient wards this financial year; however only 1 new Staff Nurse commenced in September and there are no appointees now waiting to start. With our current knowledge of planned starters, leavers and internal transfers, 7 vacancies will remain at the end of January 2019. This is a further improvement of 1 WTE over last month's forecast, but further improvements are unlikely in the short-term, since no cohorts of students are due to complete training until July 2019. A further risk has emerged, as Southampton University reported that only 11 students joined the mental health nursing programme in 2018. Around 35-40 mental health nurses retire from the NHS in Hampshire each year; so it is increasingly clear that strategies that rely on UK nurse recruitment will become increasingly ineffective and should not be the mainstay of any workforce plan.

We continue with implementation of the Assistant Practitioner development programme, which aims to replace some vacant registered nurse roles with suitably trained support workers. Under the current workforce plan – 1 Health Care Support Worker (HCSW) is already in a position to commence the role, with suitable support and 10 further internal candidates for training have also been identified, with competencies training being delivered alongside foundation degree intake from March 2019. This investment in HCSW career development has been widely welcomed by this staff group. Further work will be undertaken in November 2018 to focus on non-academic routes to Band 4 support roles, following the success of these posts in Portsmouth Rehabilitation and Reablement Team (PRRT) and Adult Community Nursing.

### Portsmouth Adult Services – Agency Use in Community Nursing (Ref to BAF#55, #59 and Operational Risk Register re: workforce)

Our vacancy position is slightly improving. At present Locality teams have 9 WTE Band 5 vacancies - equating to 18% of frontline qualified nursing resource (Band 5 and 6). This causes a capacity pressure of around 90 visits a day, for core qualified nurse skills. The current deficit, with sickness and vacancies combined is around 13WTE staff. Safety and capacity is maintained by continuous senior nursing review of workload allocation and prioritisation and by "catching up" of non-priority visits at weekends when acute demand is lower. A bank co-ordinator has now joined the team with responsibility for optimising shift fill.
The staffing position will improve during November with two new community Band 5 starters commencing. Regular caseload review is also taking place to ensure that the team remain focussed on priority patients and are ending care episodes at the right point in recovery. This will be enhanced by an eligibility criteria review during November, which will help staff and referrers definitively agree which patients should receive a service.
A review of rostering during October has improved permanent staff deployment against harder to fill shifts. The service plans to use no off-framework agency from 1st November 2018.

### Portsmouth Adult Services – Jubilee House Length of Stay pressures (Ref to BAF#55, #59 and Operational Risk Register re: workforce)

A combination of staff absence, internal administration processes and health and care assessment delays has led to discharge lengths of stay deteriorating to 51 days during October. Bed availability has only been maintained by the fact that the extended End of Life team are now able to offer more capacity in people's homes. The current length of stay compromises system resilience plans, which rely on Jubilee as a discharge destination for 4 "Closing the Gap" beds and an additional 5 "surge capacity" beds. The Clinical Director and Inpatients Specialist Lead have commenced a rapid improvement project – revisiting the findings of a "Red to Green" initiative earlier this year and agreeing actions to tackle delayed discharge decision making on the unit.

### Portsmouth Adult Services – Pulmonary Rehabilitation Waiting Times (Ref to BAF#59 and Operational Risk Register re: clinical capacity)

The number of people waiting over 18 weeks for assessment in South-East Hampshire has increased because of a surge of referrals in late Spring and early summer( which are now hitting the 18-week mark), issues with staff deployment and the availability of locations with the correct equipment to administer walking tests. The service have agreed a plan with SE Hants commissioners, to make changes to the assessment pathways, group work programme and clinic time locations to enable better patient prioritisation. Improvements to waiting times should begin to manifest from November onwards, but this is subject to receiving adequate service assurance.

### Children's Services East – CAMHS waiting times (Ref to BAF# 59 and Operational Risk Register re: Clinical capacity)

Waiting times for high and low priority patients continued to fall – for the fourth successive month - with 18 waiting over 18 weeks in September a reduction of over 55% in four months and the best position since February

2018. The service is now fully recruited, but the backlog is predicted to take until spring to clear, because referral numbers have continued to increase during Q2 and 3. Patients on the waiting list are able to self-escalate, by reporting any change in condition and are reassessed for urgency. Anybody waiting over 18 weeks is held under review and chronicity weighting added to their overall priority score.

### Children's Services East – Paediatric Medical Service Waiting Times (Ref to BAF# 59 and Operational Risk Register re: Clinical capacity)

Paediatric medical service waiting times have continued to be under pressure, with a current waiting list of 230, of which 14 are waiting over 18 weeks. The most significant recent cause has been long-term sickness affecting up to 50% of staff, since the summer. The service has poor resilience, due to small size (6 medical staff), traditional models of working and high new to follow-up ratios. Discussions began this month within the service line about re-modelling pathways to improve cross cover, matching available resource to demand and reducing out-patient follow-ups. On-going talks are being held with Portsmouth Hospitals Trust and Portsmouth City Council and CCG Children's commissioners about an integrated paediatric pathway, which is more likely to yield longer-term sustainable solutions to growing specialist demand for complex paediatric care.

### Finance (Link to BAF#53)

The year-to-date deficit is £0.9m and is in line with our submitted plan. As part of the month 6 returns to NHS Improvement, Solent has submitted a revised Forecast Outturn, which is a £0.8m deficit (£0.2m favourable to plan), pre any additional Provider Sustainability Funding (£0.4m).

### Estates (Link to BAF #27)

Construction work on "B" Block of St Mary's has made good progress. Substantial enabling works including the temporary relocation of the Pharmacy Team, relocation of the maintenance offices, relocation of the IT team and works to the facilities management offices around the site have been completed.

Discussions are progressing with Department of Health and Homes England regarding the potential disposal of surplus areas at the St James Site and the marketing strategy for the site is currently being considered. In addition, the Trust is considering other potential options for this land

The sale of Oakdene to Portsmouth City Council has still not occurred, but is expected to complete in November 2018.

No update has been received as to whether the funding application for the relocation of wards from Royal South Hants Hospital to the Western Community Hospital has been successful.

### ICT (Ref to BAF# 13 and Operational Risk Register re: IT)

Public access (Patient) WiFi was not completed by the previous delivery date of 30 September 2018. The supplier did deliver a working solution during October 2018, but it did not meet all of the requirements required. A new delivery date of 23 November 2018 has been agreed with the supplier and we are reasonably confident that this revised date will be met.

### Portsmouth and South-East Hampshire Systems update (Ref to BAF# 58)

There have been no significant changes in system performance during October. Medically Fit For Discharge (MFFD) numbers for Portsmouth were maintained at below 41 for a week in late October, but this is most likely to be associated with lower Fit to Leave identification and reduced system demand during the half-term week. The standing average MFFD numbers for Portsmouth are 42 over the past month, a great improvement over the 69 average at this point last year. Further improvements in the early part of the discharge pathway are probably only achievable by better identification of patient needs earlier in their care journey, more accurate identification of "discharge ready" status and consistent availability of Continuing Healthcare (CHC) and Adult Social Care (ASC) assessment for Hampshire County patients.

In response to the PWC "Closing the Gap" analysis of care space requirements for winter sustainability; Solent and Portsmouth City Council developed proposals for additional therapy and nursing staffing in PRRT, the continuation of the Community End of Life Team and additional transitional home care capacity. These schemes have been implemented and delivered the winter capacity requirements for the city of 30 additional care spaces. Some

community nursing capacity in PRRT will be met with temporary staffing, due to recruitment challenges. Further improvements in community capacity will now rely on improved internal outflow of patients to sustainable care arrangements. Operational work is underway in PRRT and Jubilee to optimise length of stay and ensure that available capacity is always "pulling" patients who are fit to leave acute care.
Jubilee and Brooker Units have agreed plans to create 5 additional "surge" beds that will be utilised in early January to meet the predicted rise in requirement for discharges from acute care. The additional capacity will be created by improving length of stay and internal processes.

There is a risk of pressure on Older Persons Mental Health (OPMH) beds across Hampshire as Southern Health (SHFT) are struggling to staff wards adequately to keep all of their capacity operational throughout Winter. Solent NHS Trust are in close dialogue with SHFT and systems partners to agree solutions to meet this challenge.

## 3. Current news

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

## 4. Complaints and Serious Incidents update

### Complaints

*This report has been written following an extraction of complaints data undertaken by the Solent PALs and Complaints Service on 05 November 2018.*

The table below provides a breakdown by service line of formal complaints received during October:

| Service Line | Formal Complaint | MP Query | Professional Feedback | Total |
|---|---|---|---|---|
| Adults Portsmouth | 1 | | 1 | 2 |
| Adults Southampton | 2 | | 1 | 3 |
| Children's Services | 2 | 1 | 1 | 4 |
| Mental Health Services | 7 | | 1 | 8 |
| Primary Care | 4 | | | 4 |
| Sexual Health Service | 3 | | 1 | 4 |
| Total | **19** | **1** | **5** | **25** |

In comparison to the previous two months we saw a 50% increase in formal complaints during October. Initial review does not identify a specific trend but the team are undertaking a more detailed analysis as well as reviewing against national data. The general themes identified relate to difficulties experienced with appointments, the attitude of some staff, responses to clinical queries/concerns and difficulty in relation to communication.

In addition to the formal complaints, we received a total of 41 Service Level concerns which is also an increase compared to previous months but similar to the number received for the same period last year. We will continue to monitor the position over the coming month to establish if there are any themes or trends developing in individual service lines or across the Trust as a whole.

Our PALs and Complaints team responded to 325 new contacts during October which is higher than average and reflects the increase in complaints and service concerns as previously described. In addition to responding to the complaints and service concerns, 86 contacts were made for advice and related to signposting queries (both internal and external) as well as recording 173 plaudits received for our services.

At the end of October 2018 there were 40 open complaints and 19 complaints had been closed in the month.

Every complaint or service concern provides us with the opportunity to learn and improve. Below are some examples of changes made as a result of such learning:

- One service line has reviewed processes and are now prioritising patients that are moving to other services; providing them with advice about the transition and the process itself.
- A review of discharge planning has been completed and patients will not be discharged from the ward unless the appropriate seating or suitable alternative seating is available at the nursing home the patient is moving to.

- Peer review of record keeping has been introduced in a service line to ensure the standards are being met and improvements made where required.
- As a result of concerns raised one service line has introduced multi-disciplinary reviews for all complex cases.

### Serious Incident (SI) Update

I am pleased to report an improving position in relation to SI breaches and at the end of October there are no breaches reported. However in month there was 1 reported breach for a Pressure Ulcer report which required amendments post panel and was not resubmitted within timescale by the service line which caused the breach. The Services and Quality and Safety team have worked together to make changes to the process and it is anticipated that the improvement will be sustained with the implementation of the updated SI timeline.

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

TMT meetings are held bi-monthly – an update of the meeting held on 21st November 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

| 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 |
| 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.

The full BAF report will be presented to the Confidential Board meeting.

### Operational Risk Register

As at 10th October 2018, almost 30% of staff had completed the new *Introduction to Risk Management Training* which was launched on 16th July 2018. The training must be completed by all staff and continues to be promoted through Staff News and Managers Matters.

On 10th October 2018 there were 135 open risks on the Risk Register; this is an increase of 7 risks since the last report. Notable changes include:

- 20 risks have been closed as they have been resolved or no longer exist

<u>New Risks</u>

31 new risks have been added this quarter

- 6 risks have been added in Adults Services Portsmouth – these concern the following; medicines management procedures/pharmacy resourcing, Deprivation of Liberty Safeguards compliance, demand and capacity associated with winter planning as well as bank/agency spend linked to vacancy levels
- 6 risks have been added by the Information Team – these relate to; availability of IT equipment for new starters fax lines at RSH, capacity to support 0300 changes, increased cost of mobile device management, age of network switches and WiFi accessibility
- 4 risks have been added by Specialist Dental Services – these relate to; appointments in acute care and mobilisation of IOW dental services contract and costs associated defibrillator replacement

The most prevalent risks on the Risk Register are:

- Workforce – Staffing (21 risks): risks relate to vacancy levels/ staff absence and difficulties recruiting staff. The number of risks has decreased from 25 since the last quarter (see closed risks above which identifies that risks are being closed as vacancies are being filled).
- Clinical – Community (21 risks): the majority of these risks relate to clinical capacity and ability to meet rising demand for services. There has been a small increase from 20 risks in Q2.
- Information Technology (17 risks): team and service level risks relate to problems with access to systems and IT connectivity; 6 new risks have been added by the Corporate ICT team this quarter (see new risks above). Overall the number of risks has increased from 13 to 17 this quarter.

There are 21 risks scoring 15+ on the Risk Register with 4 of the new risks added this period scoring 15 or higher. The Trust Management Team has oversight of these risks and seeks assurance they are being appropriately managed; five of the high scoring risks relate to Primary Care and include increasing demand for services, ability to deliver contractual targets and WIFI connectivity in a number of services.

All service lines and corporate departments will proactively identify risks to the delivery of their 2019/20 business objectives as part of this year's business planning cycle. Risks will be included in business plans and following approval in Q4/2018 they will be monitored through performance reviews.

## 7. Other matters to report

### Sealings

| Reference | Description |
|---|---|
| 70 | Lease for premises at 9/19 (odd) Rose Road, Southampton between Unity 12 CIC and Solent NHS Trust |

### Signings as reported to Finance Committee since last Board meeting

| Reference | Commissioner | Description |
|---|---|---|
| CPRO_0130 | NHS England | Contract Notice in relation to Public Health Services for Child Health Information Service (CHIS) – Termination (Approved – no signature required) |
| CPRO_0100 | Portsmouth City Council | School Nursing – Public Health Services – Extension & Variation |
| CPRO_0004 | Portsmouth Hospitals NHS Trust | Provider to Provider Agreement – Solent as Provider |
| CPUR_0001 | Portsmouth Hospitals NHS Trust | Provider to Provider Agreement – PHT as Provider |

Sue Harriman
Chief Executive

**Item**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Presentation to** | Public Board Meeting | | | | | | | |
| **Title of Paper** | Trust Board Performance Report Part I – October 2018 | | | | | | | |
| **Author(s)** | Alasdair Snell | | **Executive Sponsor** | | Andrew Strevens | | | |
| **Date of Paper** | 19/11/18 | | **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 bi-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 2 Report 2018/19

## Corporate Programme Management Office

By Aaron Scott and Matthew Rowsell

# 1. Executive Summary

At the end of quarter 2 2018/19, all Business Objectives underwent a 6 month review by Service Leads and the Corporate Programme Management Office (CPMO) to assess the progress of each Objective and ensure that quarter 3 and quarter 4 targets were still realistic and achievable.

There were 3 Business Objectives completed in quarter 2 and 57 milestones were met (165 milestones met year to date). There are 58 Business Objectives still active with a total of 207 (56%) milestones left to be completed before the end of March 2019.

# 2. Q2 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.

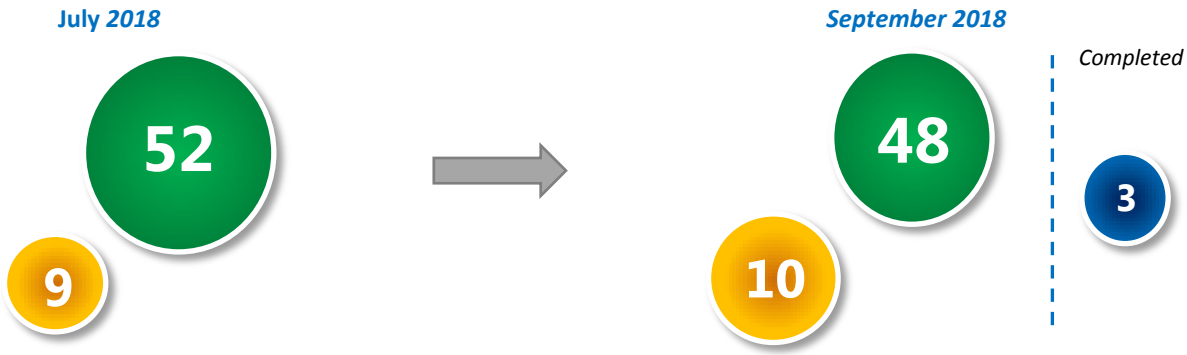
- **48 Objectives (79%)** are rated as **green,** indicating they are on target for completion by planned dates.

- **10 Objectives (16%)** 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 plan.

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

- **3 Objectives (5%)** have successfully met all their milestones and the business objectives are now complete (shown as blue below).

*Figure 1: An overview of the transition of RAGs from Quarter 1 to Quarter 2 for 2018/19:*



### 2.2 Quarter 2 successes

A total of 3 Business Objectives have completed at the end of quarter 2:

**Research and Improvement –** A key objective completed at the end of quarter 2 was to grow the culture of learning and improvement for staff and colleagues to ensure that staff are able to demonstrate and share what they have learnt from events, ideas and feedback. The Solent Research and Improvement Academy was successfully launched in June 2018 and the service has also established an extended Quality Improvement Leaders Programme which has attracted a number of applicants. Those on the programme are encouraged to work with patients to identify and deliver improvements in their service(s) and demonstrate how these have made a difference.

**Specialist Dental Services –** Due to a number of forthcoming retirements, the service had planned to deliver a fit for purpose workforce model by the end of March 2019. This Business Objective has been successfully completed ahead of schedule. A recent successful rolling recruitment programme has ensured that the service have enough dentists to deliver the contract and has enabled the service to develop existing staff to step in to future retirement posts. Staff have also been moved around the sites to ensure relevant skill mix in all areas.

**Specialist Dental Services –** NHS England (NHSE) were due to release a new Specialist Dental contract around quarter 2 of 2018/19 however this has been delayed. Our existing contract for Specialist Dental is due to expire at the end of March 2019, however NHSE are exploring awarding a 2 year extension to our current contract for 2019-21 and we are awaiting a decision from their internal governance board. Following negotiations with commissioners, the service have made good preparations for when the new tender is released which includes positive changes to how general anaesthetics are paid and claimed.

Although not yet complete, significant progress has also been made against many of the remaining Business Objectives, including the following:

**Adults Southampton –** Adults Southampton have made positive progress with their financial recovery plan. Southampton City Clinical Commissioning Group (CCG) recently acknowledged a significant contract funding gap which predominantly sits within the Adults Southampton service line. A two year plan has been developed to combat this deficit that involves a three pronged approach including a cash injection, reinvestment of existing funding and an increase in activity in high impact areas of care. Adults Southampton is fully supportive of this blueprint and is fully engaged with commissioners and partner providers in discussions around how this can be achieved. Although the specific services have yet to be identified there is confidence that this plan can be met, resolving the financial gap for both the CCG contract and Adults Southampton.

## 2.3 Quarter 2 challenges

At the end of quarter 2 there were 10 Business Objectives which were considered amber:


**1. Adults Portsmouth** - Develop and Implement a Long Term Conditions Hubs model:

⬅ Launch of Long Tern Conditions Hub pilot delayed until quarter 4 2018/19

➡ The Transformation Manager has now commenced and a detailed project plan has been developed. The Business case will be submitted at the end of November 2018 with an estimated start date of a pilot in spring 2019.

**2. Commercial –** Improve commercial and transformational capabilities to ensure Solent can proactively deliver and respond to system change:

⬅ Challenges with capacity have delayed this objective

➡ Leads allocated to specific milestones to ensure delivery. Some target completion dates are being revised.

**3. Mental Health –** Work with system partners to improve Mental Health and Primary Care Services:

⬅ Solent continues to work with Southern Health Foundation Trust (SHFT) and Portsmouth Hospitals NHS Trust (PHT) but involvement on this objective has reduced in recent months.

➡ Capital bid for the Mental Health Assessment Unit at Queen Alexandra Hospital was successful and implementation of this area within ED is now progressing.

**4. Mental Health –** Work with Southern Health (SHFT) to adopt standard approach to beds and bed management:

⬅ There has been an inconsistent approach from SHFT with regard to reducing their length of stay within their acute ward which is impacting upon this objective achieving its aims.

➡ The monthly project group continues to meet. We have begun to review staffing models within each ward to identify similarities and differences as well as looking at the barriers for SHFT in reducing down length of stay.

**5. Mental Health –** Review and redesign evidence based pathways for those with Unstable Personality Disorder:

⬅ This objective was led by South East Hampshire commissioners and has experienced delays as a result of commissioner availability.

➡ The team met on the 2 October to agree the plan going forward in order to progress the objective and new milestones are due to be set.

**6. Mental Health –** Develop and implement phase 1 of a sustainable workforce plan:

⬅ Band 4 advert failed to identify suitable candidates for the role.

➡ The service have since undertaken a staff support exercise to identify in house staff who are ready to undertake the foundation degree course in March 2019. A competency document is also being drafted for bands 2-4.

**7. People and Organisational Development –** Increase staffing capacity through effective workforce planning, talent attraction, development and retention:

⬅ There are currently challenges with creating new unregistered nursing positions with the corresponding competencies, accommodating backfill requirements for Nursing Associate placements, and the limited therapies apprenticeship pathways.

➡ Non-registered Band 4 posts filled in Adults Southampton Community Services, Adult Mental Health residential service to pursue Nursing Associate placements but will require sign off on competency framework, work will continue into quarter 4 on Assistant Practitoner apprenticeships to address capacity issues in therapies.

**8. People and Organisational Development –** Increase leadership capability at supervisory management levels using a talent development framework and core people management competency:

⬅ Work is still needed on identifying a framework for future training and succession planning. Core essentials training continues in classroom and bespoke formats for supervisory management levels, but requires a competency in ESR/OLM.

➡ A leadership and talent strategy document has been drafted, along with the formation of a Releasing and Maximising Potential Alumni to identify future leadership development interventions. Work will continue into quarter 4 to link this into a trust wide succession planning and to identify the required core essentials competency framework for people managers.

**9. Primary Care Services –** Enhance communication, technology and digital offer to facilitate better access to information, online referral systems and to support self-management / empowerment:

⬅ The PHT connectivity issues remain an ongoing concern; despite support from Solent and PHT's IT teams progress is slower than previously expected.

➡ Solent and PHT IT's team continue to support resolution, progress is slower than expected.

**10. Primary Care Services –** Will resolve Solent's diagnostic contracting issues with support from Commercial:

⬅ Cost pressure risk for Solent due to interdependency with the Salisbury, Wight and South Hampshire Domain NHS Trust (SWASH) consortia.

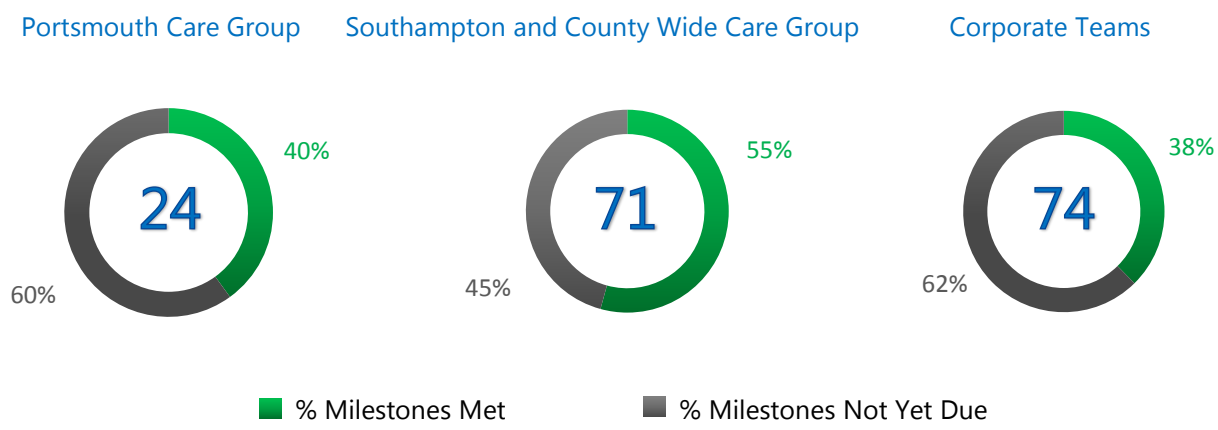
➡ Cost pressure has been minimised. SWASH consortia paper has been approved at Directors; pending agreement from all CD's and OD's. Proposal will give Solent NHS Trust a cloud based PACS platform allowing the sharing of images from acute and community providers across the HIOW geography.

### 2.4 Milestone Progress

Since April 2018, a total of 165 (44%) Business Objective milestones have been met. At the same point in 2017, Solent had met 47% of the total milestones for the year and 18% were not met. Although comparatively the number of milestones met for 2018 has decreased, there are no milestones currently not met without mitigation in place. This demonstrates that in 2018/19 Solent has been able to forecast more accurate timescales against delivery of the milestones.

From a total of 372 milestones, there are 207 (56%) that remain to be completed across 58 Business Objectives before the end of March 2019. The charts below illustrate the number of milestones that have been met at the end of quarter 2 across our two Care Groups and Corporate Teams with a percentage breakdown of met/not yet due:

*Figure 2: An overview of the current milestone status:*




*N.B. 4 Child and Family milestones met cover both Southampton and Portsmouth Care Groups.*

## 3. Additional 2018/19 Projects

### 3.1 Integrated Care Partnership

Solent NHS Trust is fully engaged in the Portsmouth and South East Hampshire Health System, Integrated Care Partnership, and alongside other partner organisations we are contributing to the system operating plan.

This work has involved the pooling of project information during workshops in late September, where partner organisations provided information on the major and minor projects that will contribute to the system objectives for each work stream. A draft project delivery timeline has been produced and will be enhanced over the next quarter to provide further detail on delivery dates and project aims and deliverables. Quarter 3 will also see how financial plans and Business Information can be brought together for the work streams to ensure that the ICP operating is robust and achievable.

# 4. Next Quarter

## 4.1 Business Objective Progress

There are 58 Business Objectives which are still being monitored and have milestones yet to be completed. Following the 6 month review of all Business Objectives, Solent has gained a more realistic vision for the final two quarters of 2018/19 which could enable higher productivity and increased benefits realisation at year end. Providing milestones are met on time, it is forecasted that 20 Business Objectives will complete in quarter 3 and the remaining 38 are scheduled to complete by March 2019.

## 4.2 2019/20 Business Objective Planning

The CPMO will be working closely with Service Lines and Corporate Teams during quarter 3 of 2018/19 as teams begin to formulate 2019/20 Business Plans for submission in quarter 4 2018/19.

## 4.3 2019/20 Cost Improvement Plan (CIP) /Equality Impact Assessment (EQIA) Process

The CPMO have started to build the CIP and EQIA process into Verto. Recording all CIPs and EQIA documentation on Verto will provide a single version of the truth at any given time and will facilitate greater accuracy with monthly CIP reporting. The new process will be officially launched in quarter 3 ahead of 2019/20 CIP drafting.

# 2.1 Benchmarking In-Focus

## Mental Health 2017/18

Sarah Howarth, Head of Performance

The NHS Benchmarking Network released the 2017/18 report on Inpatient and Community Mental Health Benchmarking. This year's benchmarking exercise has been praised by the Network for having participation from every Mental Health Trust in England, as well as the Welsh Health Boards, and increasing representation from Northern Island, Scotland and the Channel Islands.

The following gives an overview of the key points from the report, particularly highlighting where Solent NHS Trust differs significantly from benchmarking means.

# 1. Adult Acute Services (16-64 years)

Solent included the beds provided for SHFT in its data submission and increased the population served proportionately to include these – this was to allow a consistent comparison with admission and discharge data (where patients from Hampshire County and Portsmouth are counted together).

The Solent Acute Adult inpatient model is based upon beds always being available for acute assessment, quick formulation and treatment planning and timely return to a community setting, with appropriate enhanced support. Additionally; short crisis admissions – below 3 days are encouraged for patients with clinically appropriate presentations.

In a region where adult acute beds are typically at a lower quartile level – Solent NHS Trust continues to have the lowest number of acute adult beds per population in the region and the third lowest in England and Wales.

Across the benchmarking group; there is a fourfold variance in bed numbers per population between the lowest provider and the highest. This strongly suggests that there is no optimal number of beds. Comparison between providers on the beds per 100,000 population and occupancy metrics shows that there is no apparent correlation between absolute bed numbers and bed occupancy.

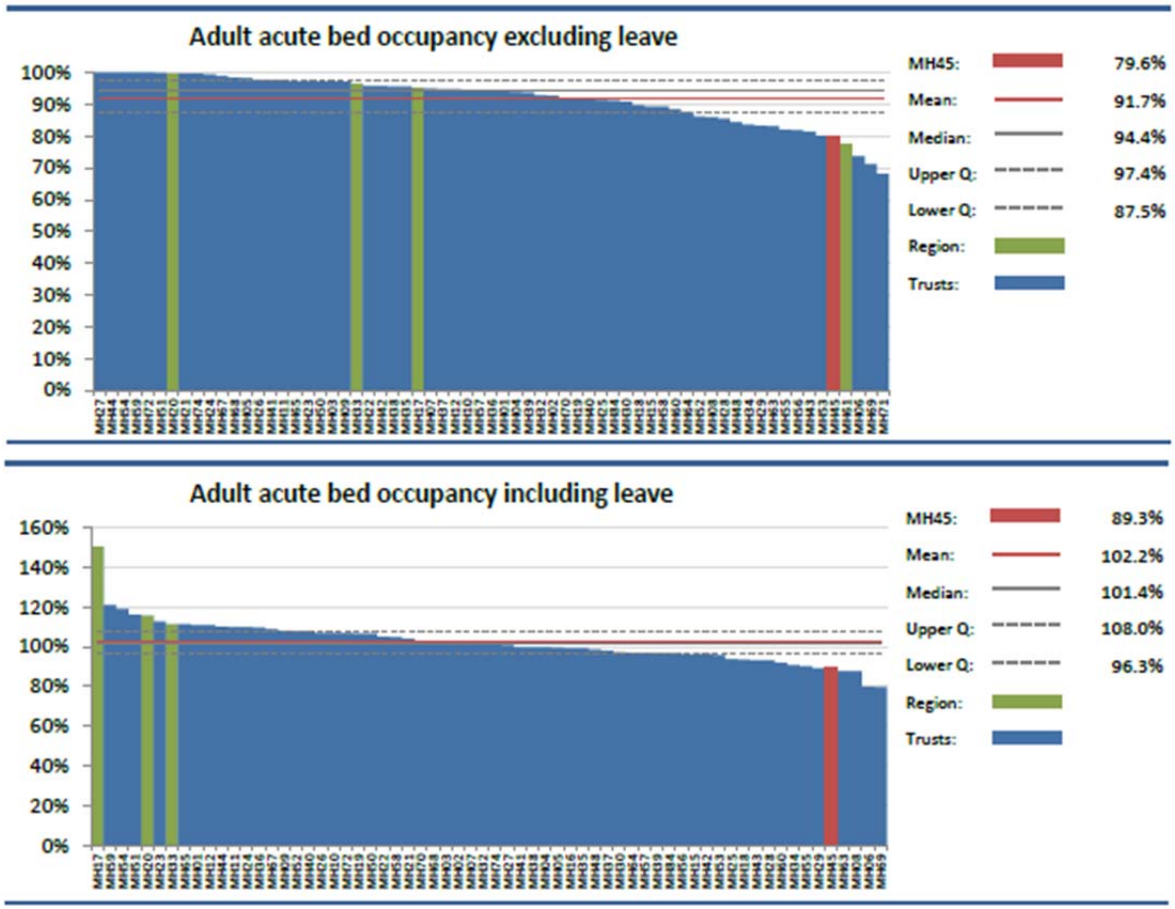
## 1.1 Number of Beds

The national average number of adult acute beds available per 100,000 population in 2017/18 was 19.9. Solent NHS Trust has 11.2 Adult Acute beds, which is considerably lower. However given the outcomes on the following metrics, it becomes clear that Solent NHS Trust have got sufficient beds to manage the needs of the local population currently commissioned.

## 1.2 Occupancy Rates

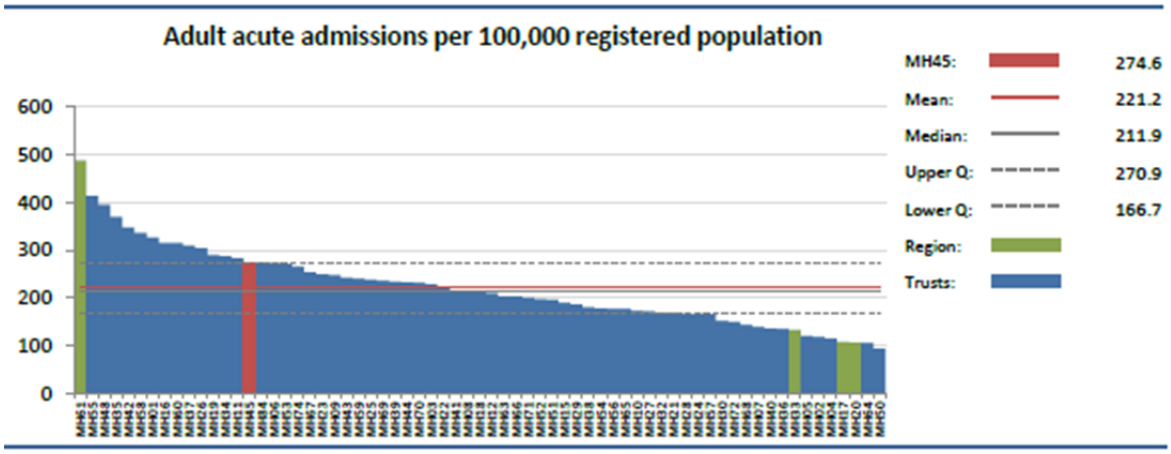
It is widely recognised that a bed occupancy rate of 85% in Adult wards demonstrates a good balance of well utilised beds whilst having the capacity to take on new admissions as needed. Occupancy can be counted inclusive or exclusive of patient leave. When occupancy rates are above 100%, inclusive of patient leave, this poses a risk to patients on leave if they require readmission as there may not be a bed available.

Solent NHS Trust has a favourable occupancy rate for both metrics, inclusive of patient leave (89.3%) and exclusive patient leave (79.6%), compared to the 85% recognised standard and the national averages (91.7% and 102.2% respectively).

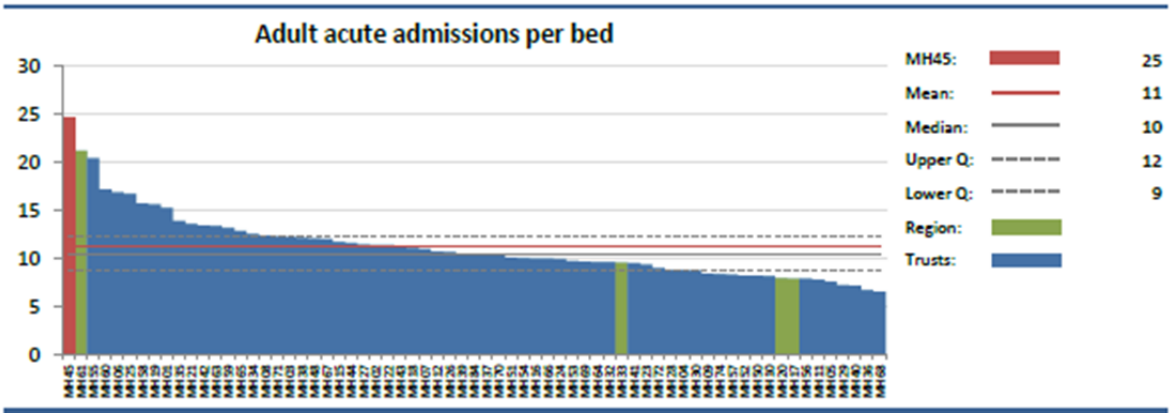



## 1.3 Admissions

Solent NHS Trust has a greater number of admissions (274.6) per 100,000 than the national average (221.2). However this has declined slightly from the 296.8 figure of 2016/17.



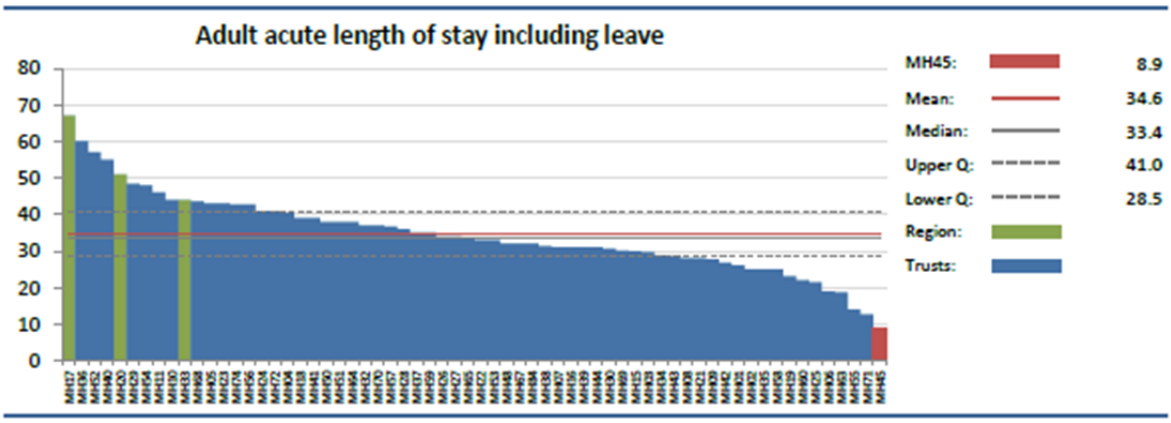

This relatively high number of admissions, paired with the short length of stay, results in Solent NHS Trust having the highest number of admissions per bed (25), across all participants (national average = 11).



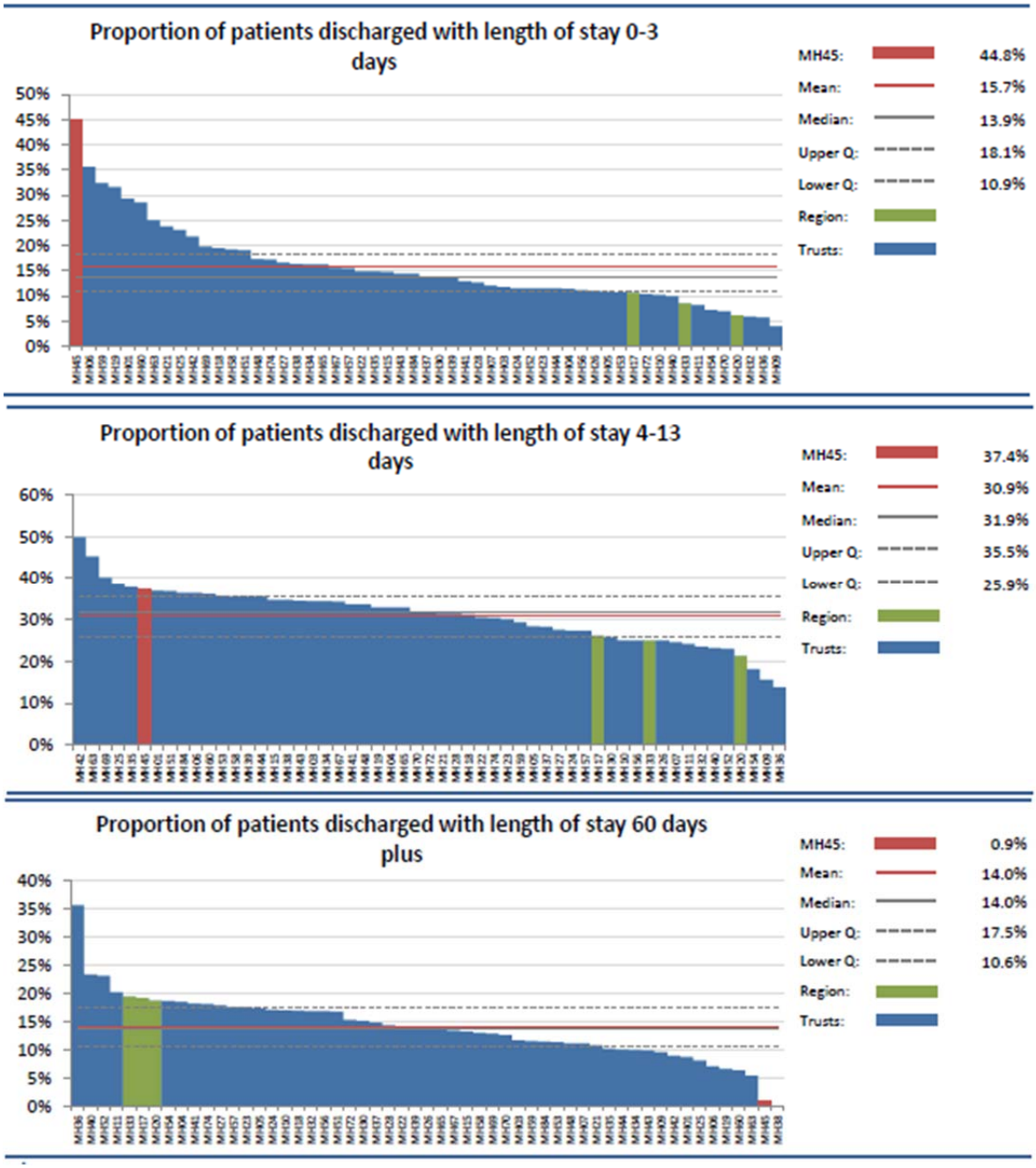

## 1.4 Length of Stay

Length of stay is calculated both inclusive and exclusive of patient leave. When excluding patient leave Solent NHS Trust has the second shortest average length of stay (7.9) from all participants (national average 31.3).

When patient leave is included, Solent NHS Trust has the shortest length of stay (8.9) nationally. This is significantly below the mean and lower quartile. This reflects the clinical model within Solent of discharging patients from detention as soon as the criteria for detention are no longer met, rather than proceeding with long periods of Section 17 leave.

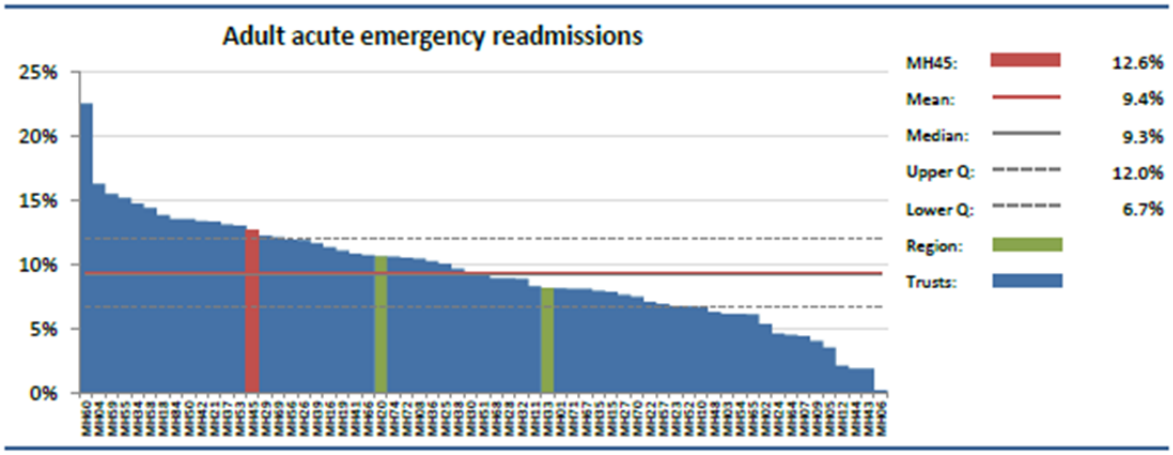



The proportion of patients discharged within certain timescales is shown in the charts below, supporting Solent NHS Trust's position of a short length of stay, with very few patients staying on the ward beyond the early acute phase of illness.




## 1.5 Emergency Readmissions

Emergency readmissions are counted as those patients who following discharge from an acute bed, are readmitted within 28 days for unplanned or unexpected reasons. Nationally, there has been a slight upwards trend from 2016/17 to 2017/18 of 0.5%. Solent NHS Trust's readmission rate sits just above the upper quartile at 12.6%. Compared to the national average of 9.4%, this is noticeably higher and has increased from the 7.9% rate of 2016/17. The service has undertaken an analysis of reasons for readmission and implemented measures to ensure that the rate returns to the interquartile level.

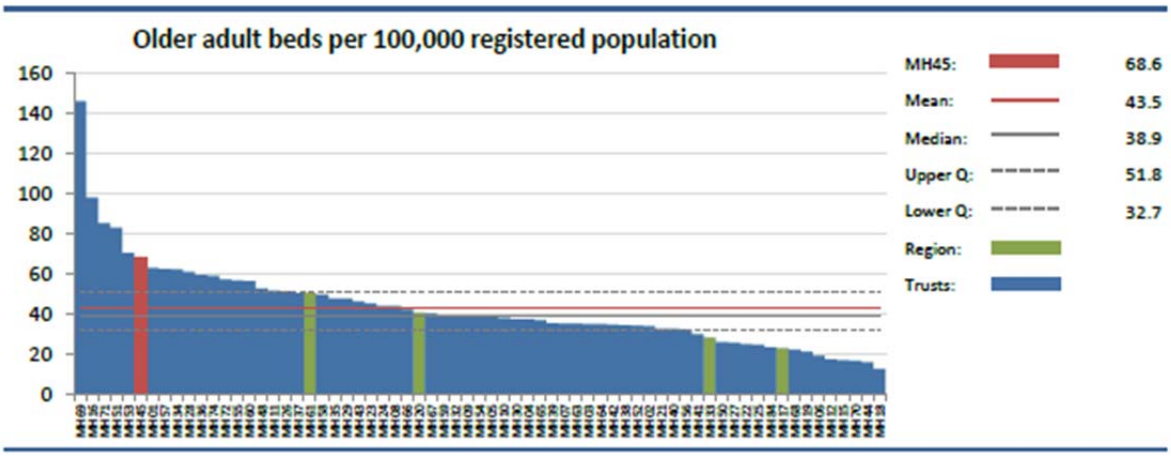



## 2. Older Adult Acute Services (65+ years)

The Older Adult services within Solent are still very reliant on inpatient beds as a solution to community crises and have a high admission rate and much larger than average bed stock. This reflects poor resilience in the care home sector and a systemic expectation that mental health admission will precede changes to care venue. The development of the Care Home Team and the extension of Crisis services to include older people are responses targeted at enabling older people to remain at home, during times of higher care need.

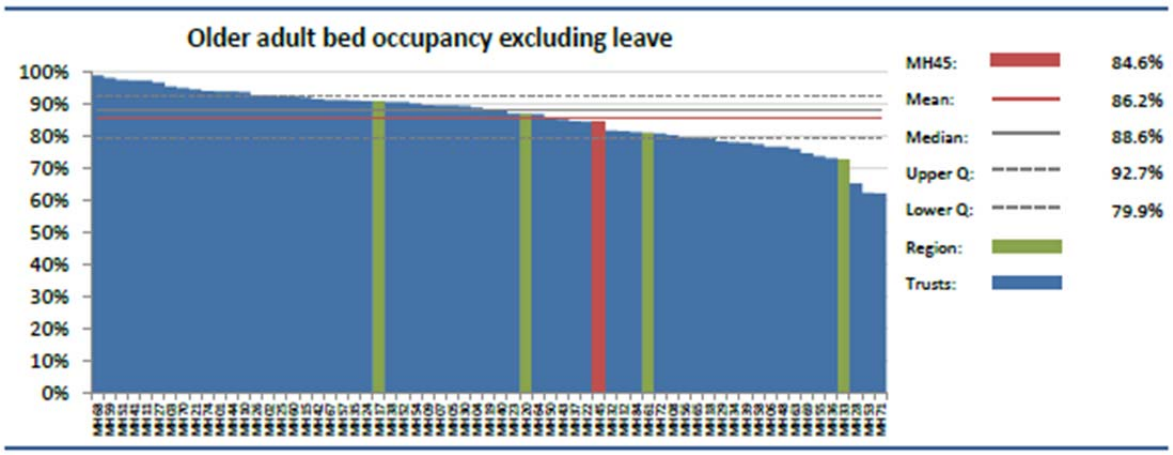
### 2.1 Number of Beds

The number of available beds for Older Adult Acute services has remained higher than for Adult services, with a national average of 43.5 beds per 100,000 population. Solent NHS Trust has above average numbers of Older Adult beds with 68.6 per 100,000 population.



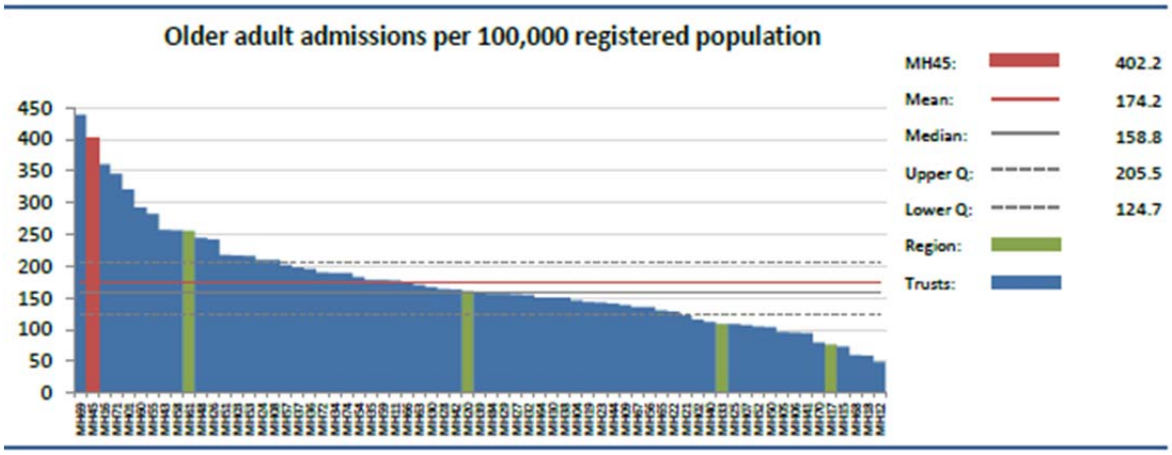

### 2.2 Occupancy Rates

Despite having a higher number of beds, occupancy rates excluding leave are in the region of both the national average (86.2%) and the recognised standard (85%), at 84.6%.



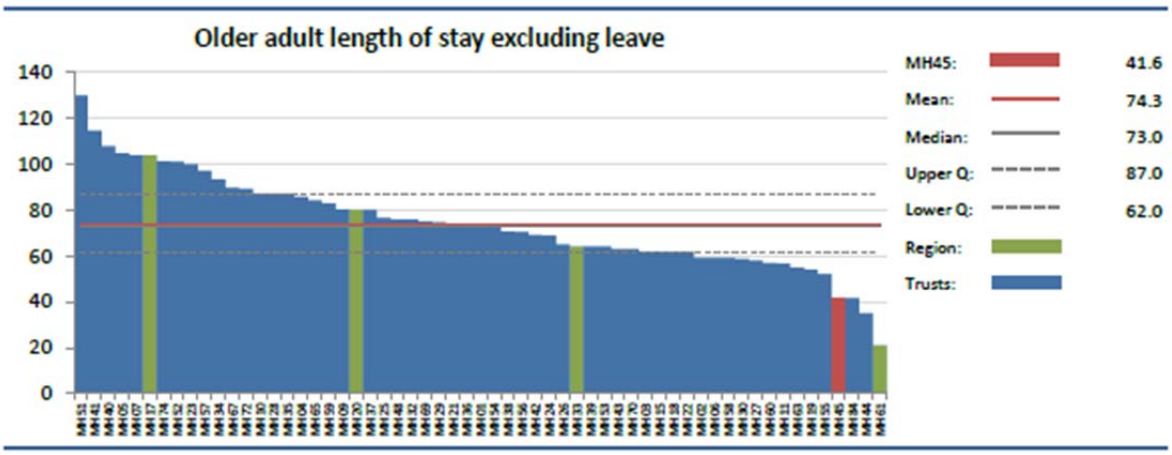

## 2.3 Admissions

The number of admissions per 100,000 nationally is 174.2, whereas Solent NHS Trust have reported 402.2 in 2017/18.



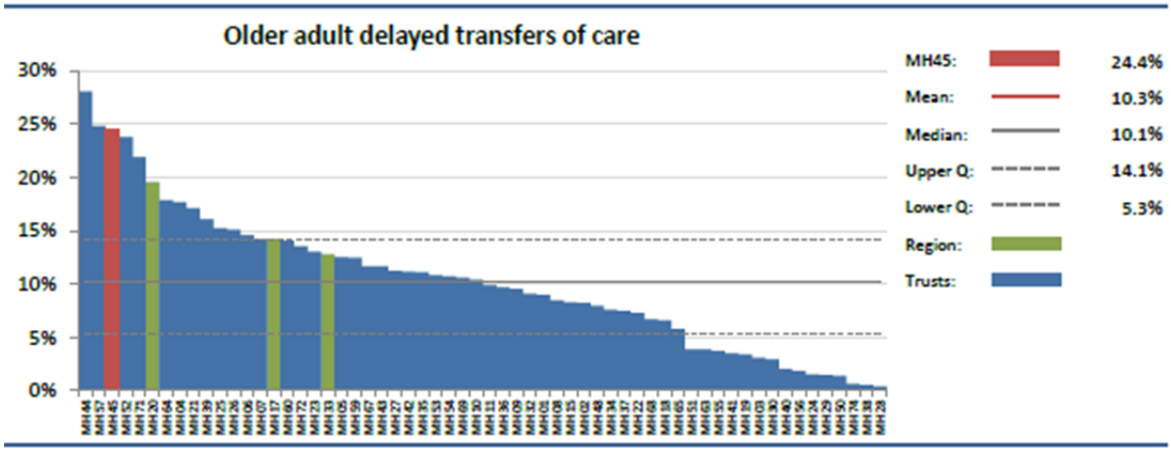

## 2.4 Length of Stay

Similarly to Adult services, the length of stay for Older Adult beds is significantly lower than the national average. When both excluding (41.6) and including (48.6) leave, Solent NHS Trust has the fourth shortest length of stay of all participants (average 74.3 and 78.4 respectively).




### 2.5 Delayed Transfers of Care (DTOC)

Delayed transfers of care are far more common for Older Adults compared to Adult services due to the complexity of arrangements required for these patients upon discharge. Solent NHS Trust has a DTOC rate (24.4%) which is greater than the national average, highlighting the demand on the system for ongoing support after discharge. This puts further pressure on bed stock.



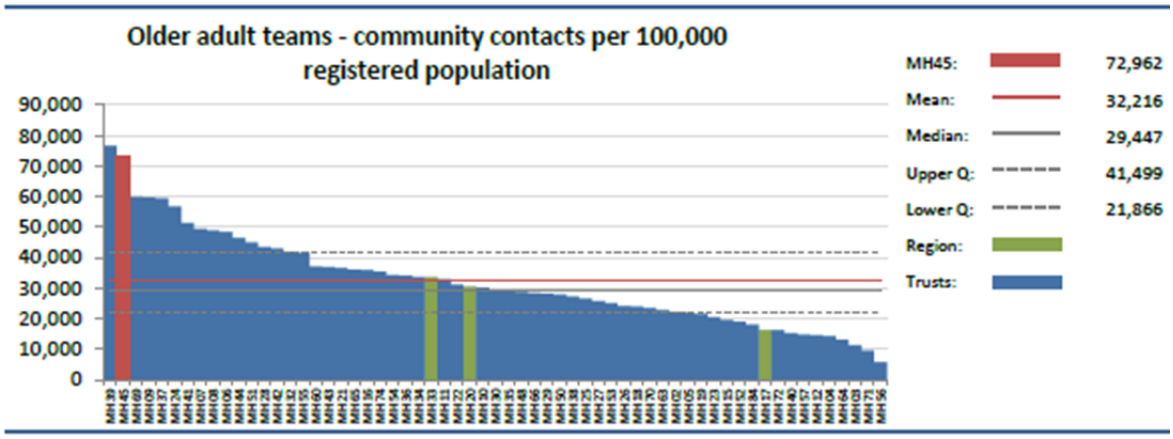

## 3. Community Services

### 3.1 Community Caseloads

Solent NHS Trust's overall community caseload is slightly higher than the national average per 100,000 population. The breakdown between Adults and Older Adults however is weighted towards Older Adults comparatively, with the caseload size at 4,353 per 100,000 compared to the average of 2,412. This reflects successive annual efficiencies savings applied to Adult Community Services, that have seen community workforce reduce by over 30% in ten years.

### 3.2 Community Contacts

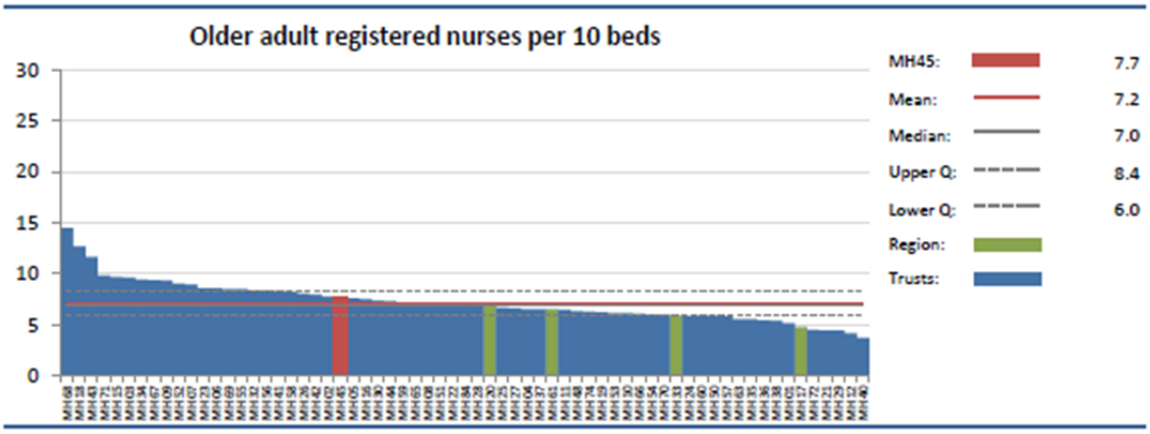
The weighting towards Older Adults is also reflected in the number of community contacts for the Older Adults population (72,962) being more than twice as many as the national average (32,216).



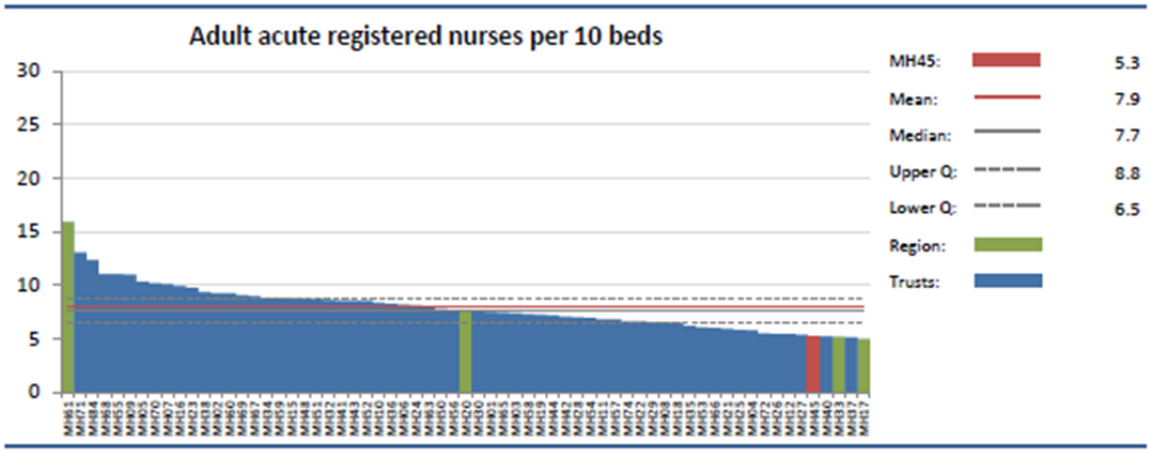

## 4. Workforce/Finance

### 4.1 Acute Services Staffing

The number of registered nurses per 10 beds varies again between Adults and Older Adult services. Older Adults are very close to the national average (7.2) with 7.7 registered nurses per 10 beds.



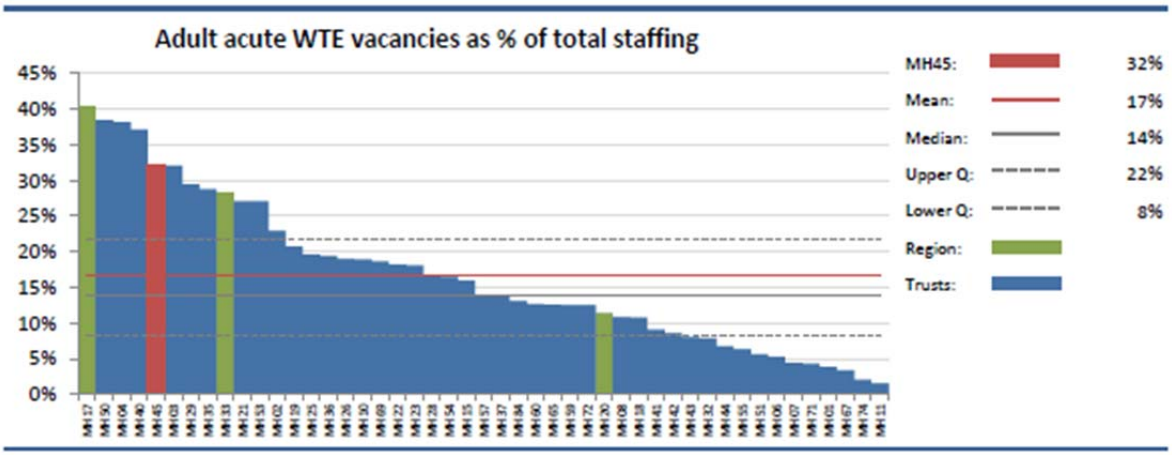

This is in contrast to Solent NHS Trust's position in Adult services, with just 5.3 registered nurses per 10 beds, far lower than the national average (7.9).




## 4.2 Acute Services Vacancies

The position in Adults services is reflected within some of the other workforce metrics as follows:

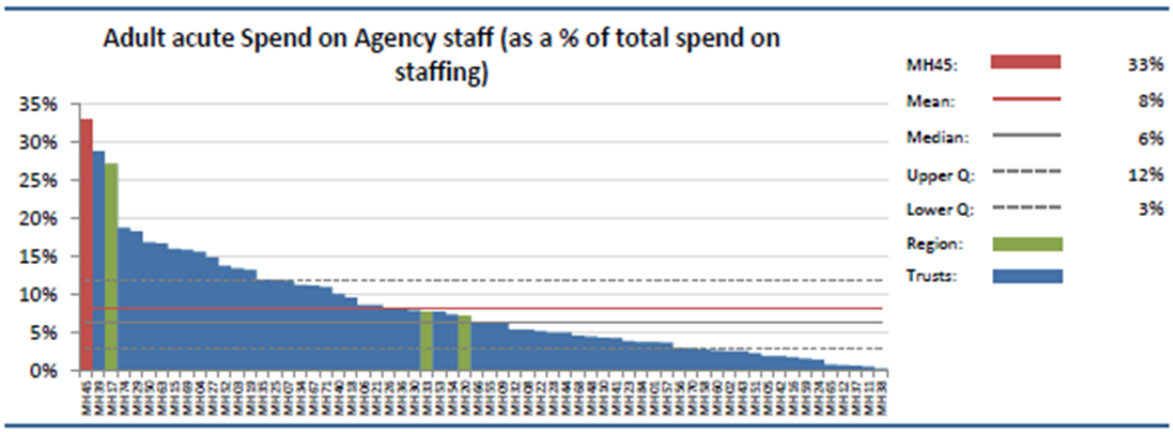
The number of whole time equivalent (WTE) vacancies as a percentage of total staffing for Solent is at 32%, compared to the national average of 17% and the highest participant nationally at just above 40%.




## 4.3 Acute Services Temporary Staffing

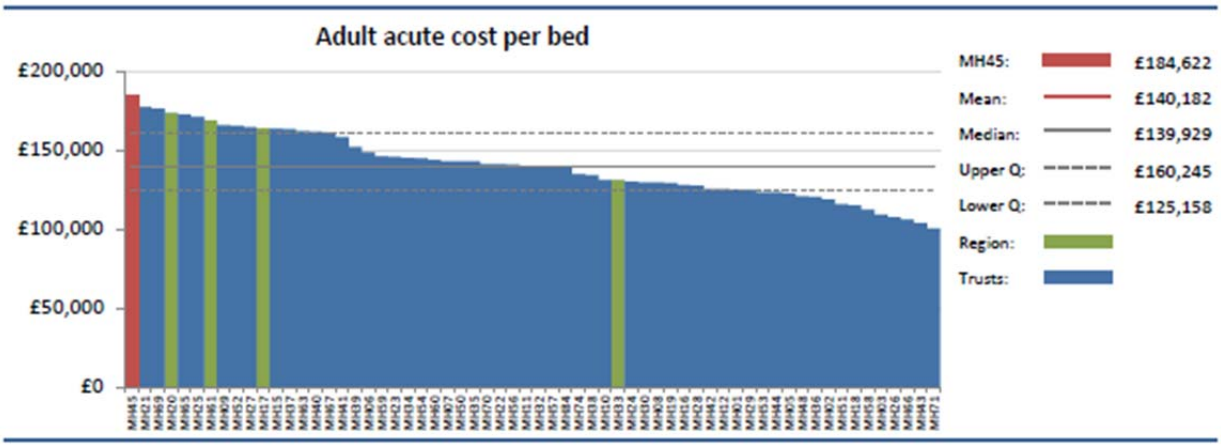
Solent NHS Trust have the second highest spend on bank and agency staffing for Adult Acute care as a percentage of total spend on staffing of all participants (41%). This is almost double the national average of 23%.

When split out further, the spend on bank staff is minimal (8%), and far less than the national average (14%), however Solent NHS Trust have the highest spend on agency staffing of all participants at 33%, compared to an average of 8%.



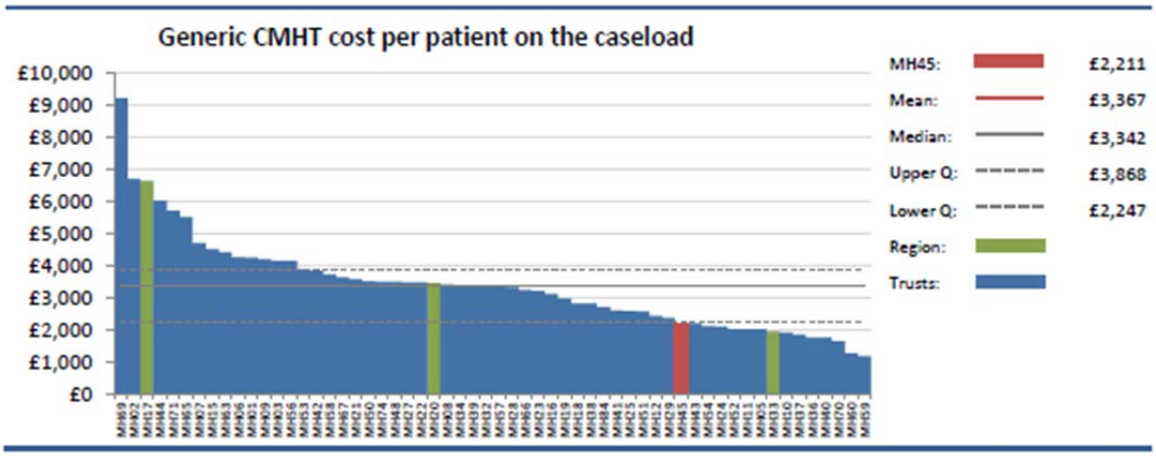

## 4.4 Acute Services Cost

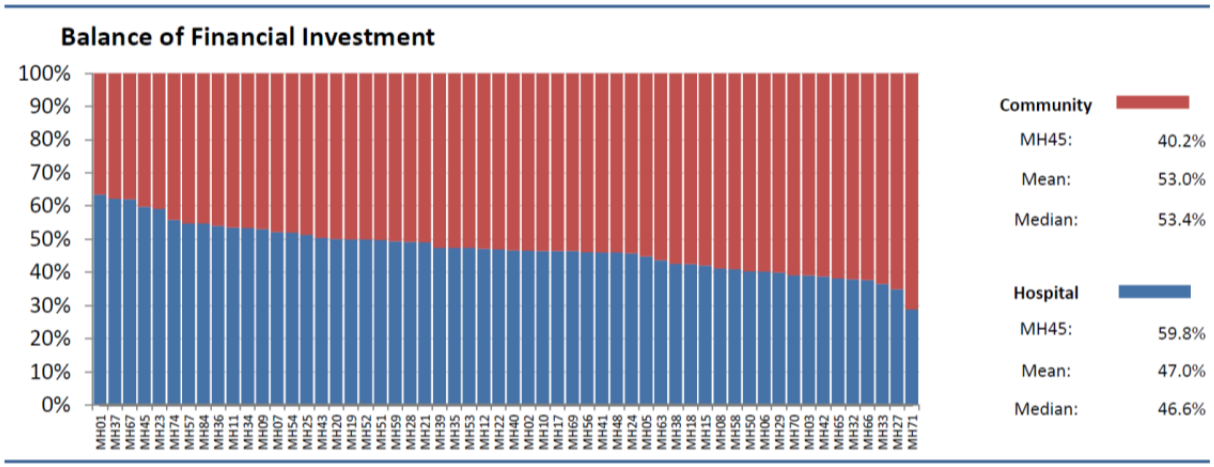
The high utilisation of agency staffing is reflected within the overall cost per Adult Acute bed. Solent NHS Trust has the most expensive cost per bed rate (~£185k) of all participants (average = ~£140k). It is probable that Solent is also challenged by scale inefficiencies, by having isolated single units that require relatively high management and service costs. Several NHS Trusts in England have begun pooling their bed base into purpose built central mental health units providing between 150 and 400 beds. This also assists with flexibility of capacity and staff deployment.




## 4.5 Community Services Cost

In contrast to the high costs associated with our Acute services, Solent NHS Trust has a comparatively low cost per patient on the caseload (£2,211) for our Community Mental Health Teams (CMHT), at almost two thirds of the average cost per patient (£3,367). This reflects the high use of clinic-based models – meeting the needs of a larger group of patients, without allocating to single care co-ordinators. The balance of financial investment shows a significant balance towards hospital based services at Solent – this is a result of the relatively high cost of providing inpatient beds and successive annual cost improvement schemes that have focussed on community services.

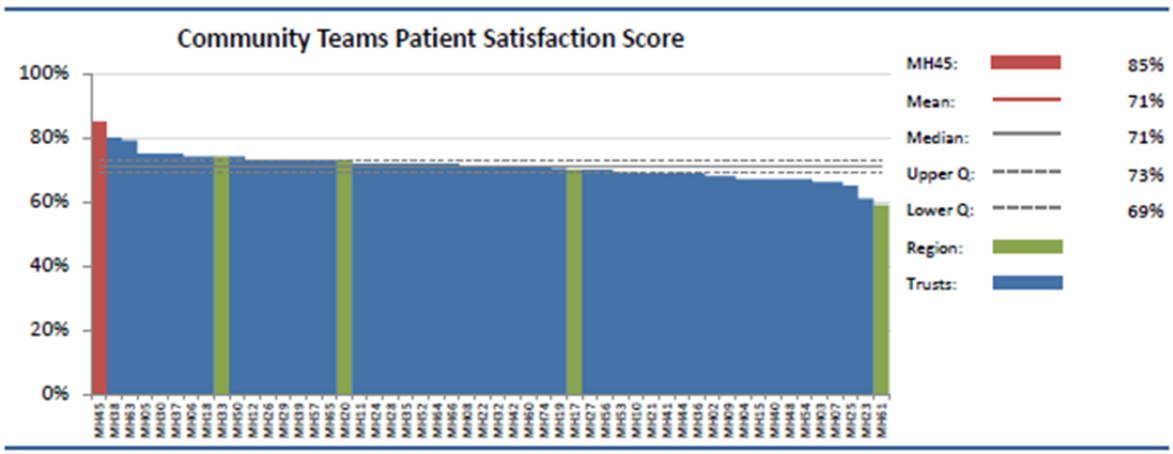


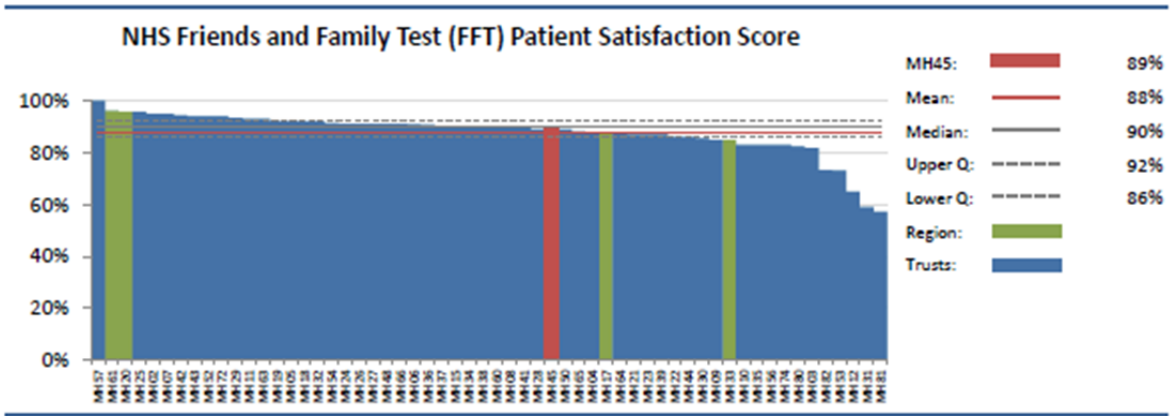

# 5. Quality

## 5.1 Patient Satisfaction

The CQC patient satisfaction score nationally is at 71% for Community Teams. Solent NHS Trust have excelled and achieved 85% satisfaction, the highest performing Trust of all participants.

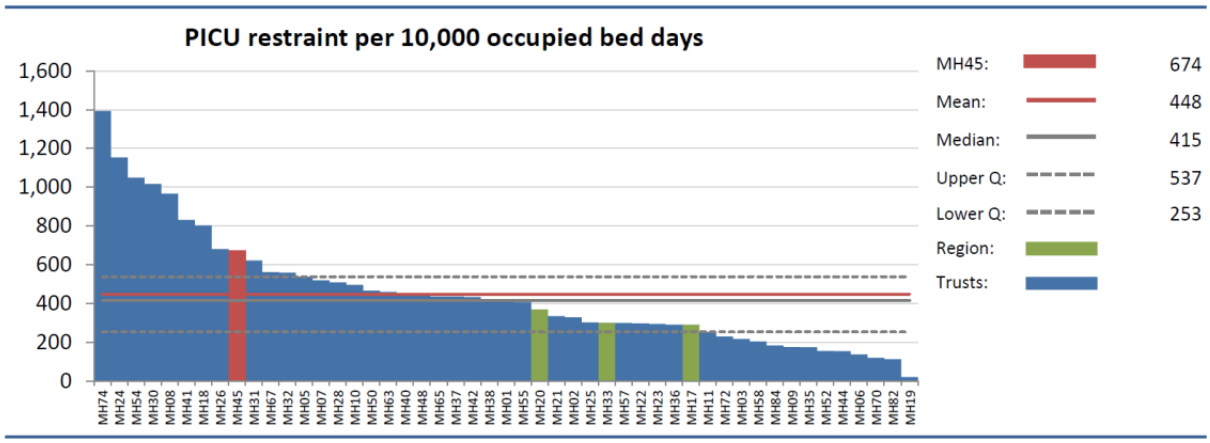


Friends and Family Test scores also demonstrate a positive patient experience, with Solent NHS Trust achieving 89%, just above the national average of 88%.




## 5.2 Use of restraint

Solent is a relatively low user of physical restraint in Acute Settings and Older People's mental health services – reflecting good patient environments, daytime structured activity and evidenced-based staff training in managing challenging behaviour. PICU rates of restraint in Solent NHS Trust, however are higher – in the top quartile range. 2016/17 results are not available for comparison. Detailed analysis of restraint incidents in Maples PICU, showed patterns which may be amenable to intervention. The service has signed up to a Quality Improvement programme, as part of the National Reducing Restrictive Practice Collaborative. The project - which will take place over 18 months from November 2018 - is supported by RCPsyc and involves Trusts across England applying the available evidence base to their clinical areas, within a framework of teaching and networking events.



# 3.1 Solent NHS Trust Performance Report - Operations October 2018/19

## Activity

| | | | Same Period 2017/18 |
|---|---|---|---|
| 16,867 | New Referrals in month* | | 16,052 |
| 64,501 | Attended Contacts in month* | | 58,347 |
| 3,553 | DNA'd Appointments in month* | 4.2% | 3,353 |
| 28 | Delayed Patients in month (DTOCs) | | 26 |
| 500 | Delayed Days in month | | 380 |
| 19,269 | Discharges in month* | | 15,958 |

## Key Performance Indicators

| | |
|---|---|
| 207 | KPIs due in month |
| 148 | KPIs achieved in-month |

## CQUIN Schemes

| | |
|---|---|
| 15 | CQUIN schemes |
| 19 | Milestones due YTD |
| TBC | 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

Wheelchair provision

Contract Performance Notice - Southampton Domiciliary Phlebotomy Service

Contract Performance Notice - Southampton Behavioural Change Service

Increasing complaints within Childrens West

CAMHs Waiting List and Vacancy Pressures

Pulmonary Rehabilitation Capacity & Demand

Training Compliance in Adults Southampton & Childrens

Improving Financial performance in Adults Southampton

Low sickness levels within Sexual Health & Dental

MH OOA Placement Days

MH FFT for recommending

Training Compliance in Southampton & County Wide Care Groups

Community Nursing Portsmouth Improved Performance

# 3.2 Performance Exceptions

## Portsmouth Care Group

The Pulmonary Rehabilitation team waiting times for assessments continue to increase as capacity is being outstripped by demand. The service are changing the assessment model to increase capacity including telephone assessments, changes to the way group sessions are run and reductions in the costing of venue hire.

Following the temporary closure of the Maples Ward over the summer, the ward has been refurbished, has opened all its beds again and consequently we have seen our Out of Area (OOA) placements return to zero.

Our Community Nursing service in Portsmouth showed very strong performance during September, with the lowest amount of temporary staffing used since last November, only one Serious Incident, which is the lowest since February, and for the second consecutive month no complaints were received from our service users. This improved performance is following considerable hard work from the service and service line to optimise our delivery as much as possible.

Mental Health patient FFT for recommending services achieved 100% in September after showing a steady increase over the last six months from 75% in April. The last time the service achieved 100% was April 2017. Performance during October reduced to 90%, however this is the second highest in 2018/19.

## Southampton & County Wide Care Groups

We have seen a rise in complaints within Childrens services in Southampton during 2018/19 compared to the previous two years. These relate to increased complexity/acuity of patients, expectation management and communication. The service reviews all complaints thoroughly to identify any themes or common trends to help avoid any recurrences in future.

CAMHS continue to actively try to recruit to nationally recognised challenging vacancies. Service and commissioners are working collaboratively to mitigate the risk and as a result commissioners have awarded LTP funding to try and bridge the vacancies, and hopefully help deal with demand. Waiting lists continue to increase for first appointments as a result.

Adults Southampton have significantly improved their processes for the utilisation of temporary staffing, including robust sign-off processes, improved rostering and management systems. This has had a positive impact on their financial position.

Training compliance across the Care Groups has continued to increase with all services achieving above target for mandatory training compliance. Sexual Health and SPA have extremely high compliance rates above 94% and Dental above 97%.

Sickness levels within Sexual Health services have continued to reduce for the fourth consecutive month, at just 2.1% during September (3.6% YTD). This reduction has also been seen in Primary Care services throughout the year, with the YTD sickness levels at just 2.9%. Both services have worked very hard with HR Support to help improve the workplace environment for our staff.

The contract performance notice from SCA for our Behaviour Change service is ongoing. We continue to meet with commissioners regularly to provide assurances on mitigations on performance against very challenging public health services.

For our Domiciliary Phlebotomy service contract performance notice with Southampton CCG, we are continuing to submit fortnightly updates against our action plan. Current progress has seen concerns from GP's around delayed appointments reduce significantly and the service are currently mobilising to an electronic patient record system which should aid the flow of patients.

# 4.1 - Quality Performance — October 2018/19

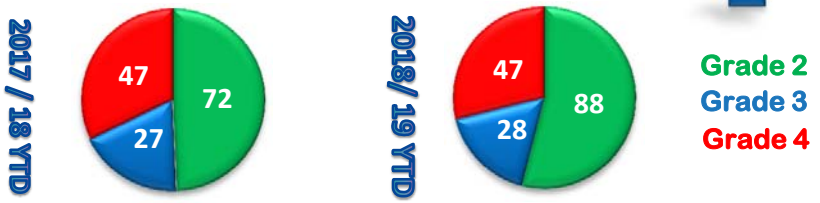
## Serious Incidents

| | |
|---|---|
| 8 | Serious incidents occurred in month |
| 11 | More year to date than 17/18 |
| 1 | YTD Healthcare Infections / Cdiff / MRSA |
| 0 | YTD Safety compliance breaches |

## Pressure Ulcers in Solent Care

25 Occurred in month

6 More than same month 17/18



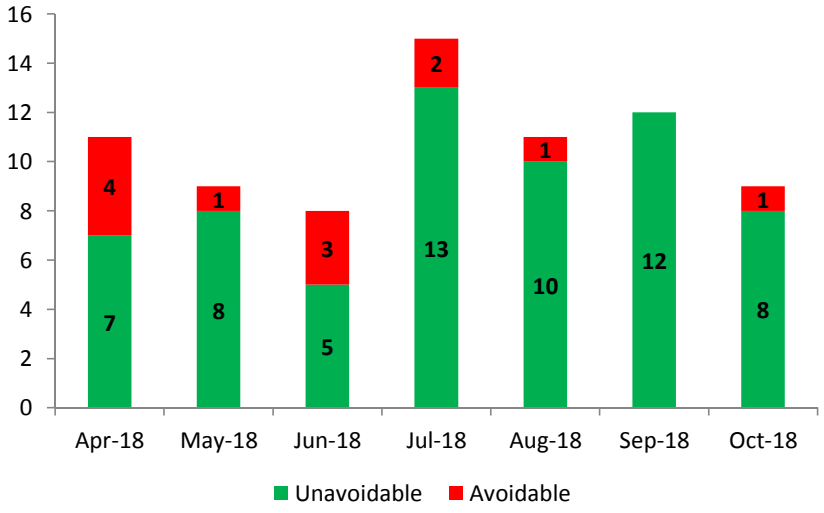

## Friends and Family Test

| | |
|---|---|
| 2269 | Responses received |
| 328 | More than same month 17/18 |
| 96% | Positive ratings % |
| 1% | Negative ratings % |

## Formal Complaints

| | |
|---|---|
| 26 | Complaints received in month |
| 12 | Required response in month |
| 0 | Breaches in month |

## Grade 3 & 4 - Avoidable / Unavoidable



# 4.2 Chief Nurse Commentary – October 2018

## Events to Note

- Care Quality Commission (CQC) undertook a Well-Led inspection of services following on from the 2016 inspection. Initial feedback has been positive and the report is expected for factual accuracy checking by the end of quarter 3.

- We welcome Sarah O Neill into a new position as the Trust Family Liaison Manager and have successfully appointed to the Head of Risk and Litigation position (due to start January 2019) and 2 other roles within the Quality and Safety team.

- A case of Clostridium Difficile Infection (CDI) occurred on Lower Brambles Ward in October. The patient was receiving a high risk antibiotic for CDI when symptoms commenced. A full investigation has been completed and shared with ward manager. Main learning noted as a delay in isolating the patient and obtaining a stool sample. Actions have been implemented to address this. This case will be discussed in more depth in the Quarter 2 Infection Control Report.

- The reporting of grade 2 Pressure Ulcer's (PU) has improved whilst grade 3 and 4 remains consistent. On review of the latter, the numbers identified as avoidable PU's continue to decrease.

- There has been a further improvement in the collection of Friends and Family Test feedback across the Trust and positive comments are consistently received.

## Complaints Update

- There were 2 complaint acknowledgement breaches reported in month. On review, one related to a service concern which was then escalated to a complaint and there was a delay in service response regarding this; the second relates to a professional feedback concern which was received by the PALS and Complaints team after the 3 day deadline. The team are working with services to ensure they are fully aware of systems and processes in order to reduce the risk of these delays occurring.

- Similar to October 2017, it is noted that there has been an increase in complaints received. The reason for this increase is not clear, however an in-depth review is in progress to identify if any themes or trends are emerging. The increase in service concerns predominantly relates to dental patient enquiries following a letter from NHS England which was sent to all dental patients on the Isle of Wight, following Solent taking on the new contract. The letter has not been seen but it informs patients to make direct contact with the PALS and Complaints teams. The team also continue to receive a number of calls relating to issues with access to appointments in the Sexual health service. Primary Care also noted an increase; on review, 3 of these related to a member of staff and the service are reviewing this. No other themes or trends were identified, however the service continue to monitor.

## Incident Updates

<u>Pressure Ulcers (PU)</u>

- The services continue to monitor and review reported PU's. No concerns or trends have been highlighted to date in Adults Southampton.
- The increase in Adults Portsmouth is reported as a result of improvements in reporting culture and earlier identification of a PU.

Information Governance (IG) Breaches:

- Sexual Health have had 2 serious IG breaches reported which are under investigation. One breach regards an HR investigation and relates to disclosure to a third party of confidential information. The second breach was due to not providing results to a patient in the format they requested due ot human error and a complaint was received as a consequence. The service has planned to raise this again in their upcoming education session and remind staff of the importance of adhering to IG guidance and the possible outcomes of not doing so.
- Adults Portsmouth had 3 incidents in October and were reviewed. The service line did not identify any concerns or trends and will continue to monitor through existing governance processes.

## Wheelchairs Update

Trend Serious Incident Investigation - A Psychological harm review has now been commissioned by the Clinical Commissioning Group, (CCG) and the anticipated completion date is December 2018.The Trust is supporting this review as required.

Millbrook wheelchair service (MWS) have confirmed that the Duty of Candour letters in relation to those patients, where harm has been caused, should not be a joint letter and should go from MWS who are the service provider. The letter will be sent after Millbrook have met with the patients concerned (where harm was caused) and they will also write to other patients that were contacted during the trend SI review. MWS have shared the leaflet that they currently send to all patients who are referred. The Trust is in the process of issuing a Duty of Candour letter for all patients on the waiting list, clearly identifying how to contact MWS (the leaflet provided by MWS will be included).The letter will include how we can support our patients while they wait and how they can escalate if their needs change.

On-going governance and management continues, clinical leads respond to patient queries with regard to clinical care provided by Solent and liaise with MWS on a patient by patient basis.

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.

The Trust has also responded to a Prior Information Notice (PIN) issued from commissioners with regard to re-commissioning of the wheelchair service by CCG's. We have highlighted concerns with current provision and the potential risks associated with retaining the current service.

## Venous Thromboembolism (VTE) Prophylaxis

In Adults Portsmouth, there is a decrease in compliance and this is a result of the changeover of medical staff in Jubilee House and non-completion on admission. The service has now produced guidance to avoid this recurring and will continue to monitor.

## Serious Incident (SI) Update

A significant amount of work has been undertaken and there is an improving position in relation to SI breaches and by the end of October there are no outstanding breaches reported. However in month, there was 1 reported breach for a PU report which required amendments post-panel and was not resubmitted within timescale by the service line which caused the breach. The services and Quality and Safety team have worked together to address and it is anticipated that the improvement will be sustained with the implementation of the updated SI timeline

Learning from October SI panel:

- A SI was heard, relating to a young person who was admitted to an Adult Mental Health ward, as there were no inpatient beds available in the system for the young person. The care provided was noted to be of a high standard and there were no concerns regarding the quality of care or safety of this young person. On discussion of the learning, it was noted that due to a shortage of inpatient beds for young people with mental health issues, this situation is likely to recur. Therefore it was agreed that a joint tool and flowchart between Children's and Adult Mental Health to support staff to manage future incidents should be produced. The teams will collaborate to complete this work.

## Friends and Family Test (FFT)

There has been an encouraging increase in the FFT response rate. The majority of feedback is received via paper surveys, however some services, where appropriate, have introduced email links and text email links, e.g. sexual health, MSK and Children's and Families whilst others are using IPads. The Trust consistently received positive feedback across the services and some of the themes from free text comments are as follows:

- Patients felt that they are listened to by staff
- The quality of care is great and staff are kind and thoughtful
- Staff are friendly and professional as well as being helpful and informative
- Staff reassuring and comforting– put patients and children at ease

In addition to identifying the positive experiences, patients and carers also help us to understand some of the challenges they face and some of the themes in October are as follows:

- Length of time to get referred to the service
- Staff always seem very busy
- Long waiting times and difficulty getting appointments

The services are reviewing the feedback and will work to address these issues and continue to improve the experience for patients, carers and families.

## 5.1 - Financial Performance — October 2018/19

### Performance

**£46k** Deficit in Month
£44k Adverse to plan

**£943k** Deficit YTD
£25k Favourable to plan

**£371k** Deficit Year End Forecast *
£600k Favourable control target

*Solent has submitted a revised forecast outturn, which is a £371k adjusted deficit, £600k favourable to plan (£200k stretch target and £400k PSF incentive)

### Purchase Orders and Debts

Eligible invoices raised in month **1227**

**1197** Purchase orders raised in month

Purchase orders raised in month against eligible invoices **98%**

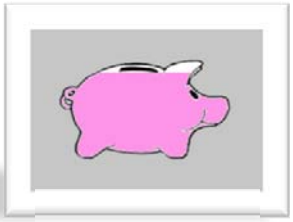
**£4,893,443** Total debt month end

**£880,035** Total debt over 90 days month end **18%**

### Savings

**£3,853,000** Savings Target YTD

**£3,285,000** Savings Delivered YTD



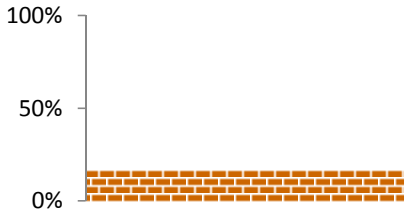
**85%** Savings Achieved

**£2,592,000** Savings Delivered YTD QIA'd

### Capital Finance Summary

**£1,461,000** YTD Spend

**£8,844,000** Year end plan




**16.5%** Spend against year end plan

# 5.2 Finance Commentary

## Month 7 Results

The Trust is reporting an in month adjusted deficit of £46k for month 7, £44k adverse to plan and a year to date adjusted deficit of £943k, £26k favourable to plan. The Trust is broadly on plan and has recognised £248k Provider Support Funding (PSF) in month and £816k YTD.

The adverse in month variance is due to –

- agency spend in Portsmouth which has been addressed past the month-end with November seeing much lower levels;
- estates receiving additional invoices for laundry; following a challenge in November, these will reverse; and
- continued overspends in ICT.

As part of the month 6 returns to NHS Improvement the Trust has submitted a revised forecast outturn of £0.8m deficit (£0.2m favourable to plan), pre any additional Provider Sustainability Funding (£0.4m), giving a net FOT of £0.4m.

The Trust is engaging in active conversations with lead commissioners regarding funding and future saving schemes. 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 7 was £467k, £292k adverse to plan. YTD the adverse variance is £568k 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

Year to date capital expenditure at month 7 is £708k. Projects totalling £4.6m have been approved and in most cases are in progress; however £1.4m 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, £753k of which has been spent YTD.

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

## Aged debt

Debt over 90 days overdue has decreased by £666k month on month due to aged invoices to CCGs and Trusts have been settled. 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.

## 6.1 - Workforce Performance October 2018/19

There were **2,955.6** FTE in post this month, which equates to 3,581 staff in post.

An increase of **26.8** since last month

**90%** YTD mandatory training compliance

**90%** YTD information governance training completed

**80%** YTD appraisals completed

## Bank and Agency

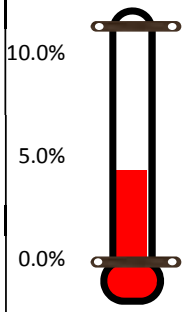
**33,102** Hours requested in month

**20,565** Hours filled by bank in month **£288,573**

**10,353** Hours filled by agency in month **£271,524**

**2,184** Hours requested not filled

In month, Solent are above agency ceiling by **£156,000**




**4.3%**

**Sickness & absence in month**

Last month, the rate was **3.9%**

**96.0%** *budgeted establishment (FTE) worked in month*

**4.0%** *vacancy factor*

*FTE Posts* **124.6**

12 month rolling turnover is **13.9%**

**67** (6065FTE) new starters in month

**36** (29.7.9 leavers in month

## 6.2 - Workforce Commentary

### Sustainable Workforce

Our vacancy factor in October is 4%; this has decreased by 1.4% since August. The number of staff in post for October was 2955.6, an increase of 26.8 since September, taking us 39.1 FTE over plan (not including additional staffing). This increase is due to 12 Dental staff from IOW transferring into the organisation, plus a high level of recruitment activity in September and October which is planned over-recruitment for the winter period. Following on from the success of the digital marketing campaign for mental health, two new digital campaigns have been started in October: Community Nurses for Bank to support winter preparedness, and a GP campaign for the three GP Practices in Southampton.

Agency spend is £431k for October, an increase of £59k since August. This is currently £156k over the Trust's monthly agency cap compared to £97k in August. This increase is due to increase in sickness, and acuity levels, and a decrease of bank supply. The Bank Co-ordinator for Portsmouth is now in place to increase recruitment activity to Bank and increase supply. Off framework requests for this month have increased by 19% with a total of 376 shifts. Adults Portsmouth services account for 52% of this usage, however a proportion of this is offset by funding received from commissioners for "bridging the gap" in PRRT. In addition, a recovery plan is in place for Agency usage in Community nursing, which has yielded significant improvement over the last two weeks.

Average annual staff turnover is consistent at 14%. We are pleased to note that nursing turnover continues to decline; in October annual nursing turnover is 15.6%, a 1.3% decrease since August. The improvement has been fed back to NHS Improvement along with the offer to share our learning.

Existing workforce plans for 18/19 will be reviewed and refreshed as part of the annual business planning cycle. Both quantative planning (FTE by band and by professional group) and qualitative planning (apprenticeship and other developmental roles, skills development and education programmes) are required for the next three years. Plans will be triangulated with 19/20 financial planning and will have an emphasis on sustainable staffing, bank and agency forecasts and costing.

The new Safe Staffing Programme Lead has continued to work in conjunction with the Chief Nurse and Roster team. A current state analysis is being undertaken to establish the priorities of the roster improvement programme and to redesign the roster performance dashboard. The outcome and recommendations of this work will be presented to the People and OD Committee in December.

### Learning & Development

The annual statutory and mandatory training compliance rate is 90.4% for October against a target of 90%. A reduction in complaints around ease of use of the online learning system has been reported by our L&D helpdesk; however significant time continues to be invested into teaching people how to use the system effectively. We will be developing a business case for replacement of the system in 19/20.

Recruitment is underway for an internal Mental Capacity Act trainer to focus on consistent transfer of learning into practice. A Trust wide training plan is in development to include simulation and testing of competencies in practice. For safeguarding, a review of the recently published intercollegiate guidance for safeguarding adults is underway with a revised training programme to

meet required standards. A newly recruited Head of Safeguarding has commenced in role, an immediate priority will be to develop a sustainable programme of training which supports excellent safeguarding practice across the Trust. A 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 with a new approach to training and managing compliance.

Both Information Governance (IG) and Performance Appraisal (PA) are reset to 0% on 1 April at the start of each financial year. The IG compliance rate for October is 90% rising 10% since August. The PA completion rate has increased from 69% in August to 79% in October.

Budgetary incentives have been offered to services to support the Registered Nurse Degree Apprenticeship. In September, nine members of our existing Healthcare Assistant workforce from Adults, Sexual Health and Primary Care services have been accepted on the programme. Work by both the Clinical Directors and the Learning & Development team on career frameworks will be coming together at the end of the year in order to further support the development of our people.

We also saw the start of our Newly Qualified Nurse Induction in September. A cohort of 20 newly qualified nurses began their Solent careers, with named clinical mentors and Educator in Practice (EIP) mentors. This programme has been written by Matrons and EIPs and aims to nurture the skills of newly qualified nurses during their transition year from student to registered clinician.

## Leadership, Culture & Values

The People and OD team continue to deliver bespoke organisational development programmes across services. In particular, Portsmouth PRRT, as well as the commencement of a new leadership programme for Dental Managers to improve leadership capability and drive team performance.

Equality Diversity and Inclusion (EDI) is a key focus based on recent learning from our EDI sub-committee, the well-led review, the Community Engagement programme and from learning at Board level. To date, the focus has been on achieving compliance with the EDS2 and WRES, and whilst this remains a key priority, our focus has shifted to developing an overarching Equality Strategy with full involvement from our local communities. This will underpin how our services are delivered, quality and accessibility of care, responsiveness to community needs and staff and patient experience. This work will be interconnected with the Community Engagement strategy, Quality Improvement and Research and the Patient Experience team.

In October, the Stonewall account manager visited to discuss how we can maximise our membership. We have agreed to carry out an equality benchmarking activity across the Trust in 2019 which will help provide a deeper understanding of our areas of strength and where more action is needed. Stonewall have been assisting with the development of staff networks.

'Our Story', a film depicting our vision and strategy, was released during October. The film includes footage from a CuriosiTea event; proud employees saying how they make a difference. This film now features at corporate induction and is being disseminated throughout the Trust. It has received positive feedback from employees who say that they can connect with our strategy.

The 2018 NHS Staff Survey campaign commenced on 1 October and our target response rate is 60%. In 2017, we achieved an actual response rate of 55%. Our communications have been continual since 1 October and we have used a range of communications. The survey closes on 30 November and we will publish the results in March.

## Health and Wellbeing

We have a challenging national target to vaccinate 75% of frontline workers against flu and our campaign continues. We have taken part in the Unicef #jabforajab campaign which helps to keep vulnerable children healthy and well during winter. For every flu jab we give to a member of Solent staff, we will support Unicef to donate a tetanus jab for a child in another country. Our target is 2800 donations, at the end of October we had achieved 1000 jabs.

The increase in employee relations cases has not continued into September and October: several cases have been closed down and employee relations cases have returned to normal levels. There was an increase in the monthly sickness absence rate from 3.9% in August to 4.3% in October, which we will monitor closely.

## 7.1 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 deteriorated to a level 3 in month. This is due to the financial plan being slightly missed during October, however the organisation is confident that this deficit will be regained during the remaining months of quarter 3. The Trust has not met 4 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 90%. The deterioration of the quality metrics are discussed within section 4.2 Quality Commentary.

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 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff sickness (in month) | 4% | 5.2% | 5.1% | 5.2% | 4.3% | 4.2% | 4.2% | 3.7% | 3.6% | 3.7% | 3.7% | 3.9% | 4.0% |
| Staff turnover (rolling 12 months) | 12% | 14.3% | 14.4% | 14.1% | 14.4% | 14.2% | 14.2% | 13.9% | 13.9% | 14.0% | 14.1% | 14.1% | 14.0% |
| NHS Staff FFT | 40% | - | - | - | - | 69.0% | - | - | - | - | - | 71.2% | - |
| Proportion of Temporary Staff (in month) | 6% | 6.0% | 6.1% | 6.0% | 5.9% | 6.0% | 5.6% | 4.9% | 5.7% | 5.9% | 5.9% | 5.8% | 5.7% |

## Caring

| Indicator Description | Threshold | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Written Complaints | | 19 | 16 | 18 | 22 | 20 | 19 | 27 | 17 | 20 | 18 | 12 | 26 |
| Staff Friends and Family Test Percentage Recommended - Care | 80% | - | - | - | - | 84.0% | - | - | 84.0% | - | - | 84.7% | - |
| Mixed Sex Accommodation Breaches | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Community Scores from Friends and Family Test - % positive | 95% | 97.0% | 96.6% | 96.2% | 96.2% | 95.9% | 95.4% | 96.4% | 96.4% | 95.4% | 96.1% | 95.9% | 96.2% |
| Mental Health Scores from Friends and Family Test - % positive | 95% | 91.3% | 83.3% | 95.6% | 84.3% | 80.5% | 74.7% | 71.2% | 88.3% | 86.5% | 85.7% | 100.0% | 90.6% |

## Effective

| Indicator Description | Threshold | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS | 95% | 100% | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 98% | 100% | 100% |
| % clients in settled accommodation | | 71% | 71% | 71% | 70% | 71% | 74% | 75% | 80% | 79% | 79% | 82% | 83% |
| % clients in employment | 5.0% | 6.0% | 5.0% | 5.0% | 5.0% | 5.2% | 4.4% | 5.0% | 5.8% | 6.0% | 5.9% | 6.7% | 6.2% |

## Safe

| Indicator Description | Threshold | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Occurrence of any Never Event | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NHS England/ NHS Improvement Patient Safety Alerts outstanding | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| VTE Risk Assessment | 95% | 97.0% | 97.0% | 96.0% | 95.0% | 92.0% | 91.0% | 99.0% | - | 91.0% | 98.0% | 96.0% | 93.0% |
| Clostridium Difficile - variance from plan | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Clostridium Difficile - infection rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias | 0 | 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 | 0 |
| MRSA bacteraemias | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Admissions to adult facilities of patients who are under 16 yrs old | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Operational Performance Indicators

| Indicator Description | Threshold | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway | 92% | 99.6% | 99.7% | 99.4% | 99.4% | 99.7% | 99.5% | 99.8% | 99.4% | 99.7% | 99.1% | 99.4% | 99.6% |
| Maximum 6-week wait for diagnostic procedures | 99% | 100% | 100% | 100% | 100% | 100% | 99% | 99% | 100% | 100% | 100% | 97% | 99% |
| Inappropriate out-of-area placements for adult mental health - services - Number of Bed Days | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 21 | 71 | 122 | 116 | 19 | 0 |
| People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral | 50% | 88.0% | 50.0% | 40.0% | 83.0% | 100.0% | 75.0% | 100.0% | 100.0% | 60.0% | 100.0% | 100.0% | 100.0% |
| Data Quality Maturity Index (DQMI) - MHSDS dataset score | 95% | - | 97.4% | - | - | 86.2% | - | - | - | - | - | - | - |
| Improving Access to Psychological Therapies (IAPT) / Talking Therapies | | - | - | - | - | - | - | - | - | - | - | - | - |
| - Proportion of people completing treatment who move to recovery | 50% | 57.8% | 53.4% | 57.8% | 57.6% | 58.2% | 51.1% | 56.1% | 60.4% | 61.9% | 58.7% | 61.2% | 55.9% |
| - Waiting time to begin treatment - within 6 weeks | 75% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.8% | 100.0% | 100.0% | 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% |

## 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 | | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Capital service capacity | Financial Sustainability | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 0 | 1.2 | 1.4 | 1.5 | 1.5 |
| *Score* | | *3* | *2* | *3* | *2* | *2* | *2* | *4* | *4* | *4* | *3* | *3* | *3* |
| Liquidity (days) | Financial Sustainability | -14.4 | -15.4 | -14.7 | -10.7 | -6.7 | -6.2 | -6.7 | -6.8 | -6.5 | -5.9 | -5.4 | -5.7 |
| *Score* | | *4* | *4* | *4* | *3* | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *2* |
| I&E Margin | Financial Efficiency | -1.0% | -1.0% | -0.9% | -0.7% | 0.4% | -0.9% | -1.3% | -1.4% | -1.2% | -1.0% | -1.0% | 0.9% |
| *Score* | | *4* | *3* | *3* | *3* | *2* | *3* | *4* | *4* | *4* | *3* | *3* | *3* |
| Distance from financial plan | Financial Efficiency | 0.0% | 0.1% | 0.1% | 0.2% | 1.3% | 0.3% | 0.2% | 0.1% | 0.1% | 0.1% | 0.1% | -0.2% |
| *Score* | | *1* | *1* | *1* | *1* | *1* | *1* | *1* | *1* | *1* | *1* | *1* | *2* |
| Agency spend | Financial Controls | 38% | 42% | 42% | 43% | 38% | 24% | 37% | 34% | 35% | 38% | 39% | 43% |
| *Score* | | *3* | *3* | *3* | *3* | *3* | *2* | *3* | *3* | *3* | *3* | *3* | *3* |
| Use of Resources Score | | 3 | 3 | 3 | 2 | 2 | 2 | 3 | 3 | 3 | 2 | 2 | 3 |
| RAG | | R | R | R | G | G | G | R | R | R | G | G | R |

## 7.2 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.<br>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.<br>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.<br>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.<br>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:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation | Confirmed | The Board is not aware of any departures from the requirements of this condition.<br>On an annual basis the Trust has implemented a process of governance reviews (via the Governance and Nominations Committee) including;<br>- Reviewing composition, skill and balance of the Board and its Committees<br>- Reviewing Terms of Reference<br>- 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.<br>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.<br>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:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(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;<br>(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);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(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<br>(h) To ensure compliance with all applicable legal requirements.<br><br>. | Confirmed | For 2017/18<br>The Trust achieved a £0.7m surplus against an agreed deficit control total of £1.5m.<br>External Auditors issued an unqualified Value for Money opinion and an unqualified opinion concerning the Trust's financial statements for the year 2017/18.<br><br>For 2018/19<br>Our agreed control total is £1.0m deficit. At month 6, a revised forecast of £0.4m was submitted; the movement of £0.6m is made up of an internal improvement of £0.2m, which creates £0.4m of additional PSF.<br><br>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.<br><br>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:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(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<br>(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.<br><br>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.<br><br>The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors.<br><br>There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer.<br><br>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.<br>The Executive team will be undertaking a 360 degree team appraisal during 2018/19.<br><br>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.<br>Details of the composition of the Board can be found within the public website.<br>Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. | |

REPORT

Item 12.1

NHS Solent NHS Trust

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Presentation to** | **Public Board** | | | | | | | |
| **Title of Paper** | **Emergency Planning, Resilience and Response** | | | | | | | |
| **Author(s)** | Elaine Peachey | | **Executive Sponsor** | | David Noyes | | | |
| **Date of Paper** | 26th November 2018 | | **Committees presented** | | | | | |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | | **W2** Vision & Strategy | | **W3** Culture | | **W4** Roles & Responsibilities | |
| | **W5** Risks and Performance | | **W6** Information | | **W7** Engagement | | **W8** Learning, Improvt & innovation | |

## Executive Summary

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

A formal review and assessment of Solent Trust was undertaken by the commissioning Emergency Planning Leads, who supported the assessment of evidence provided to NHS England. Informal feedback from the CCG overseeing the evidence presented by Solent confirmed that at the NHS England 'Confirm and Challenge' meeting NHSE accepted the rating of Substantially Assured for Solent NHS Trust. Formal letters will be sent out once all the meetings have been completed.

Solent NHS Trust provided substantial evidence in 51 of the 54 core standards and all 8 of the 'deep dive' standards.

The expectation is that full compliance will be achieved By Solent NHS Trust at the end of November 2018. Substantially assured was an excellent result given the changes in both assessment and the standards and also the changes in personnel leading the assurance process.

To achieve full compliance there is a plan in place

| Standard | Evidence required | Completion date |
|---|---|---|
| **3.** The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. | Minutes of board meeting to be added to evidence. The delay in presenting the report to the board was due mainly to the delay in the publication of the new standards not received until 31/7/18 with all evidence required by 6/9/18 | 30/11/18 |
| **11.** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework). | Debrief report following exercise Prometheus which shows a 'live' exercise and opening of the incident co-ordination centre. The original exercise had to be re-scheduled | Now completed |

| | | |
|---|---|---|
| **28.** Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation | Self- assessment results and training/ exercising attendance sheets.<br><br>Self-assessment questionnaires were sent to all strategic and tactical responders for completion and analysis | Now completed |

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

There are no risks associated with the 'substantial assurance' result however work must continue to ensure that Solent NHS trust continue to comply with the standards and that improvement is part of the overall forward planning for all of the standards.

If evidence was not available and standards not adhered to the risk is that the organisation would not be able to respond to incidents and continue to deliver the services required particularly priority or essential services.

**Key Decisions/ Action(s) requested**

To receive the annual EPRR report for Solent NHS Trust as assurance for an appropriate response to any incidents.

Item 12.2

# ANNUAL REPORT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

## OCTOBER 2018

## 1. Introduction

As all NHS-funded organisations are expected to meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS Standard Contracts, and the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR), this report identifies work undertaken to ensure that the Trust is compliant with these statutory requirements. The report therefore outlines the current position of emergency preparedness, resilience and response through the key activities that have taken place during the last year 2017-2018

## 2. Requirements and Principles of EPRR

The Civil Contingencies Act 2004 (CCA) delivers a single framework for the provision of civil protection in the UK. The principle objectives of the Act are to ensure consistency of planning across all government departments and its agencies, whilst setting clear responsibilities for frontline responders at a local level.

The Act divides responder organisations into two categories, depending on the extent of their role in civil protection work, and places a proportionate set of duties on each. Category One responders are those organisations at the core of emergency response; this category includes all Acute Trusts and Ambulance NHS Trusts, Public Health England (PHE) and NHS England. Community providers are not listed in the Civil Contingencies Act (2004), however the Department of Health and NHS England expects them to plan for and respond to incidents in the same way as category one responders in a manner which is proportionate to the scale and services provided.

Category 2 responders for health are Clinical Commissioning Groups (CCG's) who have a lesser set of duties but are expected to co-operate and share relevant information with other category 1 and 2 responders. They are unlikely to be involved in planning of the response but will be involved in any incidents that affect their own sector. Outside health category 2 responders who may offer support are transport providers, highways agency, telecommunications providers and the health and safety executive.

## 3. Civil Contingencies Act

Under the *Civil Contingencies Act (CCA) 2004* the Trust has a duty to demonstrate compliance against six civil protection duties:

- Assess local risks, using this to inform emergency planning
- Develop Emergency Plans
- Plan for Business Continuity Management
- Put arrangements in place to warn and inform the public
- Co-operate with other responders
- Share Information

The need to prepare, plan and exercise for a Major Incident is not only a statutory requirement under the CCA, but also a requirement under the NHS England Emergency Preparedness Framework, and a requirement for the NHS Standard Contract (SC 30).

## 4. Assessment of Risk

The Emergency Preparedness Framework clearly outlines the requirement for risk assessment to underpin emergency preparedness. Solent NHS Trust has clear and effective risk processes in place and contributes to the review and updating of not only our own but also the Local Resistance Forum community risk register, as part of the work undertaken by the Local Health Resilience Partnership (LHRP).

In accordance with the national and local risk assessments of the highest risk, Solent NHS Trust is in 2018/19, planning and testing the trust resilience in the event of an incident resulting in long term electricity loss and also reviewing existing plans for incidents such as adverse weather and pandemic flu.

Local potential business continuity risks are also included in the trust risk register and reviewed regularly as required.

## 5. Emergency Preparedness Plans

Work has continued, to further develop and refine Solent NHS Trust Emergency Preparedness Portfolio and the plans that have been reviewed in the year are as follows:

- Incident Response plan
- Pandemic Influenza (as part of the system wide planning group)
- Mass Casualty
- Lockdown
- Escalation and Surge
- Winter preparedness and contingency plans

## 6. Business Continuity Management

Business Continuity Plans are in place across the organisation. A full review of BCPs was carried out in 2018 and all plans were tested, during the adverse weather in March 2018 and during the loss of the email system in May 2018. A number of table top exercises have also taken place and a full peer review audit was undertaken in July 2018 which has been presented to the Audit Committee.
The Business Continuity Policy will continue to be aligned to ISO 22301 (Societal Security – Business Continuity Management Systems – Requirements).

Solent NHS Trust continued to work in partnership with the acute Trusts and CCG's in the winter of 2017-2018 as part of the acute trusts surge management response. This was particularly important when capacity was challenging for the acute trust in the East of the area as Solent assisted the Portsmouth system to cope with the higher than expected demand and capacity issues whilst continuing to provide core community services.

This year, 2018, in preparation for the potential of a 'no deal' Brexit business continuity plans will be reviewed specifically to ensure all 'at risk' contracts and supplies are covered.

## 7. Put in Place Arrangements to Warn and Inform the Public.

Solent NHS Trust has continued to work in partnership with other health providers and commissioners to provide information to both staff and the public. Throughout the year, severe weather warnings and flood warnings have been placed on the staff web site when required, and an information leaflet on caring for yourself in a heatwave was available for the public to download which in 2018 was also available as an 'easy read' version.
Flood warnings and severe weather warnings are received by email and are then circulated widely to all managers, in order to allow us to pro- actively warn and inform and prepare our services.
In preparation for winter and potential adverse weather the 'emergency zone' on solnet will contain weather warnings, alerts and responses to winter capacity issues.

## 8. Co-operate with Other Providers

Co-operation between organisations is fundamental to robust emergency preparedness.
Solent NHS Trust continues to participate as a member of the Local Health Resilience Partnership (LHRP), represented by the Chief Operating Officer.

The Emergency Planning Lead (EPL) also regularly attends local health resilience meetings and feeds back relevant information to the emergency planning group. The EPL also works in partnership with the two local community Trusts, (Southern Health Foundation Trust and Dorset Healthcare) and also with the Portsmouth and Southampton acute trusts to ensure all work undertaken is consistent across the area and that there is a greater understanding of EPRR within the organisations. Working together in this way supports the requirements of the CCA and allows for joint learning and the sharing of EPRR documents and work plans.

## 9. Training and Exercising

*Exercising*
The Emergency Preparedness Framework requires each organisation to undertake:
- 'Live' exercise every three years
- Command Post Exercise every six months
- 'Table top' exercise every year
- Communications cascade exercise every six months

The plan for 2017-18 is:

| Exercise/Training | Frequency | Content | Dates |
|---|---|---|---|
| **Communications cascade** | **6 monthly** | **Comms cascade only** | **April 2018** |
| **Communications cascade** | **6 monthly** | **Comms cascade only (Saturday)** | **29th November 2018** |
| **Table top exercise** | **Annual** | **Table top, including ICC** | **East – 26tht September 2018<br>West – 24th October June 2018** |
| **LIVEX (Multi-agency)** | **Every 3 years** | | |
| **Decision Loggist** | **As required** | **Decision loggist training to enable staff to log during an incident** | **17th October 2018** |
| **Local Resilience forum-Winchester** | **As available** | **LRF forum and information** | **18th October 2018** |
| **Director/Senior Manager** | **Annual** | **Responding to an incident and ICC command and control** | **27th November 2018** |

## 10. Core Standards

The NHS England Core Standards for EPRR are the standards which must be met; the aim is to clearly set out the standards expected of each NHS organisation and provider of NHS funded care. In addition, the standards will also:

- Enable agencies across the country to share a common purpose and to co-ordinate EPRR activities in proportion to the organisation's size and scope; and

- Provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

The Trust has now carried out a detailed self-assessment against the applicable 2018/19 Core Standards which has been supported by NHS England and the CCG, with the following results:

| **Overall assessment:** | Substantially compliant |
|---|---|

| Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Governance | 6 | 5 | 1 | 0 |
| Duty to risk assess | 2 | 2 | 0 | 0 |
| Duty to maintain plans | 13 | 12 | 1 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 3 | 2 | 1 | 0 |
| Response | 5 | 5 | 0 | 0 |
| Warning and informing | 3 | 3 | 0 | 0 |
| Cooperation | 4 | 4 | 0 | 0 |
| Business Continuity | 9 | 9 | 0 | 0 |
| CBRN | 7 | 7 | 0 | 0 |
| Total | 54 | 51 | 3 | 0 |

| Deep Dive | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Incident Coordination Centres | 4 | 4 | 0 | 0 |
| Command structures | 4 | 4 | 0 | 0 |
| Total | 8 | 8 | 0 | 0 |

**PARTIALLY COMPLIANT STANDARDS**

The three standards that did not achieve full compliance will have the evidence completed by the end of November 2018 and will then be fully compliant. This is a considerable achievement due to the number of changes in the standards in 2017/8 and also the changes in the assessment process.

| **Standard** | **Evidence required** | **Completion date** |
|---|---|---|
| **3.** The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. | Minutes of board meeting to be added to evidence. The delay in presenting the report to the board was due mainly to the delay in the publication of the new standards not received until 31/7/18 with all evidence required by 6/9/18 | 30/11/18 |
| **11.** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework). | Debrief report following exercise Prometheus which shows a 'live' exercise and opening of the incident co-ordination centre. The original exercise had to be re-scheduled | Now completed |

| | | |
|---|---|---|
| **28.** Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation | Self- assessment results and training/ exercising attendance sheets.<br>Self-assessment questionnaires were sent to all strategic and tactical responders for completion and analysis | Now completed |

## 11. Work plan

- Further review and development of and lock down arrangements and testing to take into account property alterations
- Continue with annual review and testing of Business Continuity plans.
- Work with Contracts team to help identify specific essential supplies and third party services and ensure that we are sufficiently assured that they have processed in place through their business continuity management plans to be resilient. It should be noted that this work is already progressing however will continue into 2018.
- Continue to offer further training particularly in incident management skills and knowledge, including familiarity with the Incident Coordination Centre (ICC) related procedures and offer training to teams who do not normally participate in on call.
- Further develop the current training programme at all command and control levels.
- Work with IT to establish a more robust communication system and look at the use of new technologies in emergency planning and business continuity.

It should be noted that a number of the above activities will also contribute to the Trust's ability to play its role in cooperating with and supporting other responders in a multi-agency response to a major incident such as a mass casualty event.

## 12. Summary

In summary the Trust has over the last year, demonstrated that it has the ability to respond to Major, Critical and Business Continuity Incidents. When an event occurs the incident would be formally reviewed at the 'debrief' to identify lessons and continue to improve and refine responses in the future. Solent NHS Trust has demonstrated assurance to NHS England and the CCG, through compliance with the EPRR Core Standards. The plans are reviewed annually and work will continue to take place to demonstrate full compliance for 2017/18.
Recently the EPRR Lead has reduced her working hours and the new Local Security Management Specialist will assist in this work as the Deputy EPRR Lead.

REPORT

Item 13.1

Winter Planning and Resilience report 2018

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Presentation to** | Board | | | | | | | |
| **Title of Paper** | **Winter Planning and Contingencies 2018** | | | | | | | |
| **Author(s)** | Elaine Peachey | | **Executive Sponsor** | | David Noyes | | | |
| **Date of Paper** | 15th October 2018 | | **Committees presented** | | EPRR group | | | |
| **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 | |

## Executive Summary

The purpose of this paper is to provide the information regarding the collaborative winter planning arrangements put in place and to describe the process for any emergency increase in demand and the implications of these actions.

**Summary**

Solent NHS Trust strives to continue to deliver accessible, high quality services throughout the year including the difficult winter period. Winter is nationally recognised as a pressure point where additional planning is required in order to maintain resilient services.

The aim of the winter plan is to ensure internal processes and systems are fit for purpose, resilient and flexible to meet the anticipated level of demand.

Lessons learnt from previous years have been included in the planning and business continuity plans have been reviewed particularly in view of severe winter weather conditions. A co-ordinated approach is essential to ensure that preparation is robust and both Portsmouth and Hampshire wide services have adopted a system wide approach to the preparation for winter.

Due to the adverse weather conditions experienced in March 2018 plans have also been reviewed and updated to ensure adverse weather has been considered.

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

Despite the detailed contingency there are a number of risks that could affect the response to winter these are included in the risk register

- Pandemic influenza (or similar outbreak)
- Widespread electricity loss
- Adverse weather

**Key Decisions/ Action(s) requested**

The Board is asked to **note** the status of the Winter Plan for 2018/19, which has been submitted to NHS England and that the Trust is working with partner organisations through the A&E Delivery Board to deliver those actions in the plan.

Item 13.2

# Winter Resilience and Cold Weather Planning 2018/19

**CONTENTS**

**1.0 Introduction**

1.1 The purpose of this document is to describe the planning arrangements put in place by Solent NHS Trust to support the delivery of care throughout the winter period, including the Christmas and New Year holiday period.

1.2 Solent NHS Trust plan to maintain organisational readiness and resilience, and respond appropriately to operational pressures to enable services to continue throughout the winter period. It is recognised however, that an additional focus is required during this period, when demand for some services is likely to be at its highest level.
It is essential to maintain a co-ordinated approach to ensure that preparation is robust and that processes are in place that can adapt to the different pressures as and when they arise.

1.3 To ensure the organisation can respond to significant peaks in demand Solent NHS Trust has Incident Response Plans (Major Incident Policy) which are supported by associated plans and action cards. These documents are underpinned by the individual service's Business Continuity Plans which detail how capability and capacity is maintained at peak times.

1.4. Our climate is changing and as a consequence we are seeing more frequent and severe weather events, such as droughts, heat waves, storms and extremes of cold & hot weather bringing increased disruption to our services and activities. It is however important that the Trust is able to respond, especially during these periods, to all the demands placed upon it.

1.5 The purpose of this document is to set out how Solent NHS Trust plans to:

- maintain resilience over the periods of seasonal variations in demand
- manage and improve patient flow including discharge
- focus on maximising independence and self-care models of care for our patients
- Ensure that there are no barriers that could result in transfer delays as part of the OPEL framework

**2. Key Pressures**

2.1 There are a number of key pressures which occur during the winter period:

- Increased demand on the health and social care system as a whole due to the direct effects of cold weather resulting in increased heart attacks, strokes, respiratory diseases, influenza, falls, injuries, hypothermia and carbon monoxide poisoning, and the indirect effects of cold weather such as depression and other mental health illnesses.
- Staffing problems due to the health effects of cold weather as detailed above.
- The impact of extreme weather on road and rail networks making travel to and from work and while at work difficult.
- Potential disruption to the critical supply chain infrastructures.
- System wide delays in transfer.

**3. Lessons Learnt from Previous Years**

**(a) Southampton**

- Operational Resilience Conference calls – representation has been identified for these on a weekly basis from all relevant service managers. A rota is in place which clearly identifies one person per week to assist with these calls, and any additional ones as they arise. If the local health economy is on a "black" status the rota switches to senior managers who are able to facilitate on the spot decision making. Solent have been pro-active in ensuring data is uploaded daily onto SHREWD (Single Health Resilience Early Warning Database) and is fully engaged with any further developments with this. There has been clear communication regarding expectations and also when to escalate to more senior management eg. Deep red/black status. Due to recent updates the SHREWD data now also reflects integrated services which effect the system position.

  New discharge pathways have been implemented successfully and then enhanced with further funding to support the acute sector. Further developments continue with activity to review frailty in the ED and discharge from the AMU. The Urgent Response Service also continues working with the SCCCG to enhance admission prevention activity including review of provision of IV in the community

**(b) Portsmouth**

- Key to the delivery of the response to levels of escalation within the PSEH system in QAH was our ability to effectively manage capacity and flow within the Portsmouth system - this was facilitated by partnership working with PCC and commissioners in the form of a weekly review of delayed transfers of care
- Learning from deep dives into patient safety related concerns that followed a New Year surge in urgent care demand will inform a review of the Solent actions within the local system escalation plan
- An understanding of the root cause of delayed transfers in care informed the mobilisation of an independently provided bridging service (Agincare) which has demonstrated a significant reduction in the numbers of delayed transfers of care attributable to waits for domicilary care within the Portsmouth system with agreement to extend the current contract for up to 350 hours
- Solent along with system partners have supported the implementation of SHREWD and are fully engaged in local development in its application. Further plans in advance of winter include the development of a Portsmouth system (PCC and Solent combined) submission for SHREWD as well as the use of SHREWD data to inform the narrative and agreed actions of the Daily Ops Call, which PCC are committed to joining

**4. Cold Weather Alerts**

Solent NHS Trust follows the national Met Office Cold Weather Alerts and informs staff of the alerts using the internal intranet (solnet). These alerts are also cascaded by the Trust Communications team to all staff, together with the appropriate actions to take at that level and any advice for the patients and service users. Social media is also used to notify staff of any issues such as adverse weather and traffic issues.

Cold weather alerts are classified into four categories from November 1 to March 31 :

| | |
|---|---|
| Level 0 | Long-Term Planning - *All year* |
| Level 1 | Winter Preparedness Programme<br>*1 November to 31 March* |
| Level 2 | Severe Winter Weather is Forecast – Alert and Readiness<br>*Mean temperature of 2°C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence* |
| Level 3 | Response to Severe Winter Weather – Severe Weather Action<br>*Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow* |
| Level 4 | Major Incident – Emergency Response<br>*Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health.* |

The Trust works in partnership with social care services to identify people most at risk from seasonal illness and to improve their resilience to severe weather. Warnings at level 2, level 3 or level 4 are forwarded by the Trust's Emergency Planning team to cascade to staff and managers..

The Trust's communications plan includes arrangements in place for communicating with staff during severe weather conditions for example, to advise staff how best to get to work or to advise staff on mobile/home working.

## 5. Escalation framework

### 5.1 Leads

The Chief Operating Officers, David Noyes (Southampton) and Sarah Austin (Portsmouth) are the Trust leads for systems resilience and winter planning and the Chief Nurse, Jackie Ardley, has the lead responsibility for flu planning.

### 5.2 System Networks

The Trust participates in local networks which support the development and coordination of day to day systems management and escalation. Key stakeholders involved within the networks include Clinical Commissioning Groups, neighboring Trusts, Ambulance Trusts, Out of Hours providers, 111, Social Services, and other Local Authority Departments.

The groups also have close links with Communications and emergency planning groups.

The escalation policies and frameworks for the Trust are rooted in System-wide management methodology at a local and regional level using the operational pressures escalation levels framework (OPEL) across the whole system.

| Operational Pressures Escalation Levels | |
|---|---|
| OPEL 1 | The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated. |
| OPEL 2 | The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed. |
| OPEL 3 | The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms |
| OPEL 4 | Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered. |

### 5.3 Daily Escalation Reporting – System Priority Services

Based on the model above an alert system operates within the Trust which includes routine daily reporting of the capacity and escalation status of 3 key service areas that are critical to the effective management of demand, capacity and patient flow through the system:

| **Portsmouth** | **Southampton** |
|---|---|
| Portsmouth Rehab and Reablement service/Rapid response including In Reach | Southampton Urgent Response Service |
| Community nursing including EOL Service | Community nursing |
| Community In-patient services | Community in-patient services |

Each of the services has clearly defined triggers built around agreed early warning signs of escalating pressure, which allow the service to match themselves against the levels of alert above. This traffic light system enables the services to communicate, early each day, any mismatch between capacity and demand. These triggers combine to form a Trust escalation framework which determines the alert status of the Trust overall. Throughout the year via daily status reports the alert status of each of the services and the overall Trust status are shared with the Acute Trusts and relevant stakeholders within the Southampton and

Portsmouth systems. This includes submission to a system-wide depository to enable a systems dashboard to be distributed by the CCGs, and a system wide escalation plan.

Each of the services in the table above has a capacity and escalation plan in place, which outlines their escalation triggers, actions and responsibilities. These plans are supplemented by business continuity plans when pressures occur which extend beyond business as usual. Both sets of plans are held centrally within the Trust.

The escalation framework described above can be expanded to include other services where capacity pressures arise. Managers on call out of hours are provided with a daily capacity update when the system is under pressure and are able to request more frequent reports if necessary.

- Workforce Planning: There are thresholds already in place for the numbers of staff that can have planned leave at any one time, however as part of our Winter Plan we are focussing on the robustness of business continuity plans and this will include more work on contingency planning particularly in view of Pandemic Flu risk and the need to build into escalation plan actions re transferring resource from elective to non-elective services

Figure 1: Solent Trust Escalation Triggers

## Solent Escalation Framework

A daily status report will be available to provide Managers with information about capacity and alert status as defined below. The levels and actions described relate to individual team and city wide escalation.

| Normal Service | (OPEL 1) GREEN<br><br>(Moderate Pressure) | (OPEL 2) AMBER<br><br>(Severe Pressure) | (OPEL 3) RED<br><br>(Potential Service Failure) | (OPEL 4) BLACK |
|---|---|---|---|---|
| Teams have capacity to undertake all scheduled and unscheduled clinical visits training and appropriate meetings | Capacity exceeds demand (against agreed team capacity / number of visits). The team manager undertakes the following action to ensure that all necessary clinical visits are undertaken.<br>1. Seeks support from other community nursing teams in locality with suitable capacity<br>2. Caseloads reviewed to see whether visits can be replaced with a telephone contact<br>3. Stops non-clinical activity in order of agreed priority (detail available on request) & notifies locality manager | Despite all above actions capacity within locality is not sufficient to meet demand.<br>1. Locality manager informed<br><br>2. Team manager agrees to postponement of specific non-urgent clinical visits (only able to postpone once) eg. Vitamin B12 injections, Ear care, simple dressings<br><br>3. Team manager contacts other localities for support<br><br>4. Locality manager contacts Bank for support<br><br>5. Locality manager informs Integrated Service Manager about immediate and medium term position | All above actions have not been able to match capacity with demand. At level 4 essential governance processes, patient care and staff care become compromised but direct harm to patients is not expected. Community Nursing in the city cannot continue to operate at Level 4 without immediate action.<br>1. Situation escalated and managed by duty Locality managers who prioritises management of situation<br><br>2. Postpone – as above + leg dressings<br>3. Stop all level one meetings, as agreed<br><br>4. Locality manager continues to manage teams and services but works with Integrated Service Manager who escalates within Solent and ensures actions 5 – 8 are enacted.<br><br>5. Recruit resources from all available areas – LTC's, leg ulcer, rapid response, bladder and bowel, Mountbatten House etc. | Despite all above actions demand exceeds capacity and essential visits not occurring, teams unable to take palliative patients, UHS discharges and GP referrals. Strong likelihood of patient harm. Full SIRI investigation will be required |

| | | | | |
|---|---|---|---|---|
| | | | 6. Inform system that Community Nursing are at Red and ask for resources and support from:<br><br>a. Secondary care, CEDT, & RSH asked to hold on discharges requiring immediate nursing input, palliative discharges<br><br>b. Primary Care: GP's informed of situation<br><br>7. Staff asked to cancel annual leave where possible<br><br>8. Integrated service manager commissions HRI investigation to understand cause. Review to include analysis of escalation procedure (policy followed in all localities / teams) and causes (including all available system wide data). Findings and recommendations to influence development of current escalation policy | |

| | **Community beds (at least 3 of the triggers must apply)** | **Urgent Response Service/ Portsmouth Rehab & Reablement** | **Community Nursing*** | **Urgent Care (MIU/WIC)** | **Overall Status** |
|---|---|---|---|---|---|
| | • Good capacity available across the service.<br>• No beds closed.<br>• Predicted discharges maintaining flow.<br>• Staffing pressures managed within resources available.<br>• Dependency appropriate to each clinical area.<br>• Wards accepting all appropriate referred patients for rehab.<br>• Delayed transfers of care low across the service. | • Capacity available and accepting referral | • Capacity available and accepting referral | • Service demand within expected levels and capacity sufficient to meet demand | • Community capacity available across system |
| | • Capacity available but limited.<br>• Predicted discharges low and insufficient to meet demand.<br>• Beds closed to admissions in any one area due to infections or other management issues.<br>• Staffing pressures exist that necessitate the use of agency to maintain safe shift patterns.<br>• One area has placed limitations on the dependency of admissions.<br>• Delayed transfers of care are above target levels. | • Unpredicted demand of new referrals<br>• Unpredicted demand due to increase of dependency of existing caseload<br>• Predicted demand with reduced staff<br>• At risk of breaching KPI's<br>• Capacity above 85% across the whole service.<br>• Bridge gaps accepted fitting into the available capacity. | • Unpredicted demand of new referrals/ increase of dependency of existing caseload<br>• Predicted demand with reduced staff<br>• At risk of breaching KPI's<br>• Capacity above 85% across the whole service | • Unpredicted demand during operational hours<br>• Predicted demand with reduced schedule of staff | • Patients waiting for community care capacity<br>• Lack of medical cover for community beds<br>• Infection control issues<br>• Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) |
| | • Predicted/actual combined bed occupancy - 100%.<br>• No predicted discharges.<br>• Area closed to admissions due to infections or other management issues.<br>• More than one ward can only accept low dependency patients.<br>• Delays significantly exceed target levels.<br>• Demand high. | • Patient demand cannot be managed following amber action plan<br>• KPI's are breached<br>• Capacity above 95% for the whole service.<br>• Bridge gap referrals are delayed and only community referrals are accepted. | • Patient demand cannot be managed following amber action plan<br>• KPI's are breached<br>• Capacity above 95% for the whole service. | • Pressure cannot be managed following amber actions resulting in pressure on acute sector.<br>• Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow | • Community capacity full<br>• Significant unexpected reduced staffing numbers in areas where this causes increased pressure on patient flow |
| | • More than one area is closed to admissions due to infections or other management issues.<br>• No predicted discharges and demand rising.<br>• Bed occupancy is 100%<br>• Lack of medical cover.<br>• Actions at red have failed to deliver capacity<br>• Delays exceed 25% of the bed capacity. | • At +**100%** for the **<u>whole</u>** service. Community referrals cannot be managed and are having to be admitted. | • Pressure cannot be managed following actions taken at red.<br>• Demand exceeds 100% of capacity | • Pressure cannot be managed following actions at red.<br>• Unexpected reduced staffing numbers in areas where this causes increased pressure on patient flow. Pressure is at a level that compromises service provision / patient safety | • No community capacity<br>• Pressure on patient flow is at a level that compromises service provision/patient safety |

## Capacity and Demand

### 6.1 Capacity Planning

The Trust continues to work collaboratively with partner organisations to develop system-wide predictive capacity modeling tools and to review existing escalation frameworks. System wide meetings enable sharing of information which can then act as a predictor of the peaks in demand such. SHREWD can also assist with capacity planning.

All service's Business Continuity Plans (BCPs) detail how capacity and quality is maintained at peak times and when there is a loss of critical services or resources. These BCPs link to the local health economy Escalation Plans and policies. All service BCP's are subject to annual review and validation to ensure they are effective when in use.

### 6.2 Surge and Escalation

On receipt of the alert status reports from external providers or system-wide dashboards there is a robust system in place for the forward dissemination of this information within Solent NHS Trust.

Each of the key services has agreed actions within their capacity and escalation plans on how it will respond to capacity pressures internally or within the local health and social care system. Figure 2 summarizes these actions. Where surges in any part of the system arise, CCGs and Solent will use the NHS England South Central OPEL Escalation Framework (revised2017) to determine the actions required.

Figure 2: Mitigating Actions in response to System Escalation (OPEL Framework 2017)

| Escalation level | Whole system | Acute trust | Commissioner | Community Care | Social care | Primary care | Mental Health |
|---|---|---|---|---|---|---|---|
| **OPEL One** | • Named individuals across Local A&E Delivery Board to maintain whole system coordination with actions determined locally in response to operational pressures, which should be in line with business as usual expectations at this level<br>• Maintain whole system staffing capacity assessment<br>• Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases<br>• Active monitoring of infection control issues<br>• Maintain timely updating of local information systems<br>• Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken<br>• Proactive public communication strategy eg. Stay Well messages, Cold Weather alerts<br>• Maintain routine active monitoring of external risk factors including Flu, Weather. | | | | | | |
| **OPEL Two** | All actions above done or considered<br>•Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate | •Undertake additional ward rounds to maximise rapid discharge of patients<br>• Clinicians to prioritise discharges and accept outliers from any ward as appropriate<br>•Implement measures in line with Trust Ambulance Service Handover Plan<br>• Ensure patient navigation in ED is underway if not already in place<br>• Notify CCG on-call Director to ensure that appropriate operational actions are taken to | • Expedite additional available capacity in primary care, out of hours, independent sector and community capacity<br>• Co-ordinate the redirection of patients towards alternative care pathways as appropriate<br>•Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers) | • Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible.<br>• Maximise use of re-ablement/intermediate care beds<br>•Task community hospitals to bring forward discharges to allow transfers in as appropriate.<br>• Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals. | • Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements<br>• Ensure all patients waiting within another service are provided with appropriate service<br>• Where possible, increase support and/or communication to patients at home to prevent admission.<br>Maximise use of re-ablement/intermediate care beds | • Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community<br>• In reach activity to ED departments to be maximised<br>• Alert GPs to escalation and consider alternatives to ED referral be made where feasible | • Expedite rapid assessment for patients waiting within another service<br>• Where possible, increase support and/or communication to patients at home to prevent admission |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | • Maximise use of nurse led wards and nurse led discharges<br>• Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases | | | | | |
| **OPEL Three** | •All actions above done or considered<br>•Utilise all actions from local escalation plans<br>• CEOs / Lead Directors have been involved in discussion and agree with escalation to OPEL 4 if needed | • ED senior clinical decision maker to be present in ED department 24/7, where possible<br>• Contact all relevant on-call staff<br>• Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly<br>• Enact process of cancelling day cases and staffing day beds overnight if appropriate.<br>• Open additional beds on specific wards, where staffing allows.<br>• ED to open an overflow area for emergency referrals, where staffing allows.<br>• Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure.<br>• Alert Social Services on-call managers to expedite care packages<br>Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases | • Local regional office notified of alert status and involved in discussions<br>• CCG to co-ordinate communication and co-ordinate escalation response across the whole system including chairing the daily teleconferences<br>• Notify CCG on-call Director who ensures appropriate operational actions are taken to relieve the pressure<br>• Notify local DoS Lead and ensure NHS111 Provider is informed.<br>• Cascade current system-wide status to GPs and OOH providers and advise to recommend alternative care pathways. | • Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible<br>• Community providers to expand capacity wherever possible through additional staffing and services, including primary care | • Social Services on-call managers to expedite care packages<br>• Increase domiciliary support to service users at home in order to prevent admission.<br>•Ensure close communication with Acute Trust, including on site presence where possible | • OOH services to recommend alternative care pathways<br>• Engage GP services and inform them of rising operational pressures and to plan for recommending alternative care pathways where feasible<br>• Review staffing level of GP OOH service | • To review all discharges currently referred and assist with whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible<br>• Increase support to service users at home in order to prevent admission |
| **OPEL Four** | • All actions above done or considered<br>•Contribute to system-wide communications to update regularly on status of organisations (as per local communic | • All actions from previous levels stood up<br>• ED senior clinical decision maker to be present in ED department 24/7, where possible<br>• Contact all relevant on-call staff<br>•Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly<br>• Surgical senior | • Local regional office notified of alert status and involved in decisions around support from beyond local boundaries<br>• The CCGs will act as the hub of communication for all parties involved<br>• **Post escalation:** Complete Root Cause Analysis | • Ensure all actions from previous stages enacted and all other options explored and utilised<br>• Ensure all possible capacity has been freed and redeployed to ease systems pressures | • Senior Management team involved in decision making regarding use of additional resources from out of county if necessary<br>• Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including | • Ensure all actions from previous stages enacted and all other options explored and utilised<br>• Ensure all possible actions are being taken on-going to alleviate system pressures | • Ensure all actions from previous stages enacted and all other options explored and utilised<br>• Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | ations plans)<br>• Provide mutual aid of staff and services across the local health economy<br>• Stand-down of level 4 once review suggests pressure is alleviating<br>• **Post escalation:** Contribute to the Root Cause Analysis and lessons learned process | clinical decision makers to be present on wards in theatre and in ED department 24/7, where possible<br>• Executive director to provide support to site 24/7, where possible<br>• **An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG and neighbouring trusts to agree a divert.** | and lessons learned process | | supporting ED re prevention of admission & turn around. Identification via board rounds and links with discharge team & therapists.<br>• Hospital Service Manager/Deputy Director to monitor escalation status, taking part in teleconferences as required. | | |

6.3 The Escalation Process

Please see appendix 1

6.4 OPEL level 4 (OPEL Framework)

Provider organisations should request a full system conference call if they feel that they are reaching OPEL level 4 to ensure that all actions have been completed to avoid escalation.

Should escalation to OPEL 4 be reached, de-escalation will take place once the CCG is satisfied that there is no requirement for further escalation or intervention. This will be via verbal and written notification to the system providers and the CCG will then restate the overall system escalation status. Actions relevant to the lowered status will continue.

6.5 Management of actions and conference calls

At this level it is important that a full investigation is carried out and that all lessons identified are shared.

At times of increased pressure, it may be appropriate to hold an extra-ordinary system-wide teleconference. Regular calls will take place during the winter months to ensure that weekend and out of hours systems are in place to cope with pressures. These will be individual to each system.

## 7. SITREP arrangements

7.1 Solent NHS trust will continue to monitor and report daily bed and staff statistics. These reports will be available to contribute to the whole system groups and conference calls. Solent NHS Trust also recognises the need to have availability of a bed state and staffing data on a daily basis throughout the winter period to inform the daily metrics that may be requested detailed in the table below. The information is updated on SHREWD by all organisations.

| **Data item** | **Period for reporting** | **Source** | **Lead** | **How these metrics will be shared** |
|---|---|---|---|---|
| ED performance and admission conversion rates and acuity | Past 24 hours | ED data (4 hour waits and conversion to admissions %) | Acute representative | Conference call |
| Additional flex/extra beds open | Current as at time of conference call | Hospital bed status report (Ops report) | Acute representative | Conference call<br>Escalation report |
| Bed capacity in acute and community services | past 24 and forward 24-48 hours | Rates of daily discharges and planned / predicted admissions<br>Number of patients on Discharge Ready list & discharge issues | All bed based service providers duty managers | Conference call<br>Escalation report |
| Ward closures | past 24 and forward 24-48 hours | Details of any occurring and predicted to occur | All bed based service providers | Conference call<br>Escalation report |

| | | | | |
|---|---|---|---|---|
| Adult Social Services workload capacity | past 24 and forward 24-48 hours | Details of service capacity | Duty managers HCC and SCC | Conference call<br><br>Escalation report |
| Community caseload demand / capacity to receive patients | past 24 and forward 24-48 hours | Details of service capacity | Duty managers Solent, SHFT | Conference call<br><br>Escalation report |
| OOH GP surgery predicted demand and capacity | past 24 and forward 24-48 hours | Details of OOH GP surgery | Care UK<br><br>NHUC | Conference call<br><br>Escalation report |
| OOH GP surgery | Number of non triaged calls outstanding as at the conference call | Metrics of non-triaged calls | Care UK<br><br>NHUC | Conference call<br><br>Escalation report |
| Ambulance delays | Past 24 hours and current position as at the conference call | Ambulance handover reports | SCAS duty manager | As above plus emailed on regular distribution list each day. |
| 111 issues | Past 24 hours and current position as at the conference call | Details of service capacity | 111 lead | Conference call<br><br>Escalation report |

**8. Portsmouth and Southampton Services Planning for 2018/19**

8.1 Portsmouth Adult Services:

The focus for Winter 2018/19 will be on two specific aims:

- To ensure that that robust Business Continuity Plans informed by scheduled emergency planning exercises are in place as well as daily monitoring of escalation levels
- To deliver additional capacity to support resilience in community and urgent care services that enable people to be supported at home, providing capacity to maintain flow within the Portsmouth system

Fundamental to achieving both those aims is:

- Early implementation of community front door model underpinned by the principle of home first
- Work to embed pull model through IDS into community capacity irrespective of discharge pathway

8.1.1 Sustaining current additionality and response to PSEH system 'closing the gap proposal'

- EOL Service: Agreement has been reached in principle to sustain the delivery of EOL care at home for up to 12 patients
- D2A Investment: (up to 20 additional care spaces in PRRT) : Now in contract
- Agincare bridging service: Agreement to extend the current Solent contract for up to 350 hours of bridging packages of domicilary care to support flow in the Portsmouth system

- Closing the Gap Proposal: In response to the Price Waterhouse Cooper capacity and demand modelling in the Portsmouth and South East Hants system a proposal to deliver an additional 23 care spaces has been submitted jointly by PCC and Solent. These care spaces would be created by uplifting the current Agincare contract by just over 600 hours with wrap around multidisciplinary support. This plan is scheduled to deliver additional capacity with effect from mid -September with an anticipated 75% delivery by end October and full delivery by mid -November
- Community Front Door Model: Early implementation is planned of a 'community front door' incorporating an urgent care referral hub, underpinned by the principle of home first that will at this point remain IDS based but will enable safe transfer of care into the community irrespective of the patient's discharge pathway
- Expansion of the Care Home Schemes: A schedule is in place to extend the care home team model to an additional 5 homes, further roll out is dependent on evaluation and agreement of the current business case. Community Matron/GP/Occupational Therapy and Physiotherapy resource is in place to support the delivery of this programme.
- Frailty and Interface Team: The pathway continues to be provided collaboratively by Portsmouth Hospitals NHS Trust and Solent and reflects the emerging evidence base regarding the acute management of frail patients to support both admission avoidance and early supported discharge within 72 hours
- Acute Visiting Service: PRRT continues to provide support for those patients deemed not to require ED conveyance/admission referred by the Acute Visiting Service; work to ensure timely access to the service utilising the e – referral functionality on SystemOne has been initiated in response to feedback from GPs
- Project Bridge: Voluntary Services within Portsmouth under 'Project Bridge' have initiated a programme focussing on supporting hospital discharge, the key principles of which will be incorporated into the 'Community Front Door Model'
- Community Beds: Both wards will flex their criteria as and when is needed. This is done routinely but will be made more explicit during the winter period. Where this may have a negative impact ie. Increased length of stay or delayed transfers of care, this will be highlighted in advance so the system, service, and commissioners so that they are aware of the risk and are part of that decision making process.

8.1.2 Daily Monitoring of Escalation, Capacity and Demand

Learning from winter 2017 resulted in a more systematic approach to both the management of and the reporting of capacity and demand that is informed by escalation levels at both organisation and system level

Solent along with system partners have supported the implementation of SHREWD and are fully engaged in local development in its application. Further plans in advance of winter include the development of a Portsmouth system (PCC and Solent combined) submission for SHREWD as well as the use of SHREWD data to inform the narrative and agreed actions of the Daily Ops Call, which PCC are committed to joining.

**8.2 Adults Mental Health Services**

The Solent NHS Trust Mental Health Services have not historically been affected by winter pressures (though older adults can be affected more so than working age adults) as the need for the service does not appear to be increased during the winter months. However the primary method of ensuring capacity is retained within the service is to ensure that there is a flow of patients through community and inpatient services to ensure patient needs are met at the right time by the right team in the right place. The model within the service is set up to provide care

in the community wherever possible and that inpatient admission is merely as a last resort. Bed capacity is managed daily through 'board review meetings' which are attended by senior staff from both the wards and the CRHTT (adults) ICT (OPMH) to ensure that care plans are jointly owned and understood and that discharge can be expedited. The acute inpatient unit also has the ability to re-open 2 closed beds at times of very high demand.

The community service is a tiered service from CRHTT who take all referrals and screen for urgency through to generic CMHTs who provide care co-ordination for those open to the service. Ensuring capacity within the CRHTT is paramount to enable entry to the service to remain available and resources could be pulled from the CMHT to the CRHTT if needed due to staff absence levels.

The CMHTs will be asked to risk assess patients open to them to ensure that any possible vulnerabilities that patients may have that are effected by the winter weather can be care planned and managed. This will be particularly relevant for OPMH services and the Modern Matron has already had these conversations with staff in the teams to begin to plan for winter.

The Section 136 suite is provided by an organisation, contracted by the CCG and have their own business continuity plans, to ensure that the suite remains open during winter months.

Staff will be expected to work across the service depending upon the need of the patients and all non-urgent tasks will be cancelled to ensure those at high risk receive the care they need. We would also participate in daily SITREP reporting both within the service and within local stakeholders to jointly understand and manage resources to meet the demand.

**8.3 Adults Services Southampton**

**i.** Operational Resilience Conference calls – representation has been identified for these on a weekly basis from all relevant service managers. A rota is in place which clearly identifies one person per week to assist with these calls, and any additional ones as they arise. If the local health economy is on a "black" status the rota switches to senior managers who are able to facilitate on the spot decision making. Solent have been pro-active in ensuring data is uploaded daily onto SHREWD and is fully engaged with any further developments with this. There has been clear communication regarding expectations and also when to escalate to more senior management eg. Deep red / black status.

**ii.** Operational Resilience Group meeting attendance – An Integrated Service Manager from Solent NHS Trust will attend the meetings held once a month to review the current process and planning for future requirements and escalations. In the managers absence this will be deputised so that regular attendance and feedback will continue.

**iii.** SHREWD - A new version of SHREWD has been developed and Solent NHS Trust staff teams update the live system on a daily basis.

**iv.** Workforce; Annual leave has been reviewed over the winter period to ensure adequate staffing cover to maintain resilience within all services in the service line. Flu immunisation will be widely promoted for all staff with multiple accessible clinics and SMS reminders.

**v.** Community Beds: Royal South Hampshire Hospital inpatient areas – both wards will flex their criteria as and when is needed. This is done routinely but will be made more explicit during the winter period. Where this may have a negative impact ie. Increased length of stay or delayed transfers of care, this will be highlighted in advance so the system, service, and commissioners so that they are aware of the risk and are part of that decision making process. Additionally

the inpatient continue to operate a locality based focus which streamline throughput and transfer of care for patients accessing the ward. All community beds will continue to proactively pull patients from UHS. Community wards have been aligned with the procedures at UHS with an escalation framework to support. Implementation in regard to introduction of the'choice on discharge policy', SAFER bundle and red and green days has been completed in 2018. , BCF funding has been allocated to support discharge from the RSH where a discharge to assess provides 6 reablement care support packages a week to support discharge in a timely manner.

**vi.** Reablement beds- The integration of health and social care has allowed the flexible use of additional reablement beds in the community. These beds are accessible for step down or step up care.

**vii.** Integration of Health and Social Care- During 2017 the Urgent Response Service and Community Independence Service were expanded to further develop and improve pathways for facilitating timely discharge from the acute trust using a trusted assessor model. These pathways are reliant on the provision of sufficient ongoing care to promote flow however provide increased flexibility and pooling of resource to promote patient and client management with a reduction in duplication. This service can also target the community inpatient settings to assist in discharge thereby reducing length of stay and promoting flow from the acute sector.

**8.4 Primary Care – MSK, Pain and Podiatry**

These primary care services are mostly planned in nature, the teams have however reviewed and identified the following actions that would be taken in the event of extreme weather or illness impacting on the services ability to support capacity and manage demand:

- Ensure promotion of a high uptake of the flu and pneumococcal vaccinations in order to try and prevent as much illness as possible for patients as well as staff.
- If the services were under pressure due to staff sickness or absence due to travel disruption then all non-urgent, non-priority work would be cancelled including meetings and training,
- Redeployment of staff to nearest site during extreme weather conditions,
- Urgent cases can be prioritised and potentially routine new/fu's can be postponed
- Utilise the weather alerts to plan clinic – potential to start and end earlier during these times if extreme conditions
- System1 notes now allow staff from different areas to manage other colleagues caseloads and communicate more effectively and securely if staff can get to a site closer to home that is not their normal base.
- Telephone management of review appointments are an option in some cases
- Minimum staffing levels over holiday periods this time of year are set so clinics still function and urgent patients can be offered appointments, while ensuring lone working is not an issue
- Communication on the website and any other media available would be used to update patients on the status of clinics during very bad weather.

**8.5 Primary Care - G.P surgeries**

The GP surgeries do not have any specific additional resource to use over the winter months however if required the business continuity plan would be used.

The business continuity plan would include:

- Ensure as high an uptake as possible of flu and pneumococcal vaccinations in order to try and prevent as much illness as possible (patients as well as staff).
- Focussing attention on the patients who most need our service e.g. in the summer we may have capacity to see a patient who has a viral illness, in the winter we may need to redirect patients to pharmacies and self-help.
- We are hopeful that we will have eConsult in place very soon which will be a way for patients to access self-care and also to access our GP service if needed. This will help to spread the workload.
- Promote 'self -care' during national self-care week (November 13th- 19th)
- Utilising appointments at the SPCL Hubs if we have days when demand severely outstrips capacity (we contact the Hub Manager in advance to discuss).
- Utilising the new Acute Visiting service to help in managing on the day demand.

**8.6 Children's And Families**

Children's and Families services have reviewed their business continuity plans and have highlighted that the service are that is particularly placed under pressure due to seasonal changes is the Children Community Nursing Service & COAST. These services experience an increase in activity from referrals during the period November through to February (inclusive). The service leads are further reviewing their business continuity plans accordingly to ensure they remain fit for purpose for this service area particularly during this period of increased activity.

It is also important to note that the School Nursing Service is commissioned to administer the flu vaccine to children across a number of school year groups. There is a robust mobilisation plan around this programme for the autumn school term and a business continuity plan.

Learning from March 2018 the service has considered how adverse weather affected the service and reviewed their business continuity actions particularly during periods of difficult driving conditions.

Many of the services provided for Children and Families are planned, however there are a number of specific services that are put under increased pressure due to seasonal changes. All services have reviewed their continuity plans and the following pressures (with actions required) have been identified.

- The School Nursing Service is commissioned to provide the flu vaccine to a number of year groups.
- COAST: the service experiences an increase in activity from November – February. This service will work closely with primary care and acute partners to enable comprehensive system wide service provision for urgent and emergency care. In the case of extreme weather the COAST service will continue to provide telephone advice.
- Opening times will be reviewed regularly in order to maintain safe staffing levels.
- Regular communications will be shared with primary and acute care partners to support the wider system; to GPs to support local hospitals and secondary care.
- Business contingency plans for each service will be used in cases of low staffing levels.
- Routine review appointments will be offered via telephone consultation where appropriate.
- Coverage of continuing care/end of life packages will be prioritised for the most vulnerable children including provision of taxi services and bank/agency staff.

- In the event of prolonged adverse weather, the safest health care environment will be considered for children with on-going or complex health needs. This may include carer led provision at home, care in hospital or at the local hospices.

- Taxi services will include being deployed to CCN and Therapies services for emergency cases.

- Child Protection Medical Rota: community Paediatricians and Specialist Nurses will be supported to attend child medical appointments through taxi or 4x4 services

## 9.0 Governance

**9.1** This section describes the governance arrangements for the delivery of the seasonal plan. The main group through which the delivery of the winter plan is monitored is the Trust's Emergency Planning Group, and CCG Systems Resilience meetings. Individual initiatives put in place this year to support the system in managing peaks in demand associated with the winter period 2016/17 will have their own reporting structures depending on the scheme, through which their delivery will be monitored. However each Service Line will be represented on the Emergency Planning Group, and Systems Resilience meetings in order for the progress of the schemes to be tracked.

9.2 Out of Hours Arrangements

The Trust operates a Clinical & Senior Manager and Duty Director Rota. The Clinical Manager on call and Senior Manager can be contacted via the routes below 5pm to 9am each week day and 5pm Friday to 9am Monday. The Duty Director is available 24 hours/day via 08712346125

Managers on call out of hours are provided with a daily capacity update when the system is under pressure and are able to request more frequent reports if necessary. The following structure for on call is in place (Figure 4).

10.0 On-call Structures


10.1 Individual service Business Continuity Plans (BCPs) contain information about staff groups and the skills required which would enable them to be redeployed if required. Live monitoring of absences would be through the MAPS e-rostering system and the e-pay system for the attendance recording of social care staff and Doctors.

Staff are aware of the need to ensure cover with sufficient capacity to meet any surge in demand during the winter and in particular the Christmas and New Year period when restricted annual leave is granted to staff.

**11. Communication**

| Date | Audience | Activity | Responsibility |
|---|---|---|---|
| October 31 | Staff | Add cold weather plan to intranet and circulate via Staff News | EP/ Solent Comms |
| From October 1 | Staff | Implement campaign to encourage staff to receive flu vaccine (separate plan in creation) | Occupational Health/ Solent Comms |
| Commencing November 1st | Staff | Inform staff of any met office adverse weather alerts via Staff News/ Intranet and global email (if required) | EP/Solent Comms |
| At first signs of severe weather | Staff | Remind staff of cold weather plan via Staff News/ global email | EP/Solent Comms |
| At first signs of adverse weather | Staff | Letter to all staff from HR, circulated via email and added to intranet, including safety information and flexible working information. | EP/Solent Comms/HR |
| National Self-care week | Staff and Public | Inform staff and use resources available to promote key messages from the campaign | EP/Solent Comms |
| If adverse weather affects services | Public<br><br>Staff<br><br>Stakeholders<br><br>GPs | Add latest clinic closures/ service opening times to Service Directory on solent.nhs.uk and include a banner on front page linked to pages with latest information.<br><br>Consider using media to cascade messages.<br>Include links to latest information on all social media platforms with an obvious hashtag.<br>Include information regarding clinic closures/ service opening times on intranet and if required circulate via global email. Encourage staff to look at Social Media and solent.nhs.uk<br><br>Circulate information regarding clinic closures/ service opening times to stakeholders and comms leads via email.<br><br>Circulate information regarding clinic closures/ service opening times to GPs via CCG comms leads. | EP/Solent Comms<br><br>EP/Solent Comms<br><br>EP/Solent Comms<br><br>EP/Solent Comms |
| When required | Staff and public | Pharmacy opening times to be publicized via Staff News and on public website when available. | EP/Solent Comms |
| Ongoing | Staff | Include regular updates in Staff News and circulate information via Managers' messages. | EP/Solent Comms |
| Throughout period | Public | Support CCG winter comms plans to convey messages to the public. | EP/Solent Comms |

**12. Risks**

12.1 Infection Prevention and Control & Flu Preparedness

Close links are in place with Public Health England (PHE) and surveillance information on flu and noro-virus activity in surrounding areas is e-mailed directly to the Infection Prevention and Control Team (IPCT) within Solent. These alerts are used to keep staff informed of changes in infection trends within the Community population in order for services to respond accordingly. The IPCT also monitors infection activity within the organisation on a daily basis using internal surveillance.

Specifically a weekly report will be published by PHE which will include a range of indicators on flu including:

- the amount of flu-like illness (ILI) in the community
- the prevalent strain(s) of flu circulating
- the proportions of clinical samples that are positive for flu or other specified viruses
- the number of flu-related hospital admissions
- the relative impact of flu on different groups of people, by age and by clinical condition (including data on deaths where flu is the confirmed cause) based on data from intensive care units
- excess mortality monitoring
- the international situation

12.2 Influenza

NHS Public Health is leading locally on flu and has a robust plan for uptake of vaccination. The flu vaccine targets have been altered to encourage greater uptake. The over 65 year olds and the 'at risk' and pregnant women group target is held at 75%.

Flu vaccine uptake data

Vaccine uptake information in 2017/18 will be reported by PHE for the following groups:

- people aged 65 and over
- people aged under 65 with specific clinical conditions
- all pregnant women
- all two-, three- and four-year-olds
- healthcare workers with direct patient contact
- carers
- children of school years 1 and 2 age

In relation to staff flu programme, strategies are in place to encourage maximum uptake of the vaccine by all staff groups. A campaign has been launched in September 2018 to include staff flu clinic updates which commence late September and we will be monitoring and promoting the uptake over the next few months and reporting this regularly through the Trust's flu meeting and relevant other forums.

12.3 Major Incident Escalation

The Trust acknowledges that there may be events or risks that emerge during periods characterized by seasonal pressures which may require a different level of response. If these circumstances arise, immediate actions will be taken in line with Services' Business Continuity plans and the Trust's Incident Response Plan, or other related plans invoked if necessary.

**13. Supporting documents**

**Cold Weather – Keeping Warm advice**
http://www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx

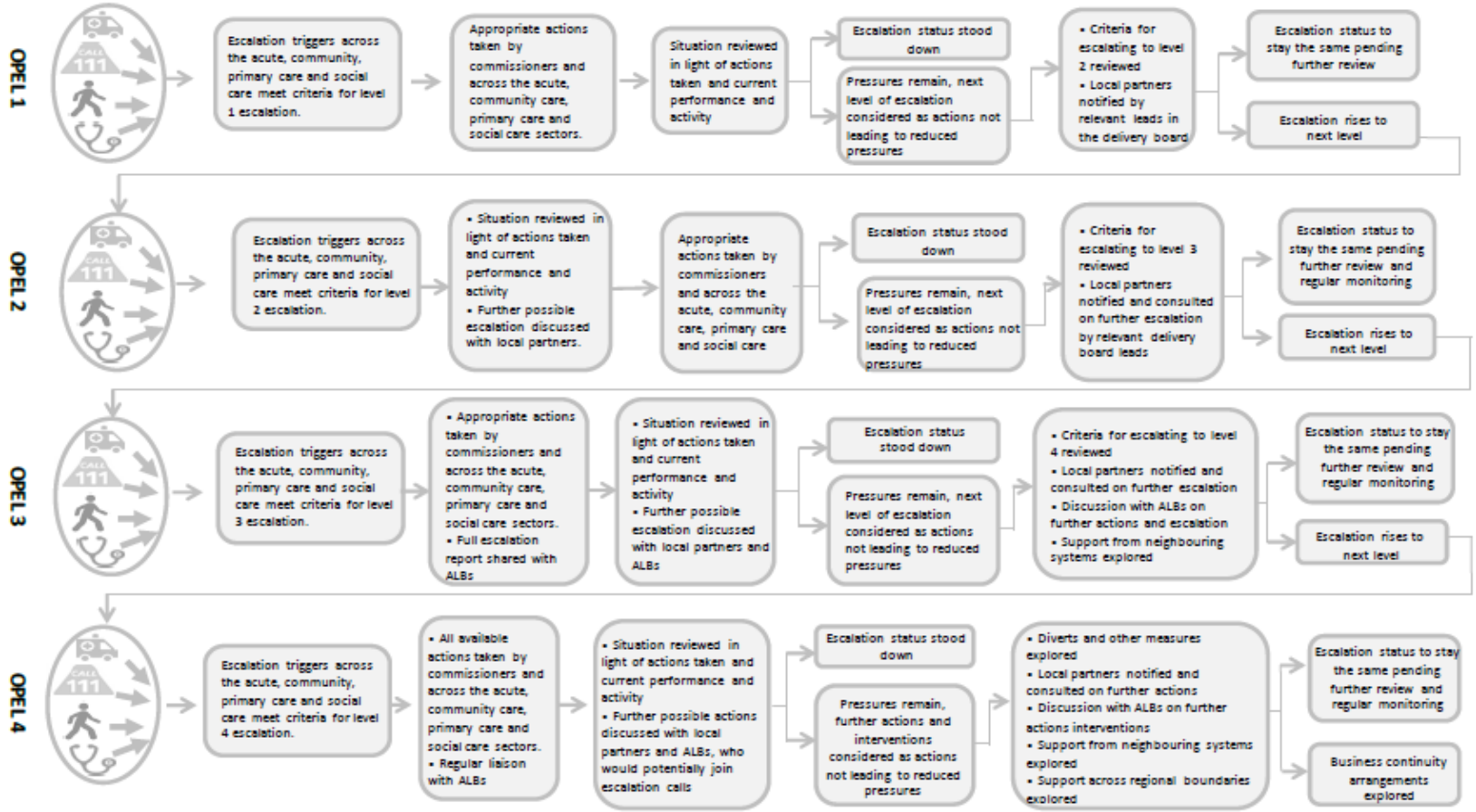
**The Met Office – Get ready for Winter**
http://www.metoffice.gov.uk/learning/get-ready-for-winter

**The Met office – Severe Weather Warnings**
http://www.metoffice.gov.uk/public/weather/warnings/?regionName=uk

**NHS England Flu Plan**
https://www.england.nhs.uk/wp-content/uploads/2018/08/flu-programme-delivery-guidance-2018-19.pdf

## 6.2 Annex – The escalation process

### 6.2.1 Local escalation processes



Item 14

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Title of Paper*** | Professional Leadership Report - November 2018 | | | | | | | |
| ***Author(s)*** | Angela Anderson, Associate Director Professional Standards | | | | | | | |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | X | **W2** Vision & Strategy | X | **W3** Culture | X | **W4** Roles & Responsibilities | X |
| | **W5** Risks and Performance | | **W6** Information | | **W7** Engagement | X | **W8** Learning, Improve & innovation | X |
| ***Date of Paper*** | 16th November 2018 | | **Committees presented** | | N/A | | | |
| ***Action requested of the Board*** | X To receive | | | | For decision | | | |

The purpose of this paper is to provide an update on the current position with regards to professional leadership activity across the nursing and allied professions in Solent NHS Trust.

**Board Recommendation**

The Board is asked to receive the report and note the work being undertaken to highlight the contribution being made by the nursing and AHP workforce.

**Background**

There are a range of professional activities across the Trust which impact on the delivery of care and the development of the nursing and Allied Health Professional (AHP) workforce. The individual work streams continue to feed into their relevant sub-committee structures. In addition a number of developments at a regional and national level will have a significant impact on the future workforce and on how the Trust approaches nurse and AHP training and recruitment in future.

This paper provides an update on developments since the November 2017 report.

## Current Position

**Nursing & Midwifery Council (NMC) & Health and Care Professions Council (HCPC) Referrals:**
The process for identifying and managing concerns in relation to professional conduct has been reviewed and agreed by the Professional Advisory Group in May 2018.
The Trust has made two referrals to the NMC for staff due to ill-health retirement who did not wish to retain their registration. There is a third referral pending relating to professional conduct.
We have made one referral to the HCPC relating to professional conduct and are awaiting confirmation from HCPC as to their intention to investigate.

**Revalidation & Reregistration:**
The Associate Director Professional Standards & Regulation receives monthly data in relation to staff that are due to re-register and/or revalidate. Managers receive alerts through ESR regarding staff that are due to reregister in 6, 3 and 1 month and there is also a prompt at one to one supervision and appraisal to ensure this is discussed with relevant staff. We have seen a reduction in the numbers of staff failing to re-register/revalidate and the main cause for lapses is when staff change address and /or has changed emails and not informed the NMC/HCPC. Individuals are encouraged to set up a direct debit to ensure annual payment is made to the professional body.
In addition HealthRoster will not allow shifts to be allocated to staff who do not have a valid registration therefore bank staff who are not registered will not be booked for clinical shifts.

During the last year the Trust has had one member of staff who failed to submit their application for revalidation due to ill health and was granted an extension by the NMC. The application has been submitted and the issue resolved.
There have been 4 cases of lapses in registration, two were staff on the Bank and the other two were staff that were on long term sick leave and subsequently retired on ill health grounds.
There was one member of staff who failed to re-register with the HCPC during the last year.
All staff are managed in line with Trust policy and have a face to face discussion with the Chief Nurse or Associate Director Professional Standards.

## Professional Leadership:

**Internal Allied Health Professions (AHP) Leadership and structure:**
From the 1 July 2018, the Head of Patient Experience and AHP Professional Lead job share post has been separated to allow more protected time for the AHP leadership (0.5 wte); Clare Mander has continued as the AHP Professional Lead alongside her Clinical Leadership for Accessible Information and her national AHP work with Health Education England.

**Professional Advisory Group:**
The group continues to meet quarterly and has considered a number of contemporary issues relating to nursing and AHP's, both nationally and locally. The group has been considering the model of professional leadership across the organisation and has reviewed the framework previously agreed.
A mapping exercise conducted during Winter 2017/18 highlighted a mixed picture of professional leadership across AHP and nursing professions; and a lack of clarity, particularly for AHPs, about the role and responsibilities of those currently in uniprofessional or multiprofessional leadership roles. There is complexity for some AHP professions that span different service lines in uniprofessional and multiprofessional teams; as well as the varying size of the professional group.

As a result and as part of the review of the Nursing and AHP strategies the November 2018 meeting was opened out to a wider group and held as a workshop with the aim of coproducing a combined strategy. A further workshop is being held in December after which the information will be collated and the work taken forward. It is intended to complete this piece of work for a launch of the new strategy in May 2019

The group has considered some national reviews including:

- RCN report 'Safe & Effective Staffing: Nursing against the Odds'. The group concluded that there are similarities across all groups of NHS staff and noted that many of the issues raised in the report are being addressed in Solent through the recruitment and retention work streams and the Health & wellbeing work.
- Consultation on 'Consultant Nurse, Midwife, AHP Competency and Impact Framework'. The group welcomed the consultation and a response was submitted on our behalf by the AHP Professional lead.
- NHS Improvement: 'AHP Leadership in NHS' report: This report summarised the variation across the NHS of AHP leadership in senior roles within organisations. The group felt there was a commitment within Solent to ensure AHP leadership at all levels was developing and that the appointment of a specific AHP lead role under the leadership of the Chief Nurse was a positive step whilst recognising the work still to do.

**New and Emerging roles for AHPs and Nurses:**

**AHPs:**

During the last 6 months there has been an increased focus on new and emerging roles for AHPs which have included;

- A successful role emerging placement for an Occupational Therapy student working in Primary Care which led to substantive funding for a part-time post
- Proposal to support rotating paramedics from SCAS within PRRT submitted to Portsmouth MCP
- Plans to develop the role of Clinical Psychologists and Speech and Language Therapists in supporting the work of Paediatricians
- Early discussions about non-medical advanced and consultant practitioners in Frailty

Our AHP Professional Lead has worked in collaboration with AHP Leads from across the system to develop a **HIOW AHP place-based planning** that includes four overarching objectives relating to the future workforce, system-wide rotational and secondment opportunities, a collaborative programme of support and development, and new and emerging roles. Each Trust is currently RAG rating itself against the objectives and collating best practice examples to be shared with the STP workforce group.

This development coincided with the publication of the NHS Improvement paper on the leadership of AHPs in Trusts. Therefore the AHP Leads convened a meeting with the Chief Nurses/Directors of Nursing and the STP workforce system convenor to discuss the local vision for the future.

**Nursing Associate**

The NMC has now regulated the nursing associate role, and have published the standards of proficiency. As a result Solent NHS Trust have asked that staff working within nursing teams and applying for the foundation degree in health and social care are entered onto the nursing associate pathway.

April 2018 saw 8 Health Care Assistants (HCAs) commence the nursing associate programme at Solent University, Southampton. Mental Health (MH) services have undergone a workforce transformation consultation and have identified that the band 4 workforce is key to their service development. MH services have identified 8 staff to commence the programme in March 2019.

**Registered Nurse Degree Apprenticeship**

Solent University, Southampton, were successful in becoming NMC accredited and now offer both direct entry and an apprenticeship route to degree nursing. Solent NHS Trust has 8 HCA's from different services commencing the 4 year adult registered nurse degree apprenticeship. The MH registered nurse degree apprenticeship commences in February 2019 with the Open University being the training provider.

Both the Nursing Associate and the Nurse Degree Apprenticeship are exciting developments and will provide real opportunities for the Trust to support career development and progression for our non-registered workforce. It also supports development of our workforce for the future.

**AHP apprenticeships**

The AHP apprenticeships are currently undergoing the approval process and the first cohorts are expected to commence from September 2019.

**Newly qualified nurse induction**

Solent NHS Trust welcomed 22 Newly Qualified Nurses (NQNs) in September 2018. To support staff from the difficult transformation from student to registrant the Educators in Practice (EiPs) ran a 4 week induction programme. The feedback from the NQNs has been extremely positive; the programme will be extended to include AHP newly qualified staff in 2019.

**Preceptorship**

Solent NHS Trust continues to run a one year preceptorship programme for both NQNs and AHPs. There have been no significant changes to the programme.

**EiPs**

The EiPs currently supervise student nurses, AHPs, Trainee Nursing Associates (TNAs) and healthcare apprentices on placements from 5 universities. The EiPs have piloted the Coaching Learners in Practice (CLIP) supervision model on Snowdon ward and continue to roll out across services to meet the change in the Standards for student supervision and assessment.

**Professional Events:**

Over the past year the Trust has run a number of events to support professional development and share experience and expertise with others. Some of the events are summarised below:

**An Audience with…**

In March two of our infection prevention and control nurses held an audience with staff from across the Trust and shared their experience of working in Sierra Leone during the Ebola crises. One of the nurses was there as part of the British Army response while the other went as a volunteer.
It is hoped to have a full programme of 'An Audience with..' in 2019.

**Professionals Week:**

It was agreed to run a professionals week in place of the Nursing conference which was held the previous year. The week held in May 2018 and aimed to provide a wide range of opportunity for staff across the Trust to access the sessions with a combination of early morning, afternoon and early evening sessions provided. Sessions were held in Portsmouth, Southampton and Aldershot. Topics were repeated to enable all to access and ranged from presentations on co-production,

transformation of Health Visiting services to sharing best practice in supporting and making reasonable adjustments for people with a learning difficulty.

**National AHPs Day #AHPsDay:**

On the 15 October 2018, we joined the national celebrations to showcase the work of our AHPs and the difference they make to people's lives. A range of activities took place across the Trust including shadowing opportunities, influencing chats with the Chief Nurse, cake competitions, information stands, distribution of 400 new AHP pin badges and scheduled social media coverage across the day. During National #AHPsDay we challenged our Chief Nurse to connect with a diverse range of AHPs through a game of 'AHP Bingo'. To get a full house Jackie had to connect with AHPs from different professional backgrounds and areas of specialty.

Jackie heard first-hand about the holistic and solution focused approaches to supporting children and their families, the findings from a local research project aimed at supporting dementia carers, advanced practice in MSK and the support available within Occupational Health. Ideas were also shared about ways in which we could maximise the potential of AHPs. Again the issue of career progression opportunities was mentioned alongside ideas for future extension of roles within primary care and a recovery approach to supporting our staff to return to work.


**AHP Network Communications:**

The key purpose of a professional network is to navigate, respond and evaluate through:

- The exchange of information;
- Provision of advice and expertise;
- Escalation of professional issues to assist with strategic vision and direction.

Professional networks should be open, participatory and peer-governed; which in turn can enable professional leadership responsibilities. In order to build strong AHP professional communities **AHP Professional Briefings** and an **AHP SolNet page** have been developed to share key documents, examples of Solent AHPs in Action, opportunities for CPD, learning from forum meetings, details of links to social media and national documents etc. See examples below:




**Matron Forum**

In 2018 the Associate Director Professional Standards established a Matrons forum to bring together our matron's from across the organisation. The group facilitates networking and is currently undertaking a piece of work to review the role of the matron and to develop consistency. They are currently exploring the variation in their roles and are working to produce a 'Matron's Charter' and core Job Description.

**<u>Workforce Developments/Issues:</u>**

In line with the national picture the Trust continues to face challenges with the recruitment of both nursing and Allied Health Professionals across a number of areas. There is a programme of work within the Trust being led by the People and OD team to support individuals and teams to make Solent a great place to work.

Over the past year the Trust has engaged with the NHSI programme to reduce turnover, the NHSI focus being on nursing but the Trust taking a whole professions approach. This work has made good progress and due to the ongoing commitment across our services we have seen a reduction in turnover across the professions and specifically within our nursing workforce, the focus of NHSI, which has gone from 21% at the start of the programme to 15% at the time of writing. The Trust is due to have a follow up discussion with NHSI in December 2018.

**AHP Workforce Current Position**

Attendance at the Trust-wide **AHP Forum** is much improved. At the recent meeting in September, 23 people were in attendance and all service lines were represented. The meeting had a specific focus on AHP workforce.

Findings from an internal AHP recruitment and retention survey were shared with the group and the findings confirmed that a high percentage, 89%, experienced difficulties and pressures in relation to both recruitment and retention over the last 2 years. Respondents identified a lack of career progression and limited senior clinical roles, as well as a limited pool of newly qualified staff for junior roles. The group also identified concerns that some roles excluded AHPs due to a need for the post holder to be NMC registered, however it was felt a registered AHP would be able to fulfil the requirements of the role.

The survey also highlighted some of the ways in which teams positively addressed the challenges and these included collecting evidence to support advanced clinical practice roles and developing businesses cases, flexible adverts in terms of potential grading, looking at different models of working to increase opportunities and challenging job descriptions to include HCPC registration as well as NMC where appropriate.

The findings have been shared with the Chief Nurse and a meeting is planned with HR to explore further.

**Nursing Workforce:**

Since the last report there have been ongoing concerns regarding the sustainability of the nursing workforce both locally and nationally. There are particular difficulties in recruiting to Band 5 positions. In addition the impact of removing the bursary is being seen with fewer people applying for nurse training in our universities. The Chief Nurse introduced fortnightly Safe Staffing meetings for all service lines in order to provide the opportunity to discuss the challenges being faced and to consider ways in which we can respond to these. During this time we have seen an acceleration of interest in reviewing skill mix and introducing the new and emerging roles referred to earlier in the report.

**Celebrations and Successes:**

A number of our staff have been recognised over the year for the innovative and excellent care they deliver. Below are some examples:

- *Beccy Burgos* (Occupational Therapist) was successful in applying for the Challenge Fund bid to host a research project looking at Occupational Therapists working in GP practices focusing on vocational rehabilitation. Subject to ethical approval, the study will hopefully commence early 2019.

- *Toni King* (Occupational Therapist) was successful in applying for the Health Education England (HEE) Wessex Trainee Consultant Practitioner in AMH programme. Toni will spend the next three years in placements across the system.

- *Sharon Simpson,* Older Person's Mental Health Research Nurse, was nominated for and won the Clinical Research Nursing Award Category of the Nursing Times Awards, 2018. She won this for the work she has done in introducing research in care homes. Working with care home staff and families, the research has given a voice to those who are seldom heard.

- Debbie Fudge, Tuberculosis Liaison Nurse, was nominated and won the Nursing Times Award 2018 in the Infection Prevention and Control category for her pioneering work in

moving tuberculosis (TB) screening into GP surgeries, helping GPs to identify and screen people at risk of latent disease.

- *Jess Gent* (Physiotherapist) was successful in applying for the HEE South AHP Leadership Fellowship that commenced in October. Jess will be joining five other fellows to drive AHPs developments across the South.

- *Bethany Kelly* (Diabetes Specialist Nurse) was part of a team who won the Diabetes Healthcare Professional of the Year award at the National Diabetes Awards in October. The award recognises diabetes healthcare professionals based in the UK or Ireland who have succeeded in raising standards of care over and above their day to day role.

- *Dr Clare Mander* (Speech and Language Therapist) has taken on a new role for HEE as the national programme lead for AHPs in Learning Disabilities and Autism services. This work involves modernisations of the workforce and maximising this AHPs potential across the life span. Clare has also been invited to be an expert advisor for the National Communication Access Steering Group.

- *Dr Kate Benham* (Clinical Psychologist) *and Dr Clare Mander* – presented the CAMHS-LD Accessible Information Sleep Project at an international conference IASSIDD in Athens. The project was well received by the international audience and connections have been made with Great Ormond Street Hospital who is keen to use the resources.

- *Ana Goncalves* (Physiotherapist) was shortlisted as a finalist for the Chief AHP Officers AHP Quality Improvement Award for her initiative entitled "Reducing rates of patient falls in an in-patient older person's organic mental health ward". Ana attended the Awards Ceremony in London on 19th June to receive her runners up prise.

- *The Solent Tissue Viability team* were nominated for the British Journal of Nursing Awards 2018 in the category of Chronic Oedema Nurse of the Year.

**Recommendation**

There is significant work taking place across the Trust to develop the nursing and AHP professional workforce and ensure that it is fit for purpose and ready to meet the challenges of the changing healthcare environment. This report has provided a summary of the key activities being undertaken since the last report.

The Board is therefore asked to note the progress being made.

Item 15

**Board Report – In Public Meeting**

| | | | |
|---|---|---|---|
| **Title of Paper** | **Information Governance Briefing Paper** | | |
| **Author(s)** | Sadie Bell, Data Protection Officer | **Executive Sponsor** | David Noyes - SIRO |
| **Link to strategic Objective(s)** | [X] Improving outcomes | [ ] Working in partnership | [ ] Ensuring sustainability |
| **Date of Paper** | 11th November 2018 | **Committees presented** | N/A |
| **Action requested of the Board** | [X] To receive | [ ] For decision | |
| **References** | | | |

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

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


**Summary**

Solent NHS Trust continues to strive for excellent Information Governance compliance and awareness, providing and operating a culture of transparency and openness, as well as continual improvement and learning. This supports the Trust's values and strategies, as well as the foundations of the new Data Protection Legislations.

The Trust has implemented new reporting structures to meet the new and heightened demands of the Data Protection and Security Toolkit, a key example of this is the Information Security Group.

- We are now receiving regular reports from CGI and discussions are taking place on how to improve the detail in the report, providing greater assurance
- Challenging conversations are taking place to improve security and discussions / actions have taken place on improving the communication between CGI and Solent on key issues
- New initiative ways or working and use of technology is being discussed at the group, to assess if there are potential security threats / risks
- There is also a focus on monitoring day-to-day security
- Information provided by the group and discussions held, as led to an increase in our DSPT compliance

The slight decrease in compliance with regards to requests for information was swiftly addressed and highlights the importance of the centralised Records Management function, which the Trust's Board supported the implementation of. This resource is now once again fully operational.

Incidents continue to be monitored and although reporting remains consistent, trends and themes change, as areas of risks and concern are identified and addressed.

The Trust's continues to meet and focus on its Information Governance objectives for 2018/19;

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

## 1. Purpose

**1.1** The purpose of this report is to provide the Trust with a summary of the Trust's current Information Governance Compliance with Law, National Requirements and Mandatory NHS Requirements.

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

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

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

- Data Protection and Security Toolkit 2018/19 (previously known as the Information Governance Toolkit)
- Compliance with legal requests for information
- Information Governance Incidents

## 2. Data Protection and Security Toolkit 2018/19 – October Baseline Assessment

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

**2.1** ***New Assessment Outline:***

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

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

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

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

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

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

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

**2.2** ***Baseline Assessment:***

On the 31st October 2018, the Trust had to complete a baseline assessment of its current compliance and identified that it was 68% compliant with the mandatory requirements.

The new toolkit has changed how it identifies Trust's overall compliance. Previously this was done by Levels of compliance from Level 1 – 3, however is now done on pass or fails bases. Trust must be compliant with all mandatory requirements by the 31st March 2019 in order to be considered compliant and pass the assessment.

Currently the Trust is not meeting this standard, but is meeting the action plan put in place to ensure compliance. The following actions are to be undertaken over the next five months, to ensure compliance;

- The following requirements are those to be collated by the Information Governance Team:
  - Data Flow Mapping
  - Information Asset Register
  - Publish Data Protection Impact Assessments
  - Audit conducted on Restore and data shredding
  - Business Continuity Plan
  - Unsupported software review
  - Penetration Testing
  - Staff Survey (to be conducted in Q4)

- The following requirements are in place but to be reviewed:
  - Data Security Improvement Plan

- The following requirements are to be reviewed with the services assigned for completion:
  - Pseudonymisation Audit
  - Data Quality Audit

NHS Digital has also confirmed that the Data Security & Protection Toolkit is a 'rolling' system for which they will continuously provide updates, new requirements / assertions and guidance throughout 2018/19. The Information Governance Team will therefore undertake monthly assessments of the Toolkit to assess both current compliance and changes in requirements.

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

## 3. Summary of Information Governance's Legal Requirements Compliance

In August 2017 Solent NHS Trust implemented a dedicated records management resource, which amongst other tasks focused on Data Protection Requests and Freedom of Information Requests. This dedicated resource allowed for a dramatic increase in compliance;

- Subject Access Requests increased from around 70% – 86% compliance, to 92% - 100% compliance.
- Freedom of Information Requests increased from around 75% – 85% compliance, to 92% - 100% compliance.

However, between June 2018 – September 2018 this dedicated resource was limited / absent due to staff vacancies; during a period in time where the number of requests also increased, in particular in July and September requests. As a result compliance decreased to an average of;

- Subject Access Requests; 82%, with the lowest being 69%.
- Freedom of Information Requests; between 71% - 76%

This highlights the importance of a dedicated centralised resource, with compliance now already restored within October 2018;

- Subject Access Requests; 98% (although subject to change as some requests are currently not due).
- Freedom of Information Requests; 100% (although subject to change as some requests are currently not due).

***A full breakdown of the Trust's current Information Requests compliance can be found in Appendix B.***

## 4. Information Governance Incidents

### 4.1 *IG Incidents, Q2, 2018/19*

| IG Incidents – Main Issues | |
|---|---|
| | **Q2** |
| Lost Notes/PID | 4 |
| PID sent to wrong address / person | 10 |
| PID in wrong record | 20 |
| Records Error | 10 |
| PID Saved / Stored Insecurely | 15 |
| NHSMail not used for PID | 3 |
| PID found in public place | 1 |
| Breach by staff - Deliberate | 0 |
| Breach by staff - Unintentional | 3 |
| Printing Issues (left on printer / wrong printer) | 3 |
| Other | 3 |
| **Sub Total** | **72** |

72 incidents were reported in Q2, 2018/19, which is a 19% reduction when compared Q1, 2018/19. Two of these incidents were reported as SIRI's

When reviewing the type of incidents reported, the three most reported incidents / areas of concern are;

- 30 incidents were reported as PID in wrong record or record error, although the number of reported incidents has decreased since the previous quarter. Services continue to raise awareness of the need of data validation when entering information within records and ensuring that where possible staff should only search for a patient's record using their NHS Number. This has led to a reduction, but further awareness is required.

- 15 incidents were reported as PID Saved / Stored insecurely. This should now be a new area of focus. However it is important to note that these incidents were near misses due to the actions taken by staff.
- 10 incidents were reported as PID Sent to Wrong Person / Address, although this number of reported incidents have decreased since the previous quarter; unlike previous incidents, this now mainly link to sending of information via email.

### 4.2 *Trust's Top 3 Security Concerns – At Present*

- Staff: The human element will always be a risk to the organisation, as this can never truly be eliminated; however the Trust has implemented a number of mitigations, in the form of; policies, training, guidance, access controls, etc… This risk will fluctuate in its ranking, but is currently in the top 3 due to a number of staff breaches reported. The following actions have been implemented as a result of this to reduce the risk to the organisation;

  - ✓ An alert was added to every unit of SystmOne to remind staff that it is a breach of Law and Trust policy to access PID without a work related reason, including accessing your own information
  - ✓ Operational Director, Clinical Directors and Professional / Governance Leads have been contacted by the IG Team to remind their staff of this
  - ✓ Message was included in Staff News to reflect this
  - ✓ Message was included in Managers Matter
  - ✓ An alert was added to SolNet
  - ✓ Training is already in place
  - ✓ Posters were re-cascaded
  - ✓ IG Team worked with patient systems to develop different types of reports, other than the Privacy Officer Alerts, to assess access in more detail
- Network Access Control to be implemented and Penetration Test to be completed: These are more controls then concerns. Other factors are in place to ensure Cyber Security compliance, but an assessment of these controls and strengthen controls have been requested to ensure greater compliance.

- Cyber Security: This should always remain in the top three due to the significant risk to the organisation, especially in light of incidents such as WannaCry. This is a key focus of the Information Security Group, to provide assurance to the Trust.

## 5. Summary

Solent NHS Trust continues to strive for excellent Information Governance compliance and awareness, providing and operating a culture of transparency and openness, as well as continual improvement and learning. This supports the Trust's values and strategies, as well as the foundations of the new Data Protection Legislations.

The Trust has implemented new reporting structures to meet the new and heightened demands of the Data Protection and Security Toolkit, a key example of this is the Information Security Group.

- ➢ We are now receiving regular reports from CGI and discussions are taking place on how to improve the detail in the report, providing greater assurance
- ➢ Challenging conversations are taking place to improve security and discussions / actions have taken place on improving the communication between CGI and Solent on key issues
- ➢ New initiative ways or working and use of technology is being discussed at the group, to assess if there are potential security threats / risks
- ➢ There is also a focus on monitoring day-to-day security
- ➢ Information provided by the group and discussions held, as led to an increase in our DSPT compliance

The slight decrease in compliance with regards to requests for information was swiftly addressed and highlights the importance of the centralised Records Management function, which the Trust's Board supported the implementation of. This resource is now once again fully operational.

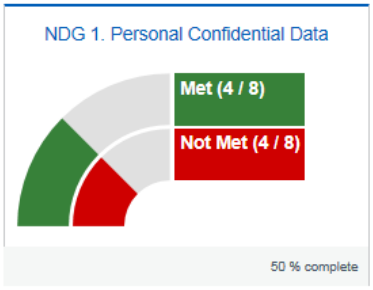
Incidents continue to be monitored and although reporting remains consistent, trends and themes change, as areas of risks and concern are identified and addressed.

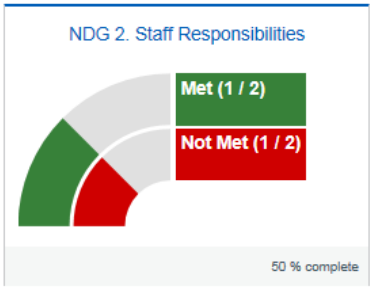
The Trust's continues to meet and focus on its Information Governance objectives for 2018/19;

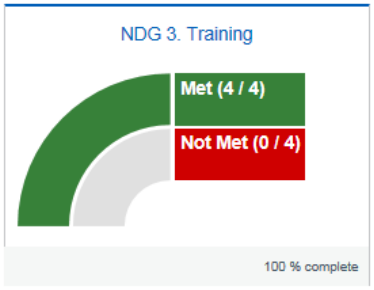
- Continue to achieve outstanding IG compliance
- Navigate new challenges introduced by the new Data Protection and Security Toolkit
- Strive for a level of assurance above average compliance for GDPR, by providing greater transparency
- Help our partners and the public understand GDPR, and assist in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

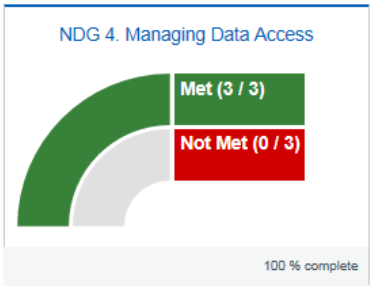
**Appendix A: Data Protection and Security Toolkit Current Compliance**

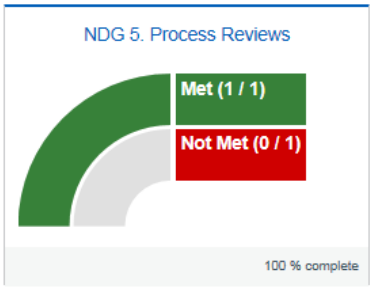
Below is a summary of Solent NHS Trust's compliancy with the Data Security and Protection Toolkit as of **2nd November 2018.**

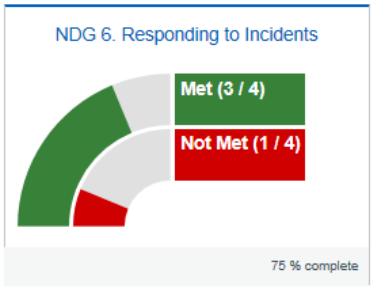


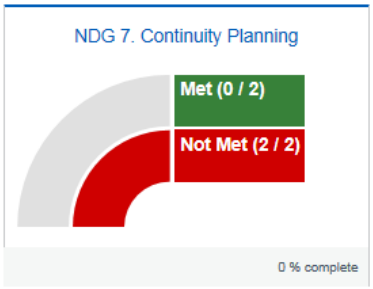



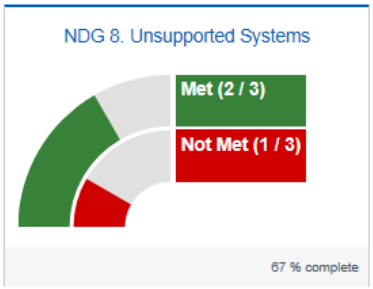



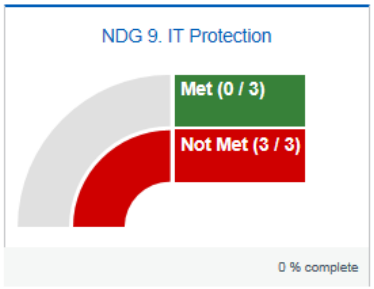



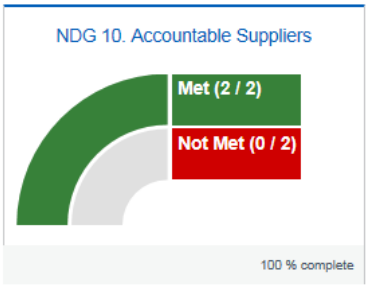




***compliance will be updated in the next reporting period**

**Appendix B: Information Request Compliance Breakdown**

***Subject Access Requests:***

Due to the recent change in legislation, the Trust is currently monitoring two states of compliance; the first being in accordance with the Data Protection Act 1998 which allows 40 days to respond to requests for records or information. The second, is in conjunction with the General Data Protection Regulations 2016 that came in to effect on 25th May 2018 – midway of the first quarter. The new legislation only allows us on calendar month (Approx. 30 days) to respond to requests. Below is a breakdown of compliance for Q1 & Q2, 2018/19, compared to all of 2017/18; in line with both legislations.

Only Subject Access Requests and Police Requests (under Data Protection Legislation) are now monitored for compliance, all other types of requests are separately monitored under the legislations that they full under, but are minimal so no longer reported on.

| | 2017/18 | Q1 2018/19 | Q2 2018/19 *TBC |
|---|---|---|---|
| Number of requests received | 798 | 226 | 285 |
| Number of requests responded to within 21 days (best practice) | 529 (66%) | 159 (70%) | 173 (64%) |
| Number of requests responded to within GDPR (30 days) | Not reported under in 2017/18 | 32 (14%) | 40 (15%) |
| Number of requests responded to within DPA (40 days) | 155 (20%) | 19 (9%) | - |
| Number of breaches within GDPR (in excess of 30 days) | Not reported under in 2017/18 | 0 (0%) | 56 (21%) |
| Number of breaches within DPA (in excess of 40 days) | 113 (14%) | 16 (7%) | - |
| **Not Due** | - | - | 16 |

* Final figures are subject to change, as some requests are currently not due to date
* % compliance = requests minus those not due

A breakdown in monthly compliance is shown below.

| Overarching | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Year** | **Month** | **Total** | **Not Due** | **21 days** | **30 days GDPR** | **40 days DPA** | **Compliance %** | **Breaches** |
| **2017/2018** | **Aug** | **86** | **0** | **50** | **-** | **15** | **76%** | **21** |
| | **Sept** | **83** | **0** | **58** | **-** | **14** | **87%** | **11** |
| | **Oct** | **71** | **0** | **59** | **-** | **6** | **92%** | **6** |
| | **Nov** | **76** | **0** | **56** | **-** | **14** | **92%** | **6** |
| | **Dec** | **49** | **0** | **38** | **-** | **11** | **100%** | **0** |
| | **Jan** | **73** | **0** | **57** | **-** | **15** | **99%** | **1** |
| | **Feb** | **63** | **0** | **41** | **-** | **12** | **98%** | **1** |
| | **Mar** | **49** | **0** | **30** | **-** | **13** | **90%** | **5** |
| **2018/2019** | **April** | **58** | **0** | **36** | **7** | **11** | **93%** | **4** |
| | **May** | **89** | **0** | **62** | **15** | **8** | **96%** | **4** |
| | **Jun** | **79** | **0** | **61** | **10** | **0** | **90%** | **8** |
| | **Jul** | **101** | **1** | **75** | **7** | **-** | **82%** | **18** |
| | **Aug** | **64** | **0** | **30** | **14** | **-** | **69%** | **20** |
| | **Sept** | **120** | **15** | **68** | **19** | **-** | **83%** | **18** |
| | **Oct** | **113** | **66** | **42** | **4** | **-** | **98%** | **1** |

***Freedom of Information Requests:***

| **Quarter** | **Q1** | | | **Q2** | | |
|---|---|---|---|---|---|---|
| Month | **April** | **May** | **June** | **July** | **Aug** | **Sept** |
| No. Requests | 30 | 29 | 16 | 42 | 28 | 21 |
| No. Breaches | 2 | 1 | - | 4 | 8 | 5 |
| No. Not Due | - | - | - | - | - | |
| % Compliance | 93% | 97% | 100% | 91% | 71% | 76% |

Item 16.1

NHS Solent NHS Trust

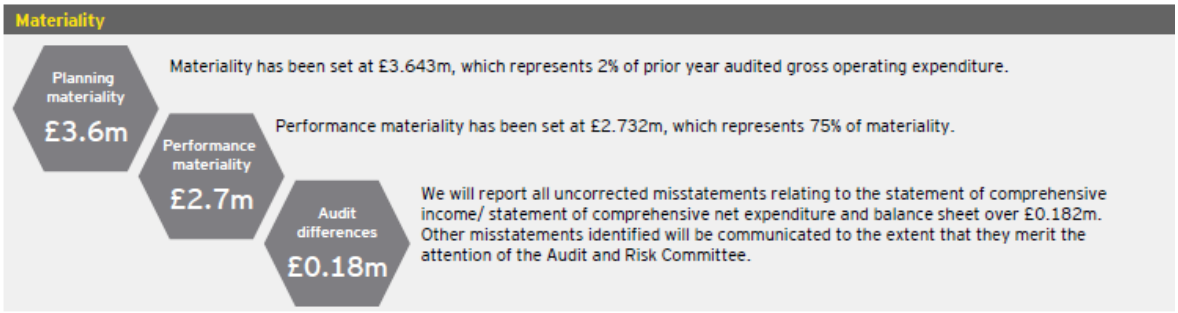
**Exception and recommendation report**

| | | | |
|---|---|---|---|
| **Committee /Subgroup name** | Audit & Risk Committee | **Date of meeting** | 8th November |
| **Chair** | Stephanie Elsy, Non-Executive Director (on behalf of Jon Pittam) | **Report to** | Board |

**Key issues to be escalated**

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

- The Director of Finance and Performance (DOF) presented a report outlining **Single Tender Waivers** processed since the last meeting – these were noted by the Committee.
- The **Audit Planning Report** was presented by the Trust's external auditors, Ernst & Young LLP. The Committee were informed of materiality levels associated with the audit as follows (extracted from the report presented);




  The Committee received the report, noting the timeline associated with the 2018/19 audit and key deliverables, as well as approving the anticipatory fees.
- The Trusts' internal auditors, PwC presented the **Internal Audit Progress Report** – a summary of progress against the 2018/19 Internal Audit Programme is as follows:

| Review to be undertaken | Target ARC Reporting Date | Identification of key contact | Scoping meeting(s) held | Terms of reference approved | Fieldwork dates confirmed | Fieldwork completed | Report issued to Solent | Review complete |
|---|---|---|---|---|---|---|---|---|
| Risk Management – Child and Family Service Line | Jan-19 | Completed | Completed | Completed | Completed | Completed | In Progress | |
| Key Financial Systems | Jan-19 | Completed | Completed | Completed | Completed | | | |
| Data Security and Protection Toolkit | Jan-19 | Completed | Completed | Completed | Completed | | | |
| Learnings Review | Mar-19* | Completed | Completed | Completed | Completed | | | |
| Mental Health Act Scrutiny Committee Review | Jan-19 | Completed | Completed | In Progress | | | | |
| Business Continuity Planning and IT Disaster Recovery | Mar-19 | Completed | Completed | In Progress | | | | |
| Demand and Capacity Review | Mar-19 | Completed | Completed | In Progress | | | | |

* Due to the Learnings Framework still being in development it was determined that the review will take place in the New Year to allow for the framework to be developed.

  The Committee noted progress and received the report.
- The **Counter Fraud, Bribery and Corruption Interim Quarter 2 Report 2018/19** was received and the Committee were informed of the latest status regarding allegations and investigations. The Committee also received the updated **Local Counter Fraud, Bribery and Corruption Policy**.
- The Chief Medical Officer attended to provide a report on **Clinical Audit & Effectiveness** as well as outlining progress on audit projects, summarising key outcomes from audits and citing examples where audit has driven improvements and change.
- The **Interim Lead Freedom to Speak Up (FTSU) Guardian** also attended to brief the Committee on the latest position – it was noted that the Trust's recently appointed Independent Lead FTSU Guardian will be commencing their role pre-Christmas.
- The Committee received the **Business Continuity Management Report** and separately also received a report presented by the Chief Operating Officer Southampton and County concerning **Brexit Preparedness**
- The Committee considered the effectiveness of the **Board Assurance Framework (BAF)** and concluded that the BAF is an embedded tool. Further consideration of the BAF will take place at

the November Confidential Board meeting. It was agreed to conduct a deep dive into the 'Third Party Supplier' risk (one of the Trust's current highest risks) at the February 2019 meeting to further stress test the BAF.

- Amendments to the **Standing Orders** were received and the Committee noted that the meeting dates for both the Audit & Risk Committee and Board meetings next year may need to be adjusted upon consideration of the Department of Health / NHS Improvement timetable for the approval of the accounts and annual report.
- The Committee noted progress made as part of the **Mid-Year Review of Objectives**
- The Director of IT attended to present a report on **Asset (laptop) Management Control.** It was acknowledged that a number of positive steps have been, and continue to be taken, to strengthen internal control processes with regards to asset management.
- The Committee were briefed by the COO Southampton and County in relation to **potential contentious issues.**
- The Committee also received the **Q3 Comprehensive Risk Report.**

**Decisions made at the meeting**

No decisions made at the meeting, reports were received as referenced above.

**Recommendations**

The Committee recommends the following to the Board:

- To approve the amended Standing Orders *(presented separately Item 16.2)*
- To consider adjusting the timings of the Audit & Risk Committee and Board (if deemed necessary) to accommodate the required deadlines for submission to DH/NHSI concerning the accounts and annual report, following consideration by the Company Secretary and Financial Controller.

**Other risks to highlight** (not previously mentioned)

There are no risks to highlight.

Item 16.2

# Solent NHS Trust

# Standing Orders

## V8

| Version | Approved by | Date | Amendment summary | Date of next review |
|---|---|---|---|---|
| V4 | Board of Directors | Jan 2017 | Document review and updated to reflect new terminology.<br>Amendments presented to Dec 2016 Governance and Nominations Committee. | Nov 2018 |
| V5 | Chairs action | 14th March 2017 | Amended 4.8.5: Mental Health Act & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee (MHA & DoLSSC) | Nov 2018 |
| V6 | Acting Chairs action | 5th February 2018 | Amendment to Section 2.10 regarding Fit and Proper Person requirements and restrictions on an individual's ability to become /continue to be a director | Nov 2018 |
| V7 | Chairs Action | 30th April 2018 | Inclusion of People and OD Committee section 4.8.8 | Nov 2018 |
| V8 | Board of Directors – via Audit & Risk Committee (Nov '18) | Nov 2018 | Logo change. Clarification re: voting /non-voting membership section 2.1, minor amendments re: FPPT requirements 2.10, inclusion of Community Engagement Committee section 4.8.9 | Nov 2020 |

# Contents



**The Standing Orders, Standing Financial Instructions and Scheme of Delegation, provide a regulatory framework for the business conduct of the Trust. Each is a separate document, but should be read in conjunction with one another.**

**All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.**

**Failure to comply with Standing Orders and Standing Financial Instructions is a serious disciplinary matter**

# Section One Interpretation and Definitions

Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board)

**"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive

**"Board of Directors"** (also known as the Trust Board) means persons formally appointed to site on the Board of Directors (including the Chairman, Non-Executive Directors and Executive directors of the Trust)

**"Chief Executive"** means the chief officer of the Trust

**"Committee"** means a committee or sub-committee created and appointed by the Board of Directors

**"Committee members"** means persons formally appointed by the Board of Directors to sit on or to chair specific committees

**"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets

**"Deputy Chairman"** means the non-officer (Non-executive) member appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason

**"Director of Finance & Performance"** means the Director of Finance & Performance of the Trust

**"Employee"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust

**"Executive member"** means an executive member of the Board of Directors who is either an executive member of the Board of Directors or is to be treated as such by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

**"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, and now contained under Schedule 2, paragraph 12; Schedule 6, paragraph 8; and Schedule 5, paragraph 8 of the NHS Act 2006, as amended. Such funds may or may not be charitable.

**"Member"** means an executive or non-executive member of the Board as the context permits. Member in relation to the Board does not include its Chairman.

**"Membership and Procedure Regulations"** means National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) and subsequent amendments.

**"Nominated employee"** means an employee charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

**"Non-executive member"** means a non-executive member of the Board of Directors and is not to be treated as an officer by virtue of the Membership, Procedure and Administration Arrangements Regulations 2000 (as amended).

**"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

**"Officer member"** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

**"Assurance Committee [Safety and Quality Committee]"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the Trust has responsibility

**"SFIs"** means Standing Financial Instructions

**"SOs"** means Standing Orders

**"Trust"** means Solent NHS Trust

# Section Two Standing Orders

**1.1 Statutory Framework**

1.1.1 Solent NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2011 under The Solent National Health Service Trust (Establishment) Order 2011 No 804.

1.1.2 The principal place of business of the Trust is:

Solent NHS Trust Headquarters,
Highpoint Venue,
Bursledon Rd,
Southampton,
SO19 8BR

1.1.3 NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the National Health Service Act 2006.

1.1.4 The functions of the Trust are conferred by this legislation.

1.1.5 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

1.1.6 The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and as now contained under Sections 256 and 257 of the NHS Act 2006 (and Health & Social Care Act 2012), to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

1.1.7 The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.8 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

**1.2 NHS Framework**

1.2.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.2.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Codes of Conduct make various requirements concerning possible conflicts of interest of Board members.

1.2.3 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS and should be considered in conjunction with the Freedom of Information Act 2000.

### 1.3 Delegation of powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (Section 5) the Trust's Board of Directors is given 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. Board of Directors: composition, tenure and role

### 2.1 Composition of the membership of the Board of Directors

In accordance with the Membership and Procedure Regulations the composition of the Board shall be:

(i) Up to 6 non-executive members, including the Chair appointed by NHS Improvement[1].

(ii) The Chairman of the Board of Directors appointed by NHS Improvement.

(iii) Up to 5 executive members (but not exceeding the number of non-executive members) including:

- Chief Executive;
- Director of Finance & Performance;
- Chief Medical Officer;
- Chief Nurse.

(iv) Solent NHS Trust is established with 11 (voting) members in total; 5 executive members (below), a Chairman and 5 non- executive members

- Chief Executive
- Director of Finance & Performance and Performance
- Chief Medical Officer
- Chief Nurse
- Chief People Officer

The Board of Directors shall have not more than 12 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State). In addition to the voting members previously listed within section 2.1; the Chief Operating Officer Southampton and County Services and Chief Operating Officer Portsmouth Services are also (non-voting) members.

[1] previously the Trust Development Authority and the Appointments Commission

The Board of Directors shall, at its discretion, appoint a Deputy Chief Executive Officer at which point the voting arrangements will be considered.

**2.2 Appointment of Chairman and members of the Board of Directors**

Appointment of the Chairman and Members of the Board of Directors - paragraph 3 of Schedule 3 to the NHS Act 2006, provides that the Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the Membership and Procedure Regulations. The Terms and Conditions of the Chairman and Non-Executive members are set out by the NHS Improvement[2].

**2.3 Terms of office of the Chairman and members of the Board of Directors**

The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in the Membership and Procedure Regulations. The terms of office of the Chairman and Non-Executive members are available via the NHSI document referenced above.

**2.4 Appointment and Powers of Deputy Chairman**

2.4.1 Subject to Standing Order 2.4.2 below, the Chairman and other members of the Board of Directors may appoint one of their number, who is not also an officer member, to be Deputy Chairman, for such period, not exceeding the remainder of his term as a member of the Trust.

2.4.2 Any member so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Chairman and other members of the Board of Directors may thereupon appoint another member as Deputy Chairman in accordance with the provisions of Standing Order 2.4 1.

2.4.3 Where the Chairman of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chairman.

**2.5 Role of the Board of Directors**

2.5.1 The Board of Directors provides proactive leadership of the Trust towards achievement of corporate objectives and oversight of the framework of sound internal controls, risk management and governance in place to support their achievement.

The Board of Directors is responsible for:

1. Setting the Trust's strategic aims;
2. Setting the Trust's values and standards;
3. The safety and quality of services;
4. Holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of internal control are robust and reliable;

[2] previously the Trust Development Authority and the Appointments Commission

5. Ensuring that the necessary financial, human and physical resources are in place to enable the Trust to meet its priorities and objectives and periodically reviewing management performance; and

6. Ensuring that the Trust complies with the Code of Conduct, Standing Orders, Standing Financial Instructions, Scheme of Delegation and statutory obligations at all times.

2.5.2 All members of the Board of Directors have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not affect the particular responsibilities of the Chief Executive as the Trust's Accountable Officer. All directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the Board of Directors and help develop proposals on priorities, risk mitigation, values, standards and strategy.

2.5.3 Executive members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.5.4 **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.5.5 **Director of Finance & Performance**

The Director of Finance & Performance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.5.6 **Non-executive members of the Board of Directors**

The non-executive members of the Board of Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.5.7 **Chairman of the Board of Directors**

The Chairman shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with the Appointments Team of NHS Improvements over the appointment of non-executive members of the Board of Directors and, once appointed, shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

## 2.7 Corporate role of the Board

2.7.1 All business shall be conducted in the name of the Trust.

2.7.2 All funds received in trust shall be held in the name of the Trust as corporate trustee and accountability for these funds is to the Secretary of State for Health

2.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in paragraph 3 of these Standing Orders.

2.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

**2.8 Schedule of Matters Reserved to the Board and Scheme of Delegation**

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board'. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

**2.9 Lead roles for members of the Board of Directors**

The Chairman will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services/Safeguarding etc.).

**2.10 Fit and Proper Person Requirements (FPPT)**

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 5) and NHS Provider License (Condition G4) places a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or a Non-Executive Director (NED) under given circumstances.

The Trust is required to ensure that directors and equivalents are 'fit and proper' for the role and make every reasonable effort to assure itself by all available means. The Trust has developed a 'Fit and Proper Person Test- Standard Operating Procedure' which sets out the Trust's systems and processes in place to ensure that all new directors and existing directors are, and continue to be, fit, and that no appointments meet any of the unfitness criteria set out in the 2014 Regulations.

A number of restrictions apply in relation to the individuals' ability to become or continue as a director.

A person may not become of continue as a director of the Trust if[3]:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;
- a person who, in the case of a non executive director other than the initial non-executive directors, no longer satisfies paragraph 29 (if applicable);

[3] *The list is taken from Monitor's Model Constitution for Foundation Trusts which is applicable*

- a person whose tenure of office as a chairman or as a member or Director of a health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

- a person who has had their name removed from a list maintained by a direction under any NHS act or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable), and due to such reasons is considered by the Trust to be unsuitable to be a Director;

- a person who by reference to information revealed by a disclosure and barring service (established under section 87 of the Protection of Freedoms Act 2012) check is considered by the chief executive to be inappropriate on the grounds that their appointment may adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

- a person who has, or has been in the last five years prior to their application to be a member, been involved as a perpetrator in a serious incident of assault or violence, or in one or more incidents of harassment, against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust (including volunteers), and following such behaviour has been asked to leave, has been removed or excluded from any hospital, premises or establishment, in accordance with the relevant Trust policy for withholding treatment from violent / aggressive patients;

- a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

- a person who is a governor of the Trust or an executive or non-executive director or a governor of another NHS foundation trust, an executive or non-executive director, chair, chief executive officer of another Health Service Body or a body corporate whose business includes the provision of health care services, or which includes the provision of any service to the Trust;

- a person who is a member of a local authority health overview and scrutiny committee;

- a person who is a subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

- a person who has failed without reasonable cause to fulfil any training requirement established by the Board of Directors;

- a person who has failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the Directors' Code of Conduct;

- a person who has knowingly or recklessly made a false declaration for any purpose provided for under this constitution or in the 2006 Act;

- a person who is the spouse, partner, parent or child of a member of the Board of Directors (including the chairman) of the Trust; or

- a person who is the subject of a sex offenders order and/or his name in included in the sex offenders register.

Directors are required to complete a pre-employment and annual declaration in respect of FFPT considerations, in accordance with the Trust's Standard Operating Procedure. A full list of the considerations/requirements can be found within the self-declaration form and Board Code of Conduct.

## 3. Meetings of the Trust

### 3.1 Calling meetings

3.1.1 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board may determine.

3.1.2 The Chairman of the Trust may call a meeting of the Board of Directors at any time.

3.1.3 One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

### 3.2 Notice of meetings and the business to be transacted

3.2.1 Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under paragraph 3.6 of these Standing Orders.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least **15** clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than **15** days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.5 Before each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least **three** clear days before the meeting (section 1(4)(a) Public Bodies (Admission to Meetings) Act 1960).

### 3.3 Agenda and supporting papers

The Agenda will be sent to members no later than **five** working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than four clear days before the meeting, save in emergency.

### 3.4 Petitions

Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

### 3.5 Notice of motion

3.5.1 Subject to the provisions of paragraphs 3.7 and 3.8 of these Standing Orders, a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least fifteen clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

### 3.6 Emergency motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

### 3.7 Motions: procedure at and during a meeting

3.7.1 **Who may propose**

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

3.7.2 **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(i) The reception of a report;
(ii) Consideration of any item of business before the Board of Directors;
(iii) The accuracy of minutes;
(iv) That the Board of Directors proceed to next business;
(v) That the Board of Directors adjourn;
(vi) That the question be now put.

3.7.3 **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 **Rights of reply to motions**

(i) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(ii) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

(i) An amendment to the motion;
(ii) The adjournment of the discussion, or the meeting;
(iii) That the meeting proceeds to the next business;
(iv) That the question should be now put;
(v) The appointment of an 'ad hoc' committee to deal with a specific item of business;
(vi) That a member/director be not further heard;
(vii) A motion under section 1(2) or section 1(8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

**3.8 Motion to rescind a resolution**

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Board of Directors it shall not be competent for any director/member other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

**3.9 Chairman of meeting**

3.9.1 At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairman and Deputy-Chairman, if there is one, are absent, such member (who is not also an Officer Member of the Trust i.e. a Non-Executive Director) as the members present shall choose shall preside.

**3.10 Chairman's ruling**

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.

**3.11 Quorum**

3.11.1 No business shall be transacted at a meeting of an NHS trust unless the following are present:

- a minimum of two Executive Directors and
- at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair

3.11.2 A senior employee in attendance for an executive member of the Board of Directors but without formal acting up status may not count towards the quorum.

3.11.3 If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

**3.12 Voting**

3.12.1 Save as provided in paragraphs 3.13 and 3.14 of these Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote).

3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a member so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A senior employee who has been formally appointed to act up for an executive member of the Board of Directors during a period of incapacity or temporarily to fill an executive director vacancy shall be entitled to exercise the corresponding voting rights.

3.12.7 A senior employee attending a meeting of the Board of Directors to represent an executive member during a period of incapacity or temporary absence without formal acting up status may not exercise the corresponding voting rights. Their status of such attendees shall be recorded in the minutes.

### 3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the provisions of these Standing Orders with respect to a quorum, any one or more of the Standing Orders may be suspended at any meeting, 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.

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit and Risk Committee shall be advised of and review every decision to suspend Standing Orders.

### 3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

(i) Upon a notice of motion under paragraph 3.5 of these Standing Orders;
(ii) Upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
(iii) that two thirds of the Board members are present at the meeting (i.e at least 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; or
(iv) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

### 3.15 Minutes

3.15.1 The nominated secretary shall record the minutes of every meeting.

3.15.2 The secretary shall submit the draft minutes to the Board of Directors in advance of its next meeting for agreement, confirmation or otherwise.

3.15.3 The record of the minutes shall include:

(i) The names of:

(a) Every member present at the meeting;

(b) Any other person present; and

(c) Any apologies tendered by an absent member;

(ii) The withdrawal from a meeting of any member on account of a conflict of interest; and

(iii) Any declaration of interest.

3.15.4 Minutes shall record key points of discussion. They shall not, however, attribute comments to specific members unless this is specifically required by the Chairman presiding at the meeting.

Where personnel, finance or other restricted matters are discussed, the minutes shall describe the substance of the discussion in general terms.

### 3.16 Admission of public and the press

#### 3.16.1 Admission and exclusion on grounds of confidentiality of business to be transacted

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)

#### 3.16.2 General disturbances

The Chairman (or Deputy Chairman if one has been appointed) or the person presiding at the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public" (Section 1(8) Public Bodies (Admissions to Meetings) Act 1960)

#### 3.16.3 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in 3.16.1 and 3.16.2 above shall be confidential to the members of the Board.

Members of the Board of Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

#### 3.16.4 Use of mechanical or electrical equipment for recording or transmission of meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board of Directors or Committee thereof. Such permission shall be granted only upon resolution of the Board of Directors.

### 3.17 Observers at meetings of the Board of Directors

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors' meetings and may change, alter or vary these terms and conditions as it deems fit.

Requests from personnel to observe the meeting must be made to the Company Secretary, and where appropriate sponsored by an Executive member. All requests will be referred to the Chairman and CEO for consideration and wider Board as appropriate.

# 4. Appointment of Committees and sub-Committees

## 4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Secretary of State for Health, the Board of Directors may appoint committees of the Board of Directors.

4.1.2 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 Joint Committees

4.2.1 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.

4.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Board of Directors or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

## 4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings of, and any committees established by the Board of Directors. In which case the term "Chairman" is to be read as a reference to the Chairman of other Committees as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. There is no requirement to hold meetings of committees established by the Board of Directors in public.

## 4.4 Terms of reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

## 4.5 Delegation of powers by Committees to Sub-Committees

Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-Committee unless expressly authorised by the Board of Directors.

## 4.6 Approval of appointments to Committees

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted (via the Governance and Nominations Committee concerning NED and Exec membership). Where the Board determines, and regulations permit, that persons, who are neither non-executive nor executive members, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Secretary of State. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

### 4.7 Appointments for statutory functions

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.

### 4.8 Committees established by the Board of Directors

The committees, established by the Board are:

#### 4.8.1 Audit and Risk Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, an Audit and Risk Committee will be established and constituted to provide the Board of Directors with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis. The duties of the Committee will include Governance, Risk Management and Internal Control, Internal Audit, External Audit, Other Assurance Functions, Management and Financial Reporting.

#### 4.8.2 Remuneration Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Remuneration Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

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 make decisions on behalf of Solent NHS Trust Board and where necessary make recommendations to NHS Improvement 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 compromise agreements/severance pay or other occasional payments to individuals and out of court settlements, taking account of national guidance

The Committee will also receive and note decisions of the Clinical Excellence Awards (CEA) panel.

#### 4.8.3 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 2.7 above and Standing Financial Instruction, Section 18.

#### 4.8.4 Assurance Committee

The Board shall establish an Assurance Committee to seek 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 also review the exception performance report alongside the Quality report to ensure the triangulation of information.

The Committee will seek assurance and scrutinise exception reporting from the clinical service lines (and their clinical governance subcommittees ) and its reporting subcommittees, being:

- Emergency Planning Committee
- Medicines Management Committee
- Health & Safety Committee
- Infection Prevention & Control Committee
- Quality & Risk Subcommittee (including exception reporting on SIRIs and Complaints)
- Dignity & Safeguarding Subcommittee
- Research & Development Subcommittee
- Clinical Audit & Effectiveness Subcommittee
- The SIRI Panel
- The IM&T and Information Governance Subcommittee – will be required to provide assurance reports on IG matters.

4.8.5 **Mental Health Act & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee (MHA & DoLSSC)**

A MHA&DoLSC will be 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.

4.8.6 **Governance & 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.

4.8.7 **Finance Committee**

The 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.

4.8.8 **People and Organisational Development (OD) Committee**

The People and OD Committee oversee all matters relating to workforce planning, talent acquisition, learning & development, employee productivity and workforce performance. It is responsible for ensuring that effective People & OD programmes are developed, which align with

organisational strategy and deliver continuous improvement in organisational effectiveness -all within the context of system transformation and organisational change.

4.8.9 **Community Engagement Committee**

The Committee is responsible for assuring the Board on delivery and development of the engagement strategy. In particular the Committee shall be concerned with assuring the Board that the Trust is fulfilling the three aims of the engagement strategy:

1. To improve our internal capacity, understanding and expertise on engagement.
2. To develop positive and constructive relationships with local community and voluntary sector organisations so that they can become equal partners in service design and delivery.
3. To develop the Trust's reputation as a system leader for engagement.

4.8.10 **Other Committees**

The Board of Directors may also establish such other committees as required to discharge their responsibilities.

# 5. Arrangements for the exercise of Trust functions by delegation

## 5.1 Delegation of functions to Committees, Executive Directors or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board of Directors may make arrangements for the exercise, on its behalf, of any of its functions by a committee, sub-committee appointed by virtue of Section 4 of these Standing Orders, or by an Executive Director or senior employee of the Trust, or by another body as defined in paragraph 5.1.2 below, in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

5.1.2 Where a function is delegated to another Trust in accordance with the respective provisions of the NHS Act 2006, (and subsequent amendments) and Health and Social Care Act 2012, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or Executive Directors or senior employees of the Trust, the Board of Directors delegating the function retains full responsibility.

## 5.2 Emergency powers and urgent decisions

The powers which the Board of Directors has reserved to itself within these Standing Orders (see paragraph 2.8 of these 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.

## 5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors in respect of its sub-committees.

5.3.2 When the Board of Directors is not meeting in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Board of Directors in public session.

### 5.4 Delegation to Executive Directors and senior employees

5.4.1 Those functions of the Board of Directors which have not been retained as reserved by the Board of Directors or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive.

The Chief Executive shall determine which functions they shall perform personally and shall nominate officers to undertake the remaining functions for which they shall still retain accountability to the Board of Directors.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance & Performance to provide information and advise the Board of Directors in accordance with statutory or Department of Health requirements. Outside these statutory requirements the Director of Finance & Performance shall be accountable to the Chief Executive for operational matters.

### 5.5 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers

The arrangements made by the Board of Directors as set out in the Schedule of Matters Reserved to the Board and Scheme of Delegation of powers

### 5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or approval. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

## 6. Overlap with other Trust policy statements/ procedures, regulations and Standing Financial Instructions

### 6.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of staff employed by Solent NHS Trust. The decisions to approve such policies and procedures will be recorded in the minutes of the Board meeting in question and will be deemed, where appropriate, to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

### 6.2 Specific policy statements

Notwithstanding the application of paragraph 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following policy statements:

(i) the Code of Conduct Appendix 2 to these Standing Orders

(ii) the staff disciplinary and appeals procedures adopted by the Trust, both of which shall have effect as if incorporated in these Standing Orders.

**6.3 Standing Financial Instructions**

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

**6.4 Specific guidance**

Notwithstanding the provisions of section 6.1, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

(i) Caldicott Guardian Report 1997 (and all subsequent guidance);
(ii) Human Rights Act 1998; and
(iii) Freedom of Information Act 2000.

# 7. Duties and obligations of members of the Board of Directors and senior employees under these standing orders

7.1 **Declaration of Interests**

7.1.1 **Requirements for declaring interests and applicability to members of the Board of Directors**

The NHS Code of Accountability requires members of the Board of Directors to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

7.1.2 **Interests which are relevant and material**

(i) Interests which should be regarded as "relevant and material" are:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

(d) A position of authority in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for NHS services;

(f) Research funding/grants that may be received by an individual or their department; and

(g) Interests in pooled funds that are under separate management.

(ii) Any member of the Board of Directors who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in paragraph 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, shall declare his/her interest by giving notice in writing of such fact to the Chairman of the Board of Directors as soon as practicable.

7.1.3 **Advice on Interests**

(i) If members of the Board of Directors have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Board of Directors, the Chief Executive or the Company Secretary.

(ii) Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 **Recording of interests in minutes of meetings of the Board of Directors**

(i) At the time Board members' interests are declared, they should be recorded in the minutes of the Board of Directors.

(ii) Any changes in interests should be declared at the next meeting of the Board of Directors following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report and on the Trusts website in accordance with the Trusts Managing Conflicts of Interest Policy. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a meeting, of the Board of Directors if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 **Register of Interests**

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in paragraph 7.1.2 above) which have been declared by members of the Board of Directors.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

## 7.3 Exclusion of Chairman and Members of the Board of Directors in proceedings on account of pecuniary interest

### 7.3.1 Definition of terms used in interpreting 'pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "Contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(a) he, or his nominee, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(b) he is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:

(a) Neither he or any person connected with him has any beneficial interest in the securities of a company of which he or such person appears as a member; or

(b) any interest that he or any person connected with him may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him in relation to considering or voting on that contract; or

(c) those securities of any company in which he (or any person connected with him) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with paragraph 7.1.2 (ii) of these Standing Orders.

### 7.3.2 Exclusion in proceedings of the Board of Directors

(i) Subject to the following provisions of this paragraph, if the Chairman or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this paragraph in any case in which it appears to him in the interests of the National Health Service that the disability should be removed.

(iii) The Board of Directors may exclude the Chairman or a member of the Board of Directors from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chairman or member of the Board of Directors by virtue of paragraph 11 of Schedule 4 to the National Health Service Act 2006 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this paragraph.

(iv) This paragraph applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such Committee or sub-Committee (whether or not he is also a member of the Board of Directors) as it applies to a member of the Board of Directors.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(i) Power of the Secretary of State to make waivers

Under the Membership, Procedure and Administration Arrangements Regulations 1990 and subsequent amendments ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver shall be agreed in line with sub-paragraphs (ii) to (iv) below.

(ii) Definition of 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3 (iii) below, the "relevant chairman" is:

(a) At a meeting of the Board of Directors, the Chairman presiding at the meeting;

(b) At a meeting of a Committee:

- in a case where the member in question is the Chairman of that Committee, the Chairman of the Board of Directors;
- in the case of any other member, the Chairman of that Committee.

(iii) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to a member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:

(a) services under the National Health Service Act 2006; or

(b) services in connection with a pilot scheme under the National Health Service Act 2006;

For the benefit of persons for whom the Trust is responsible.

Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

- are members of the same profession as the member in question; and/or
- are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(iv) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (ii) (b) above, except where that member is the Chief Executive;

(c) in the case of a meeting of the Board of Directors:

- the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
- may not vote on any question with respect to it.

(d) in the case of a meeting of the Committee:

- the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
- may vote on any question with respect to it; but
- the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board of Directors.

## 7.4 Standards of Business Conduct

### 7.4.1 Trust policy and national guidance

The Board of Directors and all employees must comply with the Trust's Code of Conduct. Full requirements are set out Appendix 2

7.4.2 **Interest of executive directors and employees in contracts**

(i) 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 by giving notice in writing of such fact to the Chief Executive or the Company Secretary as soon as practicable.

(ii) 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.

(iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and recommendations by, members of the Board of Directors in relation to appointments**

(i) Canvassing of members of the Board of Directors or of any Committee of the Board of Directors directly or indirectly for any appointment by the Trust shall disqualify the candidate for such appointment. The contents of this paragraph shall be included in application forms or otherwise brought to the attention of candidates.

(ii) Members of the Board of Directors shall not solicit for any person any appointment by the Trust or recommend any person for such appointment; but this paragraph shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

(i) Candidates for any staff appointment by the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member of the Board of Directors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(ii) The Chairman of the Board of Directors, every member of the Board of Directors and senior employees shall disclose to the Board of Directors any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

(iii) 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.

(v) Where the relationship to a member of the Board of Directors is disclosed, the provisions of paragraph 7 shall apply.

## 8. Custody of seal, sealing and signature of documents

8.1 **Custody of seal**

The common seal of the Trust shall be kept by the Chief Executive or a manager nominated by him in a secure place.

8.2 **Sealing of documents**

Where the Trust (or supplier) decides that a document shall be sealed, the senior authorised person recommending the sealing shall make sure appropriate checks are made and the documents are correct.

The common seal shall be affixed in the presence of, and the document signed by:

- the Chief Executive (or Director acting CE) or Finance Director
- plus one other Director or Associate Director.

The signatories must be different to the senior authorised person recommending the sealing.

The administrator witnessing the sealing must sign the supporting paperwork.

Appendix 3 summarises when the Company Seal should be used.

8.3 **Register of sealing**

The Chief Executive shall ensure that a register is maintained in which he, or another manager authorised by him, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by:

- the Chief Executive or any other executive member of the Board of Directors.

In land transactions, the signing of certain supporting documents will be delegated to senior employees and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer, for example, sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed. The Commercial Team maintain a register of signatures.

Item 17

**Exception and recommendation report**

| | | | |
|---|---|---|---|
| **Committee /Subgroup name** | **Assurance committee** | **Dates of meeting** | 16th October & 20th November 2018 |
| **Chair** | **Mick Tutt** | **Report to** | Trust Board |

**Key issues to be escalated**

We received the following:-

- an up-date on action taken to address the **concerns raised by continued problems experienced with the** (3rd party) **Wheelchair provider**
  These included continuing communication with NHSi regarding the Trust's concerns and the request from NHSi; that the Trust hold discussions with the CCG to consider communication options with Millbrook
  Additionally, we heard about work-in-progress to close those investigations where there had been deemed to be 'physical harm' and a review of cases where it was deemed that 'psychological harm' had occurred

  Concern was shared regarding the number of children and vulnerable adults who were waiting, which appeared to be increasing. It was confirmed that those impacted would received written communication, including signposts for mechanisms of support during waiting times

- a briefing on **CQC activity**; focussed on visits to Core Services, ahead of the Well-Led Inspection in November '18

- the **Quarter 1 and 2017/8 Annual Patient Experience Reports** – where a change in format, from now on, would see a collective report on Serious Incidents, complaints and Learning from Deaths and of a change in reporting frequency from quarterly to bi-monthly.

- a detailed report on ligature risk assessment and the plan of works to address these. It was noted that assessments of what constituted a ligature risk were constantly evolving, and toleration of risk changed, over time

- confirmation of Winter Planning, within the Portsmouth System – including adjustments in staffing capacity; to ensure the appropriate discharge when fit to leave hospital. We were assured that both this staffing, and System-wide staffing generally were successfully integrated. It was noted that workforce recruitment and bank and agency staffing were being considered at STP level.

- an update following the Isle of Wight dental service mobilisation. It was noted that colleagues had assisted with migration and the induction of colleagues within the Trust. Issues with referrals not being appropriately administered were noted. Findings were to be audited and shared for quality assurance purposes. Staff enthusiasm for changes made was noted.

| Decisions made at the meeting |
| --- |
| It was agreed that:-<br><br>The following were ratified by the Committee following approval via chair's action:-<br>• **Use of Unlicensed and Off-Label Medicines Policy**<br>• **Policy Steering Group Terms of Reference**<br><br>The following policies were ratified:-<br>• **Missing and AWOL Patients Policy for Psychiatric Units and Community Teams (*previously Missing Persons Policy*)**<br>• **Transportation of Clients / Colleagues by Staff in Vehicles Policy**<br>• **Pre-Employment Health Assessment Policy**<br><br>The Committee also noted the decision to extend the Domestic Abuse Policy by 3 months until January 2019<br><br>Chair's Action had also been taken to endorse the **Terms of Reference for the Quality Improvement and Risk (QIR) group** and it was also noted that the frequency of the Assurance Committee would change from January 2019; to bi-monthly on the third week of the month |
| **Recommendations to the Trust Board** |
| **The Board are asked to**<br><br>➢ **note the issues set out above** |
| **Other risks to highlight** (not previously mentioned) |
| None of note |

Item 19

# Solent NHS Trust
# Charitable Funds Committee – Terms of Reference

**1 Constitution**

1.1 The Charitable Funds Committee (The Committee) is a Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference will be reviewed at least annually by the Trust Board to ensure they remain appropriate.

1.2 The Charitable Funds Committee exists to carry out functions delegated to it by Solent NHS Trust, which is the Corporate Trustee of the Charity that is registered with the Charity Commission as Portsmouth & South East Hampshire Charitable Fund (number 1053431), now Solent NHS Charity.

1.3 The Corporate Trustee, through its board, has delegated day to day management of the charity to the Committee, including delegable functions as defined in regulation 16 of the NHS Trusts (Membership & Procedures) Regulations 1990 [*and under section 11 of the Trustee Act 2000 once authorised as a Foundation Trust].*

1.4 The Corporate Trustee may at any time review and alter any aspect of the delegation.

**2 Purpose**

- The Committee will ensure that funds are spent in accordance with the original intention of the donor (if specified).

- The Committee will oversee and review the strategic and operational management of the Solent NHS Charity (or non-exchequer funds as they are sometimes known).

- The Committee will ensure that all requirements of the Charity Commission are met and all legislation relating to charitable funds is adhered to in the administration and application of funds.

- The Committee will ensure co-operation with the external auditors in the regulation of the funds.

**3. Duties**

3.1 <u>Policies & Procedures regarding Charitable Funds</u>

3.1.1 To establish policies and procedures required for the effective day to day management of the Charitable Funds.

3.1.2 To ensure that the Trust's policies and procedures for charitable funds and investments are followed.

3.1.3 To review and approve the Trust's policies and procedures for the use and

investment of charitable funds.

3.1.4 To approve the Charity accounts on behalf of the Board, as Corporate Trustee.

3.2 Investment Portfolio

3.2.1 To ensure that all Trust Fund monies are properly managed and invested in accordance with current charity legislation and in accordance with the investment and reserves policy approved by the Charitable Trust Funds Committee.

3.2.2 To monitor the performance of the charitable funds investment portfolio.

3.3 Brand Development and Fundraising

3.3.1 To support brand development in relation to the charity taking into consideration the views of stakeholders

3.3.2 To develop and recommend new strategies to the board as Corporate Trustee and implement when approved.

3.3.3 To regulate fund raising and donations and determine the appropriateness of these activities, ensuring all activities are legal, liabilities are covered and trading activities are accounted for accordingly

3.3.4 To ensure that the generosity of the Trust's benefactors and the purposes to which funds are put, are appropriately publicised and recognised.

## 4 Membership

4.1 The Committee is appointed by the Corporate Trustee and comprises;

- Two Non Executive Directors
- Chief Operating Officer
- Financial Controller

4.2 The Chairman of the Committee shall be a Non-Executive Director (NED) appointed by the Trust Board.

## 5 Attendees

5.1 Attendees invited to the Committee will be;

- Finance Lead for Charitable Funds
- Associate Director of Corporate Affairs and Company Secretary
- Estates representative
- Other persons as required and invited by the Chairman
- Service Line Operational Directors
- Representative from the Communications team
- ~~Observer: Governor~~
- Charity Director (Volunteer)

5.2 When appropriate, the advisors as appointed by the Trust will be invited to attend meetings in order to provide professional advice on the investment portfolio.

**6 Secretary**

6.1 The Executive Assistant to the CEO shall act as the secretary of the committee**.**

6.2 The administration of the meeting shall be supported by the Executive Assistant to the CEO who will arrange to take minutes of the meeting and provide appropriate support to the Chairman and committee members.

6.3 The agenda and any working papers shall be circulated to members at least five working days before the date of the meeting.

6.4 The Finance Lead will ensure that the delegated approvals for expenditure are recorded and reported to the next Charitable Funds Committee, when these are above the limits noted in Financial Regulations, and approved by the Chief Executive.

**7 Quorum**

7.1 The Committee shall be quorate if two members are present of which one shall be a Non Executive Director and one shall be an Executive Director. A finance representative must also be in attendance.

**8 Frequency**

8.1 Meetings shall be held at least Quarterly.

8.2 Additional meetings can be called by the Chairman of the Committee as deemed necessary.

**9 Notice of meetings**

9.1 Meetings of the committee shall be summoned by the secretary of the committee at the request of any of its members, or at the request of external or internal auditors if they consider it necessary.

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

**10 Minutes of meetings**

10.1 Minutes of the meeting will be circulated to members once agreed by the Chairman.

**11 Authority**

11.1 To make decisions involving the use of charitable funds for investments with regard to existing and subsequent legislation, policy and guidance.

11.2 To receive the Annual Accounts and Annual Report of the Trust's Charitable Funds for consideration and recommendation for final approval, or otherwise, to the

Trust Board (the Corporate Trustee).

11.3 To receive and review the quarterly charitable funds income and expenditure accounts and other supporting financial information as requested by the Committee.

11.4 To receive the Annual Independent Examiners report.

11.5 The Committee will be responsible for establishing delegated authorisation limits to be implemented within the Trust regarding the expenditure of Charitable Funds.

11.6 The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external expertise with relevant experience if it considers this necessary.

**12 Reporting**

12.1 The Chairman of the Committee will report to Trust Board after each meeting.

12.2 The Chairman of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the Board, issues of significance or require executive action.

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

| | |
|---|---|
| Version | 10 |
| Agreed at Charitable Funds Committee | Date: October 2018 (via Chairs action at the October meeting) |
| Date of Next Review | Date: October 2019 |

Item 21

**Exception and recommendation report**

| | | | |
|---|---|---|---|
| **Committee /Subgroup name** | **Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee** | **Date of meeting** | 15th November 2018 |
| **Chair** | **Mick Tutt** | **Report to** | Trust Board |

**Key issues to be escalated**

We were joined by colleagues from PwC, our Internal Auditors – who are conducting a review of the effectiveness of assurance provided for the Board from the committee's scrutiny of Mental Capacity & Mental Health Acts application, and also by our (CQC) MHA Reviewer – who, in addition to her routine (unannounced) visits to any service where the MHA is applied (the last being the Kite unit) was also part of the recent CQC Well-Led process. We also had colleagues from Portsmouth Hospitals Trust – helping to ensuring effective, close liaison between mental health providers within the city, and Solent MIND – who, in effect, help to ensure that we have a 'proxy voice' for people we detain under either Act

As with our previous meeting, in September '18 **the Operation of the s136 suite** was a matter for some discussion. Two matters were considered:-

i) (as, briefly, reported from the previous meeting) **compliance with the reduced time threshold allowed by the Policing & Crime Act 2017** has been exceeded on three occasions since its introduction in December 2017. On the first occasion the breach was technical – because the Responsible Clinician had deemed an additional 12 hours were necessary for assessment, and the latter two incidents (both in August '18) are subject to internal investigation processes
The Board should note that such a level of breach is an outlyer (from the perspective of being low) from anecdotal benchmarking with other providers. Our management colleagues were going to attempt to provide a more rigorous comparison for future meetings

ii) as a consequence of comment made by one of the CQC representatives during the recent core service Inspection of the suite, **the service are investigating the potential – and implications, for registering the facility as an In-patient bed**. This arises because the suggestion was that use of the suite infers the requirement to apply the Code of Practice expectations for seclusion – a position challenged by our MC/MHA lead, the (CQC) policy advisor and our (CQC) MHAR

We spent some time considering the – implied – implications of the data provided regarding **the application of the MHA to people from differing ethnic communities**. This is because the national picture is that, traditionally, people from BAME communities are disproportionately more likely to both by detained under the Act and then both restrained and secluded. This is not a scenario which data provided (over time) for our service has demonstrated and we have asked for further work to be undertaken; to ensure that we have

been provided with an accurate understanding of the position

We undertook our **standard scrutiny of the use of the various powers** (for example s5 (practitioners' holding people pending an assessment) and s62 (prescription and administration of medication without consent) of the MHA and the application of the Deprivation of Liberty Safeguards with respect to the MCA) **and obligations** (for example s132 (ensuring people understand their rights whilst detained) and were content that there were no concerns to escalate
We also undertook our **standard scrutiny of the use of restraint and seclusion** and, again, were content that there were no concerns to escalate

We received an initial assessment of performance against a **recent report 'Women in Crisis'** [1] and will undertake more detailed scrutiny of this at our February '19 meeting [2]

Part B of the committee was our usual **training session for Associate Hospital Managers** (AHM), regarding **the implications of working with people experiencing dementia**

**Decisions made at the meeting**

We

a) reviewed and confirmed the Mid-Year Review of Objectives
b) reviewed the Terms of Reference and asked that further thought by given, by management colleagues, regarding the expectation that the committee would scrutinise all aspects of the training provided with regard to the MCA and MHA

**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

[1] published by Agenda, the Alliance for Women & Girls at Risk (august '18)
[2] it should be noted that this review will be reconciled with a similar review undertaken through the Assurance committee and reported to the November Quality Improvement & Risk group following the publication of 'Sexual safety on mental health wards' CQC (september '18)

Item 22

**Exception and recommendation report**

| | | | |
|---|---|---|---|
| **Committee /Subgroup name** | Governance & Nominations Committee | **Date of meeting** | 27th September 2018 |
| **Chair** | Alistair Stokes | **Report to** | Board |

**Key issues to be escalated**

The Committee met out of the normal planned meeting schedule to specifically consider the following matters:

- Succession planning for the Trust Chair – the committee discussed the recruitment process led by NHS Improvement and the associated timeline (which has subsequently been shared with the Board). Committee members were asked for views on the Information Pack (including the job description and person specification) which forms part of the candidate brief.
  Key dates associated with the recruitment timeline are as follows:
  - Closing date for applicants: 20th November 2018
  - Stakeholder engagement event for shortlisted candidates and 1:1 meetings with CEO: 11th December
  - Interviews: 11th January 2019. The interview panel to be chaired by the Executive Regional Managing Director (South East) NHSI and NHSE, and other panel members are sought by NHSI/E. Following interviews a recommendation is made to the NHSI Provider Leadership Committee who approves the appointment.
  - Appointment commences 1st April 2019, with anticipated shadowing period prior.
- Board Development – the Chief People Officer provided a summary on intended Board Development activities.

**Decisions made at the meeting**

No decisions made at the meeting.

**Recommendations**

No recommendations of concern for the Board were made at the meeting.

**Other risks to highlight** (not previously mentioned)

There are no risks to highlight.

**COMMUNITY ENGAGEMENT COMMITTEE TERMS OF REFERENCE**

**Explanation of terms used**

**Community Engagement –** the term 'community engagement' is used to describe the way in which the Trust wishes to involve a range of different people in how it delivers services to improve health and wellbeing including:

- people who currently use or have used services provided by the Trust (service users and patients);
- friends, families and carers of service users and patients;
- people who may need the services provided by the Trust who haven't yet used the services.
- people and community groups who may not use or need the Trust's services but who live in the areas where the Trust provides services and want to be involved supporting the Trust to make health care better
- community and voluntary sector agencies who work with and represent the interests of people who live in the areas where the Trust provides services.

**Empowerment –** the term 'empowerment' is used when services support people to feel in control of their lives, enabling them to make active decisions about their health and wellbeing.

**Equality** – the term 'equality' is used to mean any individual or population group, for example, people from Black and Minority Ethnic communities have access to, experience of and outcomes from the Trust's services in an appropriate and sensitive way that meets their needs. Also, that the Trust treats all employees and prospective employees fairly and with respect for their identity. Equality does not mean treating everyone the same or expecting all people to have the same needs and capabilities.

**Service user and/or patient** – the term 'service user and/or patient' refers to anyone who currently, or who has in the past used any of the Trust's services that they have used.

**Service user involvement** – the term 'service user involvement' refers to the ways the Trust actively involves people who are currently or have in the past used any of the Trust's services to improve the way cares for people.

**Service user experience** – the term 'service user experience' refers to service users' knowledge, understanding and feelings about the Trust's services.

**The Committee** – the term 'The Committee' is used to mean the Community Engagement Committee, which is a sub-committee of the Trust Board and reports directly to the Board on how the Trust is making community engagement part of everything it does.

**The Board** – the term 'The Board' refers to the group of individuals who are responsible for the decisions of the Trust.

## 1. The principles that will decide how the Committee works

1.1 **Empowerment** - Supporting people to feel in control of their lives so that they are more able to make decisions about their health and wellbeing.

1.2 **Equality** - Providing access to, experience of and outcomes from the Trust's services and/or employment in the Trust that meets the needs and capabilities of any and all individuals. For example, ensuring that there is an appropriate representation of people from Black and Minority Ethnic communities using the Trust's services and that their experiences of and outcomes from using services are appropriate to their needs. Equality does not mean treating everyone the same or expecting all people to have the same needs and capabilities.

1.3 **Inclusion –** Helping the Trust's services and workforce to reflect the needs the local community and population..

1.4 **Mainstreaming** – supports activity which deliveries community engagement across the Trust, so it becomes part of everything the Trust does, and is always 'how we do things'.

1.5 **Time limited** – The Committee is expected to be in place for two years, subject to review by the Board (at 18 months).

1.6 **Communication** - The Committee will have regular meetings to discuss and decide actions on how to meet the community engagement strategy and delivery plan. This will be communicated across all stakeholders using a variety of accessible information methodologies.

1.7 **Open discussion -** The Committee supports and encourages open and honest opinions throughout its activity.

1.8 **Assets –** The knowledge, values and experience of all Committee members is listened to and everyone's views are considered for their contribution to the community engagement activity.

## 2. The purpose of the Committee

2.1 The purpose of the Committee is to drive the delivery of the community engagement strategy.

2.2 The Committee will report to the Board on progress on how it is doing in delivering the community engagement strategy.

2.3 The Committee will use its knowledge, skills and experience to provide constructive challenge to the Board, executives and managers of the Trust on their behaviours and values in community engagement.

## 3. What the Committee will do

3.1 The Committee will:

3.1.1 Provide support, leadership, advice and guidance for staff so that they feel supported and able to make community engagement part of every thing they do.

3.1.2 Ensure that the Trust is accessible to local people and communities who want to be involved in contributing their knowledge, skills and experiences to improving the Trust. It will also ensure that the Trust does not exploit people's willingness to contribute their time, energy and assets.

3.1.4 Ensure the Trusts meets its obligations and duties under equality and human rights legislation as an employer by working collaboratively with the People and Organisational Development Committee.

3.1.5 Provide assurance to the Trust Board that community engagement is becoming part of the culture and practice of the Trust as a 'must do'.

3.1.6 Make recommendations on revisions to the Community Engagement Strategy as required and appropriate.

## 4. Membership

4.1 Members of the Committee will be appointed by the Board and will include:

- 2 Non-Executive Board members (one to act as Chairperson)
- Chief Nurse (as Deputy Chairperson)
- Community Engagement Framework lead
- Senior managers responsible for each care group (County, Portsmouth and Southampton)
- Associate Director Research and Improvement
- Service user and patient group representatives, for example Healthwatch
- Representatives (either officer or elected member) from local government
- Academic advisor(s)
- Community and voluntary sector agencies

4.2 The Board will appoint a Non-Executive Director to be the Committee Chairperson. In the absence of the Committee Chairperson the Deputy Chairperson, will chair the meeting.

4.3 For the first six months the Committee members will be drawn from internal staff with lead roles for developing the community engagement strategy. After this time the membership of the Committee will be reviewed and changed as appropriate and in keeping with the principles and purposes of the Committee.

## 5. Quorum

5.1 At least four members of the committee, including either Chairperson or Deputy Chairperson to be present for the committee to conduct activity.

## 6. Attendance

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

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

**7. Frequency of meetings**

7.1 The Committee will meet at least on a quarterly basis.

**8. Administration**

8.1 The Community Engagement Framework Lead or their nominee will be responsible for maintaining a record of actions agreed by the Committee and support the actions being achieved.

8.2 Members of the Committee will be notified about meetings in advance and receive the agenda, minutes of previous meetings and other papers as required in sufficient time to read and understand these prior to the meeting.

8.3 The Community Engagement Framework Lead will record minutes of the meeting, including name of attendees, decisions, actions and timescales.

8.4 Minutes of Committee meetings will be circulated promptly to all members of the Committee and the Chairman of the Board. The Board to agree the minutes unless a conflict of interest exists.

**11. Annual General Meeting**

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

**12. Authority**

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

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

**13. Reporting**

13.1 The Committee Chairperson shall report formally to the Board on its activities after each meeting on all matters within its duties and responsibilities.

13.2 The Committee shall make recommendations to the Board which it deems appropriate on any area of community engagement including any issues relating to community engagement and the duties of the Committee that need attention from the Board.

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

13.4 5 The Committee should make the Terms of Reference available and explain its role to the board or people who request it.

**14. Community Engagement Delivery Plan -** The Community Engagement Delivery Plan defines the aims, actions and activities required for the committee to achieve the Community Engagement strategy.

14.1 The Committee Chairperson will appoint a sub-group with members of Committee who with be responsible for day-to-day monitoring and development of the community engagement delivery plan.

14.2 Members of the Committee sub-group will include:

- Community Engagement Framework Lead
- Engagement Lead for Academy of Research & Improvement
- A senior representative for People and Organisational Development
- A senior member of the Communications Team
- A lead representative for patient experience
- Equality and inclusion lead officer
- Volunteer and membership co-ordinator

14.3 The sub-group will keep the Chairperson of the Committee informed of developments and maintain a risk register for actions and programmes that form the delivery plan.

**15. Other**

15.1 The Committee, as a minimum, will hold a yearly review of its:

- its own performance,
- constitution
- terms of reference

And recommend any changes it considers necessary to the Board for approval.

Version 2 (November 2018) Date of Next Review Date: May 2019