Agenda

Solent NHS Trust In Public Board Meeting

Tuesday 29th May 2018 09:00am – 12:35pm

Kestrel 1+2, Top Floor, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

**Timings are tentative*

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Well Led Domains
1	09:00	5mins	**Chairman's Welcome & Update** • **Apologies to receive** *To receive*	Deputy Chairman	-
2			**Register of Interests & Declaration of Interests** *To receive*	Deputy Chairman	-
3			**Confirmation that meeting is Quorate** *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Deputy Chairman	-
4	09:05	5 mins	***Minutes of Last Meeting and action tracker** *To agree*	Deputy Chairman	-
5	09:10	5mins	**Matters Arising**	Deputy Chairman	-
6	09:15	5mins	**Any Other Business**	Deputy Chairman	-
7	09:20	10mins	**Audit Results Report** *To be circulated following Audit & Risk Committee on 25th May – to receive*	Director of Finance and Performance	W6-W8
			Letter of Representation *To be circulated following Audit and Risk Committee on 25th May – to receive*		W6-W8
			Audit Opinion *To be circulated following Audit & Risk Committee on 25th May – to receive*		W6-W8
8	09:30	5mins	**Annual Accounts** *To be circulated following Audit & Risk Committee on 25th May – to approve*	Director of Finance and Performance	W5, W6
9	09:35	10mins	**Annual Report – including the Annual Governance Statement** *To approve*	AD Corporate Affairs and Co. Sec	W1-W7

10	09:45	10mins	**Quality Account** *To receive*	Chief Nurse	W5-W8
****15 minute break for signing ****					
11	10:10	10mins	**Safety and Quality First** *To receive*	Chief Executive / Chief Nurse	W3
Strategy & Vision					
12	10:20	20mins	**Chief Executive's Report** *To receive*	Chief Executive	W1-W8
Programme Delivery					
13	10:40	10mins	**Board to Floor- Six Monthly Summary Report** *To receive*	Chief Nurse	W1, W3-W8
14	10:50	20mins	**Performance Report** - including • Annual Business Plan 17/18 Review • Operational Performance • Quality Performance • Financial Performance • Workforce Performance • NHSI Compliance *To receive*	Executive Leads	W5, W6
15	11:10	30mins - including 10mins Q&A	**PSEH Workstream deep dive- Urgent Care** *To receive*	COO Portsmouth	W2, W6
***Reporting Committees and Governance**					
16	11:40	10mins	***Audit & Risk Committee** *To receive update from meeting held on 24th May 2018* *Updates including:* • *Committee Annual Report (to July Board)* • *Freedom to Speak Up Board Report – to receive*		W5
17	11:50	10mins	***Assurance Committee Chair's Update** *To receive exception report from April and May meeting* *Including:* • *Committee Terms of Reference – to approve* • *Committee Annual Report – to receive*	Committee Chair	W4, W5, W6, W8
18	12:00	5 mins	***Chairs report on Members Council** *To receive exception report from 20th April 2018 meeting*	Deputy Chairman	W7
19	----	----	***People and OD Committee** *No meeting held to report* *(Committee Annual Report to July Board)*	Committee Chair	-

20	12:05	5 mins	***Charitable Funds Committee Minutes & Chairs update** *To receive verbal report from 15th May 2018 meeting* *Including:* • *Charitable Funds Plan –to approve* *(Committee Annual Report to July Board)*	Committee Chair	W4
21	12:10	5 mins	**Complaints Review Panel** *No meeting held to report*	Committee Chair	-
22	12:15	5 mins	*** Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update** *To receive exception report from May meeting* *Including:* • *Committee Annual Report– to receive*	Committee Chair	W5, W6, W8
23	-------	------	***Governance and Nominations Committee update** - *no meeting since last report to Board (Committee Annual Report to July Board)*	Committee Chair	-
24	12:20	5 mins	**Governance updates – including:** • **Board Code of Conduct- annual review and declarations -** *To agree* • **Declarations of interest - annual review -** *To receive* • **NHSI Provider Licence Compliance – annual declaration -** *to agree*	AD Corporate Affairs and Co. Sec	W4
Any other business					
25	12:25	5 mins	**Governor comments and questions**	Deputy Chairman	
26	12:30	5 mins	**Any other business & future agenda items**	Deputy Chairman	
27	12:35	------	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Deputy Chairman	

-------------------------- break --------------------------------

Supplementary papers are available on request from the Assistant Company Secretary

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

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

Date of next meeting: 30th July 2018, 10:30-13:00

Item 4.1

Minutes
Board In Public
Monday 26th March 2018 10:30-14:05
Kestrel 1 & 2, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

<table>
<tr><td colspan="3">Chair: Mick Tutt, Acting Chairman (MT)</td></tr>
<tr><td colspan="2">Members:
Alistair Stokes, Chairman (AMS)
Sue Harriman, Chief Executive (SH)
Andrew Strevens, Director of Finance (AS)
Dan Meron, Chief Medical Officer (DM)
Jackie Ardley, Chief Nurse (JA)
Helen Ives, Chief People Officer (HI)
Jon Pittam, Non-Executive Director (JP)
Francis Davis, Non-Executive Director (FD)
Mike Watts, Non-Executive Director (MW)
Stephanie Elsy, Non-Executive Director (SE)

Observing:
Katie Griffin, Internal Audit- PWC (KG)
Michael North, Public Governor (MN)</td><td>Attendees:
Rachel Cheal, Associate Director of Corporate Affairs and Company Secretary (RC)
Jayne Edwards, Corporate Support Manager and Assistant Company Secretary (JE)
Sam Stirling, Corporate Affairs Administrator (SS)
Philip Krinks, Community Engagement (Item 9) (PK)
Jo York, (Item 10) (JY)

Apologies:
Sarah Austin, Chief Operating Officer, Portsmouth and Commercial Director (SA)
David Noyes, Chief Operating Officer Southampton and County Wide Services (DN)
Sarah Williams, Associate Director of Research and Clinical Effectiveness (SW)</td></tr>
<tr><td>1</td><td colspan="2">Chairman’s Welcome & Update</td></tr>
<tr><td>1.1</td><td colspan="2">Apologies were received as noted above.

MT welcomed KG as an observer and explained final observations of our internal auditors to review the quality and regulation of the Quality Improvement and Risk Group (QIR) and Assurance Committee. MT also welcomed PK to the meeting presenting work for the Community Engagement Strategy.</td></tr>
<tr><td>2</td><td colspan="2">Register of Interests & Declaration of Interests</td></tr>
<tr><td>2.1</td><td colspan="2">There were no further updates to report.</td></tr>
<tr><td>3</td><td colspan="2">Confirmation that meeting is Quorate</td></tr>
<tr><td>3.1</td><td colspan="2">The meeting was confirmed as quorate.</td></tr>
<tr><td>4</td><td colspan="2">Minutes of Last Meeting and action tracker</td></tr>
<tr><td>4.1</td><td colspan="2">The minutes of the last meeting held on 29th January 2018 were agreed as an accurate record subject to minor amendment.</td></tr>
<tr><td>4.2</td><td colspan="2">The following actions were confirmed as complete: 600, 602, 603, 604, 606, 607, 608</td></tr>
<tr><td>5</td><td colspan="2">Matters Arising</td></tr>
</table>

5.1	RC highlighted requirement to consider amendments to the Trust Standing Orders. It was agreed to discuss at the Confidential Board.
5.2	JP queried potential update regarding the service tender. SH confirmed that a full update would be provided at the Confidential Board due to commercial in confidence. *MN joined the meeting.*
5.3	No other matters arising discussed.
6	**Any Other Business**
6.1	RC informed the Board of decision to include reference to the CQC Key Lines of Enquiry (KLoE) on all Board and Committee agendas from 1st April 2018. The Board discussed usefulness for ensuring familiarity and embeddedness of CQC requirements and terminology across the Trust. MT suggested that the CQC handbook was used as guidance to ensure all Board and Committee reports were fully aligned. SH requested that the KLOE diagram was included at the bottom of all agendas for ease of reference going forward. **Action- RC to ensure.**
6.2	No other business was discussed.
7	**Safety and Quality First**
7.1	Board to Floor Visit- Eastleigh Dental Service JA confirmed that there was no update to provide.
7.2	Board to Floor- Maples Ward • SH provided reflections and commented on the highly engaged and motivated team with a clear demonstration of strong leadership. • SH reported acknowledgement of environmental issues within the seclusion unit and lack of opportunity for patient interaction. • The Board were informed of positive relationships and effective management of beds. • Regarding the deterioration of the main road following the adverse weather conditions, AS confirmed immediate actions taken and review on the backlog maintenance tracker.
7.4	MT informed the Board of positive visits to the new Kite Unit and Southampton Podiatry services and confirmed that observations were shared with DN for consideration. **The Board noted the update.**
Strategy & Vision	
8	**Chief Executive's Report**

8.1	<u>Executive Portfolios</u> SH highlighted amendment to the lead director responsibilities as follows: • Chief Medical Officer- responsible for Learning from Deaths (mortality) agenda • Chief Nurse- responsible for all other patient safety matters (excluding mortality) SH explained division of the role in order to suit the individual strengths amongst the executive team.
8.2	• SH explained work on the updated Trust narrative to build on the organisational vision and strategy and ensure further engagement with service users and staff. • The Board noted hard work of staff during the adverse weather conditions and shared positivity of staff going above contractual duties to ensure high delivery of care. • SH informed the Board of renaming 'New Models of Care' to the 'Community Health & Care Programme' and the focus on out of hospital services. • The Board were briefed on the feasibility study stage of the Royal South Hants Hospital and Western Community Hospital Outline Business Case. The Board reviewed the need for public consultation through individual Clinical Commissioning Group (CCG) Boards and it was agreed to discuss further at the Confidential Board meeting. • SH commented on full considerations given surrounding potential continuation of the Foundation Trust (FT) Status application and confirmed agreement that it was not an appropriate priority for Solent. • The Board were informed of review of the Trust Management Team Meeting (TMTM) Terms of Reference and confirmed presentation to the Board for information only. • SH highlighted agreement to review the Board Assurance Frameworks (BAF) key strategic risks rated 15 and above only.
8.3	JP queried the use of the Single Point of Access (SPA) system across the Trust and progression of establishing a centralised booking system. SH confirmed previous review of SPA quality issues leading to a review of how the system fits across all geographies, with current Trust coverage of approximately 60%. SH informed the Board that the execs were reviewing fully and would provide an update to Finance Committee or Assurance Committee when appropriate.
8.4	SE reflected on Non-Executive Director Induction training with NHS Improvement and highlighted potential opportunities with Portsmouth Hospitals Trust Non-Executive Directors. It was agreed to discuss further outside of the meeting.
8.5	MT informed the Board of successful appointment of Sexual Health Consultant in Aldershot and Basingstoke and commented on the effective succession planning in place. **The Board noted the Chief Executive's Report.**
9	**Developing A Community Engagement Strategy for Solent NHS Trust**
9.1	MT briefed the Board on considerations held by the executive directors and the Members Council and highlighted ongoing discussions with the Chair of Portsmouth Hospitals Trust regarding work required across the system.

9.2	PK provided a presentation on recent review of engagement work and explained intention to establish a clear and sustainable approach aligned to the public services agenda. PK presented the key focus areas as follows: • Patient engagement • Civil Society engagement (charities and local businesses) • Volunteer groups • Engagement with public bodies (other Trusts and city councils)
9.3	PK highlighted priorities, links to other areas of work and potential implications. The Board were informed of the importance of emphasis on interfacing with all groups and engaging fully with representatives. Ongoing discussions with the Members Council and the anticipated approach were confirmed.
9.4	FD queried the use of an implementation plan and metrics for this. SH explained the need for a cultural approach with a matrix style of working across the organisation and confirmed input from Sarah Williams linked to the current QI programmes.
9.5	SE emphasised the importance of engagement and ensuring appropriate resource to effectively lead change. AS suggested usefulness of measuring change and lessons learned as a result of metrics and engagement plans. JA commented on evidence of cultural changes and full considerations of all groups, particularly driven by people in the community.
9.6	JP emphasised the need for a higher profile surrounding carers and considerations in the culture based approach. HI agreed and commented on core and integral work to consider with how the organisation is led, as well as links to equality improvement to ensure fully diverse representation. **The Board agreed to continuation of this proposal.**
9.7	MN provided reflections and shared positivity of the STP in bringing this work together. MN provided full support for the engagement strategy and emphasised the importance of ensuring constant communication.
10	**Portsmouth and South East Hampshire presentation from Community Health & Care Programme Work Stream**

10.1	*Jo York (JY) joined the meeting.* JY provided a presentation from the New Models of Care Work Stream. • JY explained name change to New Models of Care to ensure clarity of aims and ensuring that a consistent model was built across the footprint with shared language. • The Board were briefed on the principles on integrated work streams and explained the key ingredients required for delivering benefits with engagement from the voluntary and community sector. • JY explained the model localities and work as part of a 'neighbourhood module'. • The Board were informed of examples of care models to be considered as part of a single system wide business case. • Learning following the period of significant change was discussed.
10.2	DM highlighted challenges and urgency surrounding planning for winter issues and ensuring mitigations were in place. JY agreed and commented on review of care homes to ensure full balance against cost and highlighted the benefits of working differently to mitigate challenges as a system. SH reported the need for further understanding of demand and capacity across the system and emphasis on strategic change to support the STP.
10.3	SE queried the challenges for implementing change. JY explained challenges surrounding funding and programme of work to ensure savings that utilise plans and ensure transparency. JY also shared challenges surrounding operational leadership and culture changes required across all organisations.
10.4	AMS shared the importance of realistically quantifying the record of admissions and recognising where admissions were not a failure. JY agreed and acknowledged the importance of full understanding of pathways and length of stay.
10.5	The Board acknowledged the challenges and importance of this work across the system. SH commented on the importance of strong leadership and opportunities to empower the workforce to think differently. **The Board noted the presentation.** *JY left the meeting.*
Performance & Delivery	
11	**Annual Staff Survey Feedback and Update on the 'Great Place to Work' Initiative**
11.1	The Board discussed positivity of Staff Survey results and improving staff engagement. HI reported an improved engagement score of 3.86% and aspirations to reach a 4% target. HI summarised the key focus areas and challenges including retention, encouraging feedback and sustainable staffing.

11.2	SE commented on the 24% of staff that wouldn't recommend the Trust and SH highlighted the importance of continuous learning aligned to the 5 year forward view for growing services. AS agreed and emphasised positivity of results when benchmarked against average mental health and community Trusts. HI confirmed work with other Trusts to reflect on findings and discuss potential learning, including input from wider CCG colleagues.
11.3	MW informed the Board of regular discussion regarding engagement at the People and OD Group and confirmed further information to be provided from output reports. **The Board noted the Annual Staff Survey Feedback and Update on the 'Great Place to Work' Initiative.**
12	**Performance Report**
12.1	Operational • Regarding the Portsmouth Care Group hotspots Mental Capacity Act and Safeguarding training, MT reminded the Board of Bevan Brittan training being held on 10th May and requested bookings submitted to RC. • HI informed the Board of the successful appointment of Jo Pinhorne to the role of Operational Director for the Adults Southampton Service.
12.2	Quality • The Board discussed mixed feedback following the visit to Lower Brambles unit and expected update from the CQC regarding the wider system review and outcomes. • Regarding the Safe Staffing Sessions, the Board reviewed the 4 key themes including, the role of administrators for leadership and E-Rostering, training and development and retention surrounding the future roles for nursing and apprenticeships. JA confirmed fortnightly reviews with each service line over the next 6 months to monitor. • MT commented on positive reputational impact of work surrounding the system pressures and partnership working with other organisations and emphasised the importance of continuing multi Trust QIA processes. • AS reported huge achievement in the reduction across Portsmouth Hospital Discharge, now at 39.
12.3	Finance • There was nothing further to report.
12.4	Workforce • HI reported a decline in the sickness absence rate to 4.3% and the Board discussed positivity of work with the senior leadership team. • The Board were informed of improved vacancy out turn rates and recruitment efforts. • HI confirmed on that the Trust was on target with statutory training compliance now over 80% and highlighted ongoing work to support teams below training targets. • MT queried full reporting of non-compliance figures for staff on sick leave. SH requested narrative to show percentage of staff on sick leave going forward.

12.5	<u>NHSI</u> RC informed the Board of new guidance issued by the provider licence and spot check audits taking place from July. **The Board noted the Performance Report.**
13	**Information Governance Briefing Paper & Information Governance Strategy**
13.1	*SB joined the meeting.* SB provided update and confirmed that all outstanding tasks within the IG toolkit had been completed. The Board were informed of staff training completion and submission of level 3 compliance across the Trust.
13.2	SH queried the increase in incidents reported and SB informed of improved reporting culture and suspected trends identified. *SB left the meeting.*
14	**Risk Management Framework**
14.1	JA briefed the Board on the new Risk Management Framework submitted to a number of Committees and confirmed Audit and Risk Committee discussion surrounding the triangulation of the number of low risks and application across the whole system. **The Board approved the Risk Management Framework.**
Reporting Committees and Governance matters	
15	**Audit and Risk Committee**
15.1	• RC informed the Board of the revised timetable for submitting accounts to the Audit and Risk Committee prior to Board. • Regarding the recommendation to Assurance Committee, MT requested that Clinical Supervision was included on the July Assurance Committee agenda. **Action- SS.** • RC highlighted requirement to extend the May Trust Board meeting to ensure timely submission of the Annual Accounts following Audit and Risk Committee review. It was agreed to discuss outside of the meeting. **Action- RC.** **The Board approved the Audit and Risk Committee recommendations.**
16	**Assurance Committee Chair's Update**
16.1	• MT confirmed that the updated Learning from Deaths report would be shared when updates based on service change and learning was completed. • MT provided a verbal update following the March meeting and confirmed the reports noted by the Committee. • The Board were informed of the usefulness of promotional work for the Making Every Contact Count agenda and feedback from the Patient Experience Report.

17	**People and OD Committee**
17.1	• MW provided an overview of discussions held at the meeting and review of key assurances required. • MW commented on Quoracy issues and queried inclusion of another Non-Executive Director (NED). It was agreed to discuss requirements at the next NEDs meeting. **Action- NEDs to review.**
18	**Governance and Nominations Committee Update**
18.1	Following recommendations from the Committee, the Board: • Noted the Committee mid-year review • Approved the amendments to Board agendas to change the order of committees reported • Approved the amended Mental Health Act Scrutiny Committee Terms of Reference
19	**Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update**
19.1	*There were no further comments made.*
20	**Complaints Review Panel**
20.1	SE briefed the Board on the new format of the meeting and discussion of cases selected for review. SE commented on themes including the need for appropriate balance between accepting fault and sending apologies to complainants. The Board acknowledged the importance of following Duty of Candour procedures whilst ensuring staff were protected. JA informed of work with the patient experience team and clinical directors to produce appropriate complaint responses and discussed the value of implementing change following these reviews.
21	**Charitable Funds Committee Minutes & Chairs update**
21.1	*There was no meeting to report.*
22	**Chairs report on Members Council**
22.1	*There was no meeting to report.*
Any other business	
23	**Governor Comments and questions**
23.1	MN thanked the Board for efforts in facilitating the engagement work and for the opportunity to hear about ongoing Portsmouth and South East Hampshire work. MN highlighted the importance of positive staff engagement and the commitment of staff to improve the Trust.
24	**Any other business & future agenda items**
24.1	KG provided immediate reflections following observations at this meeting. It was confirmed that the full report would be shared when completed.

24.2	No other business was discussed and the meeting was closed.
25	**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
609	26/03/2018	6.1	Any other Business- CQC Key Lines of Enquiry (inclusion on agendas)	SH requested that the KLoE diagram was included at the bottom of all agendas for ease of reference going forward. **Action- RC to ensure.**	RC		**May 2018 update**- Action complete. Administrators informed.
610	26/03/2018	15.1	Audit and Risk Committee- Recommendation to Assurance Committee (clinical supervision)	Regarding the recommendation to Assurance Committee, MT requested that Clinical Supervision was included on the July Assurance Committee agenda. **Action- SS.**	SS		**May 2018 update** - Action complete. Planned on Assurance Committee Agenda Cycle.
611	26/03/2018	15.2	Audit and Risk Committee- Start time of May Trust Board	RC highlighted requirement to extend the May Trust Board meeting to ensure timely submission of the Annual Accounts following Audit and Risk Committee review. It was agreed to discuss outside of the meeting. **Action- RC.**	RC		**May 2018 update** - Complete - starting May In-Public Board at 9am
612	26/03/2018	17.1	People and OD Committee - Quoracy issues (inviting another NED)	MW commented on Quoracy issues and queried inclusion of another Non-Executive Director (NED). It was agreed to discuss requirements at the next NEDs meeting. **Action- NEDs.**	NEDs		**May 2018 update** - Complete - Francis has agreed to be a named member of the meeting.
601	29/01/2018	4.2	Action tracker- Deficit position / Breach of statutory duties (re action 564)	Concerning the deficit control total position and breach in statutory duties and implications, JP queried the legal interpretations and potential seperate external review required. **Action- SH/AS to consider.**	SH/AS		**March 2018 update -** AS has chased again with NHSI. **March 2018 meeting update**- JP queried management of potential breech in statutory duties and AS confirmed that the Trust continue to seek guidance. It was agreed to consider specific wording for NHSI to review regarding the deficit control total. **Action- JP & AS.** **May 2018 update-** NHS I has provided guidance which will be discussed at the Audit and Risk Committee in May. Guidance shared with JP via an e-mail exchange.
605	29/01/2018	9.8	Six Monthly Safe Staffing Report - Sustainability- Safe staffing within smaller services	SH explained challenges with providing assurance within small services and suggested review of the live picture at a Board seminar session, with potential consideration of learning required. DM highlighted the national challenges with modernising smaller services and it was agreed that executive directors consider appropriate method for progressing outside of the meeting. **Action- Executive directors.**	Execs		**March 2018 update**: Executive directors reviewing with services ongoing sustainability **March 2018 meeting update**- SH confirmed that the Execs were currently reviewing and expected to be closed by June 2018. It was agreed to review at the June Finance and Assurance Committee and July Trust Board. **Action- SS to include on agenda cycles.** **May 2018 update**- Complete.
598	27/11/2017	15.4	Information Governance- 'Your information, your rights' inclusion in Shine	SB briefed the Board on the launch of the 'Your information, your rights' internet page. An increase in information shared was noted. AMS suggested inclusion within the SHINE magazine. It was agreed that SB discuss with the Marketing and Communications Team.	SB		**January meeting update**- DN confirmed that this was still in progress and confirmed that an update would be provided at the next meeting. **March 2018 meeting update**- It was agreed to provide a post meeting note. **Action- DN.** **May 2018 update-** There is a scheduled plan to publicise this and the Trust's GDPR compliance post the 25th May (GDPR date), to illustrate to our stakeholders the work we have done to ensure compliance with the new law and the security of their data, as well as individuals rights.

NHS Solent NHS Trust

Presentation to	X In Public Board Meeting		☐ Confidential Board Meeting				
Title of Paper	Annual Report (including the Annual Governance Statement)						
Author(s)	Rachel Cheal, AD Corporate Affairs & Company Secretary		Executive Sponsor		Sue Harriman, CEO		
Date of Paper	18th May 2018		Committees presented		• Reviewed by executive team. • Draft Annual Governance Statement was presented to the April Assurance Committee. • Annual Report and AGS presented to May 2018 Audit & Risk Committee		
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy	x	**W3** Culture	x	**W4** Roles & Responsibilities X
	W5 Risks and Performance	x	**W6** Information		**W7** Engagement	x	**W8** Learning, Improvt & innovation X
Action requested of the Board	☐ **To receive**		X **For decision**				

Every year we are required to produce an **Annual Report** and **Annual Governance Statement (AGS),** in accordance with the Department of Health Group Accounting Manual 2017-18 and guidance from NHS Improvement. The Trust also takes into consideration the NHSI's Foundation Trust Annual Reporting Manual for the relevant good governance practice requirements. In addition, this year NHSI have requested that Trust submit their Annual Report together with other public disclosure documents by midday on 29th May 2018.

The draft annual report has been shared with the External Auditors as part of the annual auditing process.

Matters still outstanding are highlighted in yellow – these include

- consideration of the External Auditor Opinion and confirmation of the Head of Internal Audit Opinion within the Annual Governance Statement
- consideration given by the Audit & Risk Committee at their meeting on 24th May with regards to the statement on pg 52)

An update will be provided at the Board meeting in respect of these matters.

- Section 3 the Auditors Report, Section 5 Quality Account, Appendix 1 Full Accounts - all of which will presented separately at the Board meeting

(Please note that page cross- references have also been omitted at this stage pending comments from the Audit & Risk Committee, but will be included for final submission to NHSI on 29th May).

Board Recommendation

The Board is asked to;

- Approve the Annual Report
- Approve the Annual Governance Statement **(pg 56 - 73)**

The Chief Executive will be asked to separately sign the AGS at the scheduled recess during the Board meeting on 29th May 2018.

Solent NHS Trust

Annual Report and Accounts 2017/18

incorporating the Quality Account 2017/18

Solent NHS Trust

DRAFT Annual Report and Accounts 2017/18

incorporating the Quality Account 2017/18

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Statement from the Chairman and Chief Executive Officer

We are pleased to present to you our Annual Report and Quality Account for the 2017/18 financial year. The report provides you with an overview of what we do, how well we have done and the challenges we face going forward, as well as a detailed analysis of our activities and accounts.

We have had another busy and challenging year, and we would like to take this opportunity to say 'thank you' to all of our teams who have continued to work so hard to make a difference to the lives of thousands of people across Hampshire, helping them to stay well and be cared for in the community. Within this report, you will read stories of dedicated people giving great care to service users and delivering best value services. We are proud to lead an organisation full of inspiring people.

We are also incredibly fortunate to have support and input from local people. Feedback from people who use our services is core to our culture of continuous improvement. We actively seek views from people who use and access our services and ask them to tell us when things aren't right. In 2017/18, 95.89% of respondents said that they would recommend our services to their friends and family if they needed similar care or treatment. We know there is more we could do to involve people in our services and we are looking forward to launching a new community engagement framework during 2018/19.

Providing safe effective and quality services remains our top priority and we are very proud of our strong improvement culture. We are always reviewing and improving our systems and processes to ensure that we provide the care people should expect of an NHS organisation. However, there are times when we don't get it right, and when that happens we make sure that we do everything we can to learn and improve. Our positive reporting culture was well recognised by our teams in the 2017 NHS Staff Survey. We encourage our employees to speak up when they believe that we are not delivering the care we aspire to. Together, we review what went wrong and take action to make sure we do better in the future. During 2017/18 we delivered against a wide range of quality targets, including measures of safety, effectiveness and patient experience. You can read more about our quality performance and our quality priorities for the year ahead in our Quality Account on page [n].

We continue to invest in Solent as a great place to work, creating an environment where people feel engaged in their work and motivated to deliver, embedding our HEART values throughout. For the second year running we saw a positive increase in our Staff Survey results, achieving a higher than average overall engagement score. On page [n] you will find a summary of our survey results and the work we are doing to continue to build our levels of engagement.

During 2017/18 we placed even greater emphasis on working with other organisations and have continued to actively participate in the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP), as well as the developing local integrated care systems (ICS). Within this report you will read many examples of how working with others has ensured that care is joined up and is making a difference to the people who use our services. Public sector funding continues to be limited. Despite ongoing financial constraints and ever-growing demand for services, we achieved a better position than our agreed financial control target of £1.5m deficit, with a year-end outturn of

£0.7m surplus; the improvement was aided by an additional £1.9m of Sustainability and Transformation Funding (STF) due to our £0.3m in underlying finances. This is a huge achievement by our teams. You can read more about our financial position within the Performance Report and Summary Accounts sections.
We are constantly thinking about the future, how to improve the quality of our services and what services need to be like in years to come. Our focus for the coming year is on achieving our ambitious plans to make a difference by keeping more people healthy, safe and independent in, or close to, their own homes. To achieve our plans we will continue to invest in our workforce, and work with local people, commissioners and partner organisations to develop seamless care irrespective of organisational boundaries.

Finally, it is thanks to strong leadership and our team of caring and compassionate people that we can proudly say that Solent is truely a place that aspires to provide great care, be a great place to work and provide great value for money.

[signed]

Sue Harriman
Chief Executive Officer

Date: xxxxx

[signed]

Alistair Stokes
Chairman

Date: xxxxx

Section 1:
Performance Report

Overview

The purpose of this section is to provide a summary of the organisation including our purpose and activities, and our principle risks and uncertainties facing us during the year head. Our Chief Executive, Sue Harriman, also reflects on how we performed over the past year.

Consideration of the going concern basis can be found on pg [n]

Statement from the Chief Executive

Our unwavering focus on providing great care, creating a great place to work and delivering great value for money has led to continued improvement in the quality of our services and high levels of performance. This would not have been possible without leadership at all levels throughout the Trust, and by individuals who go above and beyond to make a difference every day, even when faced with significant challenges.

During 2017/18, we were faced with a very difficult winter. By working with partners in the system, we relieved some of the pressures felt by our local acute hospitals. Credit must go to the teams who worked hard to help people remain at, or return, home. Our teams also continued to provide care, and keep people safe and well, whilst faced with challenging weather and working conditions.

Our role in the Southampton and Portsmouth systems has been fundamental in reducing the number of people who are medically fit for discharge from acute care, but who are unable to leave hospital due to other circumstances. By actively transferring these service users to our wards, we have been able to help our acute partners free up beds in their hospitals. At the same time we have been working with our social care colleagues successfully, to reduce the rate of delayed transfers within Solent provided wards, again freeing up beds to allow service users to transfer to us from acute hospitals. Our wards across Portmsouth, including both community and mental health wards, showed a decreased delayed transfer of care rate from previous year, again with an average of 10% in 2017/18. Our Southampton wards also showed improvement over the year and had an average delayed transfer of care rate of 9.6%. This reduces waiting times and helps the flow of service users through the health care system.

We take pride in our commitment to quality, and in our improvement culture. We demonstrated this to our regulators on three separate inspections during the year. On each occasion, we were able to show how learning and action has led to better outcomes for service users. We were proud that the changes made within service were recognised as delivering a better quality of care to people who use our services. Due to the significant improvements made by our teams, two core service ratings were increased to overall ‘Good’ from ‘Requires Improvement’, and to our delight, our child and adolescent mental health services were awarded ‘Outstanding’ in the ‘caring’ domain. We hope to further demonstrate our continued commitment to improvement in future inspections.

The voice of the people we care for is paramount. Their feedback provides insight to help us understand what we are doing well and to make improvements. I am thrilled that our Friends and Family score has increased for the third year running. In 2017/18, 95.89% of respondents said that they would recommend our services to their friends and family. We encourage our teams to deal with concerns and problems at a local level. This means that if issues arise, they can be resolved quickly and in a way that is responsive to the patient’s needs and circumstances. We have seen an increase in the number of concerns raised, and a reduction in the number of formal complaints, received year-on-year.

We have continued to invest in the ways in which we gather feedback. In the year, we introduced more digital methods and have developed the options available for children and young people to share their feedback. You can read more about our performance and achievements in quality, safety and patient experience in our Quality Account

on page [n].

We finished the year financially sound, achieving a surplus of £0.7m against our previously agreed deficit control total of £1.5m. As a result of us performing financially better than our agreed plan by £0.4m, we received £3.0m of Sustainability and Transformation Funding, £1.8m of which related to our improved underlying position. Achieving our financial plan is reliant on the input and support of all leaders and their teams. I am thankful to our team who have been able to make changes, and think innovatively to find savings to help us be as efficient as possible, whilst putting patient care as our top priority. 2018/19 will bring increased financial challenges as further recurrent savings need to be made. In order to realise these, we will need to think differently, working with our partners to deliver major system transformation and safe efficiencies.

I am delighted that, for the second year running, we improved upon our NHS Staff Survey results, and when benchmarked with other Trusts, our scores are higher than average. Listening into Action, who rank trusts based on 32 key findings around culture and leadership, ranked us as the best performing mental health, learning disability and community trust and highlighted that we are demonstrating a positive trend in our results year on year. This reflects our ongoing investment in making Solent a great place to work. The results show that we continue to make service users our most important priority, and I was particularly pleased to read that our team believe we take positive action on their health and wellbeing. We are proud of our many, and varied, health and wellbeing initiatives. Helping people to feel happy and well, whilst at work, and have a positive impact on the care we provide.

I recognise the need to continually invest in our workforce. Our performance measures for staff sickness absence and turnover rate also provide us with a good indication about the health and wellbeing of our staff. Whilst we experienced an increased absence rate towards the end of 2017, through health and wellbeing initiatives we have been able to bring sickness levels back in line with what we would aspire to. Our turnover rate has gradually decreased during 2017/18, meaning that our employee retention rate has steadily improved. However, this is an area we would like to improve further and there is already an improvement programme in place to help with employee retention. Thanks to our culture and reputation as an employer of choice, our vacancy rate is comparatively low against other trusts as a whole. We remain committed to continually valuing, engaging and empowering our people.

We have experienced some performance challenges in our services during the year. Nationally, there is a recognised shortage of band 5 nurses (staff nurses) and, like other providers; we have found it difficult to recruit to these positions in our community nursing teams. In addition, meeting the staffing levels required to safely manage the increasing needs and acuity of some of our service users within our mental health services has been challenging. To ensure we continue to provide a safe level of care we have used temporary staffing solutions which has, in turn, increased our agency rate.

In addition, we have found limiting our access times, for some services, difficult. For instance, limited available theatre space has created longer waiting lists than we aspire to for service users requiring a general anaesthetic in our dentistry services. However, we stringently monitor waiting times for all our services and triage our service users based on clinical need to ensure the best possible quality of care. You can read more about our significant issues in

year within our Annual Governance Statement on page [n].

When our performance is below expected standards, we work with our commissioners, people who use our services and regulatory bodies transparently, openly and collaboratively. Together we resolve any issues as quickly and safely as possible. We learn so that we can do things differently in the future.

What remains clear is the commitment and dedication shown by our team. Year-on-year our people continue to make a difference to those that use our services, often going above and beyond. I end 2017/18 proud of what we have all achieved and the determination our team show when faced with challenges. I look forward to 2018/19, working with the team to keep more people healthy, safe and independent at, or close to, home.

Sue Harriman

Chief Executive Officer

About us

Who are we?

Solent NHS Trust was established under an Establishment Order by the Secretary of State in April 2011.

We are a specialist community and mental health provider with an annual income of over £187m for 2017/18. Last year, we employed 4,086 clinical and non-clinical staff (including part time and bank staff) which equates to 2,899 whole time equivalents (WTE) and delivered nearly 1 million service user contacts.

What do we do?

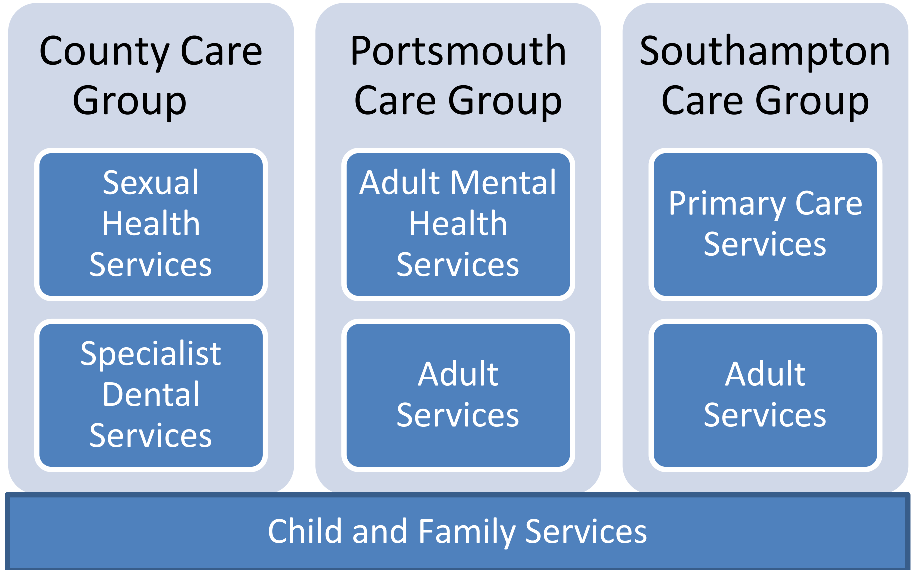
We specialise in providing high quality, best value, community and mental health services to people living in Portsmouth, Southampton and in some parts of Hampshire. Our team of talented staff work from over 100 clinical locations.

We support families to ensure children get the best start in life, provide services for people with complex care needs and help older people keep their independence. We also provide screening and health promotion services, which support people to lead a healthier lifestyle.

We actively promote strong out of hospital services and take an active role in integrating care. Working closely with other trusts, primary care, social care providers and the voluntary sector we make sure care is joined-up and organised around the individual.

We always endeavour to maintain our focus on providing safe, effective and quality services and pride ourselves on being a learning organisation. We are creating a culture of continuous improvement, providing our staff with the tools, capability and capacity to continuously improve to ensure we provide people with the best, and most effective, services we can.

The following diagram illustrates our Care Group Structure:



Who do we serve?

We are the main provider of community health services in Portsmouth and Southampton and the main provider of adult mental health services in Portsmouth. We also provide a number of pan-Hampshire specialist services, including sexual health and specialist dentistry.

We are commissioned by NHS England, Clinical Commissioning Groups and Local Authorities in Southampton, Portsmouth and Hampshire. Southampton and Portsmouth together have more than 450,000 people resident within the cities each covering a relatively small urban geographic area with significant health inequalities, which are generally significantly worse than the England average for deprivation. Hampshire covers a wider geographical area, which is predominantly more rural and affluent, but also has urban areas of higher population density, significant deprivation and health need.

Our story – our vision and goals

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

The best people, doing their best work, in pursuit of our vision.

People dedicated to giving great care to our service users and patients, and great value to our partners.

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

How we deliver our vision…

We know our vision is ambitious, but we have excellent foundations. We will:

Deliver great care

- Involving service users in shaping care and always learning from their experiences
- Working closely with partners to join up care
- Treating people with respect, giving equal emphasis to physical and mental health
- Ensuring we provide quality services which are safe and effective

Make Solent a great place to work

- Supporting people to look after their health and wellbeing
- Improving the workplace by listening to ideas and acting on feedback
- Developing leaders to support and empower people in making a difference

Deliver the best value for money

- Spending money wisely and by working with partners
- Involving people in decisions about spending money
- Enabling services to have more time to provide care

Our values

Our shared values support the development of a strong working culture – guiding and inspiring all of our actions and decisions. They enable us to be better at what we do and create a great place for our people to work, whilst ensuring we provide the highest quality of care to people who use our services.

Our HEART values are meant to reflect the deep belief that we are a caring organisation at the centre of our community.

How do we work together as a values-based organisation?

Our values create the foundation for everything we do – for our employees and our community. During the annual appraisal process, we asked people to reflect on what the values mean to them personally and how they bring them

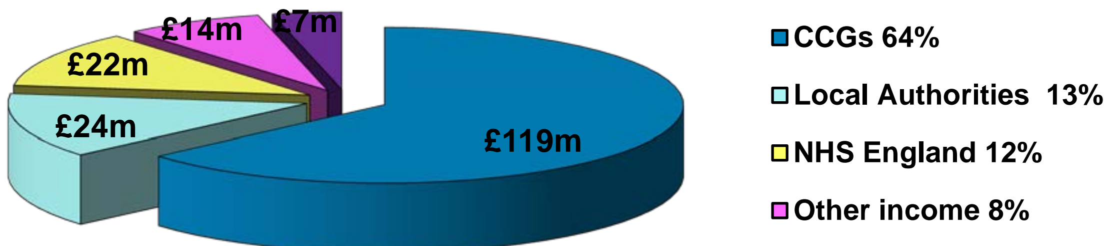
to work. We have also reshaped our recruitment and leadership practices to make HEART a part of our daily culture.

We will continue to develop ways of working that draw our values into all that we do, creating a great place to work and a great experience for people who use our services.

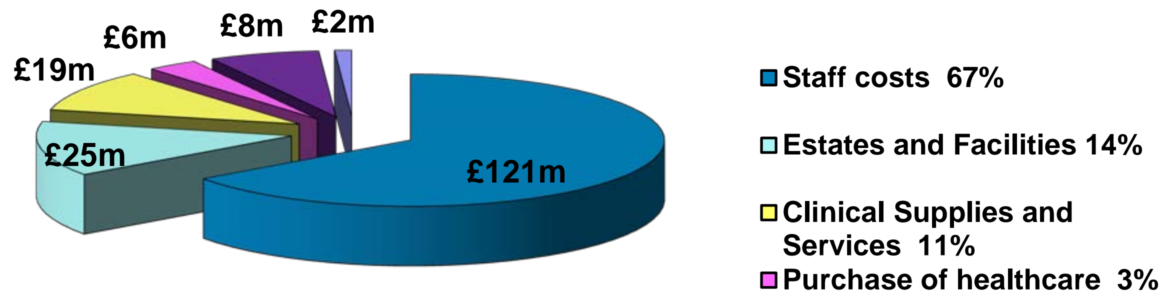
Our finances

During 2017/18 we had an income of over £187m.

Our income is illustrated below:



Our expenditure is summarised below:



Our 2017/18 business priorities

Every year we focus on a small number of priorities. These guide the work of our teams and are used to set individual staff objectives.

Our priorities for 2017/18 are summarised below:

Great care

1. Improve quality in line with CQC inspection requirements
2. Provide safe staffing
3. Use technology to work differently

Great place to work

4. Plan for long term sustainable staffing
5. Enhance our leadership throughout the organisation
6. Provide training that enables us to deliver great care

Great value for money

7. Further pathway integration with other providers
8. Benchmark our services to improve productivity
9. Change front line and corporate services to live within our income

Our performance against our priorities is detailed on pg [n]

The year in review

Summary of financial performance

A summary of financial performance can be found in Section 4.

Principle risks and uncertainties facing the organisation

Our focus during 2017/18, like the previous year, has been on maintaining service quality and sustaining financial recovery. Despite the financial challenges, service performance generally held up well throughout the year.

We achieved a modest adjusted surplus (excluding revaluations and impairments) of £0.7m for the financial year, representing a favourable variance of £2.2m against the deficit control total of £1.5m agreed with NHS Improvement. This compares to a deficit of £2.1m for the previous financial year. During 2017/18, Solent received £3.0m of Sustainability and Transformation funding, £1.8m of which related to the Trust improving its underlying position by £0.4m.

Our efficiency target (Cost Improvement Plan) was £6.1m, of which £4.2m was delivered; the balance was achieved by other measures.

Our plan for 2018/19 is a deficit of £1.0m.

Our business risks

The great majority of our business is with Clinical Commissioning Groups (CCGs), NHS England, and local authorities, as commissioners for NHS patient care services and preventative services. As CCGs, NHS England and local authorities are funded by Government to buy NHS patient care and preventative services; the Trust is not exposed to the degree of financial risk faced by business entities, apart from the normal contract negotiation/renewal that is normal in any organisation. Cumulative deficits have been incurred over the last three years, which have been funded by Department of Health loans with differing repayment dates. It is anticipated that these are rolled over until the Trust returns to making in-year surpluses.

Commissioning budget reductions

There will be risks to our income in the year ahead with commissioning budgets expected to reduce further in line with the national requirement for greater efficiencies, particularly given the financial pressures being exhibited in both the health provider and commissioner sectors. In addition, the financial constraints within local government are such that significant savings will be required, which will require difficult choices to be made.

The risks are such that solutions that are more radical in nature will be required over the next few years, which may mean that we will have to reduce, or stop, the provision of some services due to insufficient funds to deliver them safely and effectively. In addition, we will need to work more creatively with our partners to find solutions which may involve merging resources and teams, looking differently at our joint estate.

Changes to the commercial environment - Sustainability and Transformation Partnerships (STP)

The commercial environment continues to evolve and the Trust is working in collaboration with our health and social care partners to develop and implement system-wide plans to enable local providers and commissioners improve and manage services within collective budgets.

This includes exploration of integrated care system (ICS) models across our geography, in line with latest national guidance within the 2018/19 joint national planning guidance from NHS England and NHS Improvement.

All organisations with responsibility for health and care in Portsmouth and South East Hampshire (PSEH) have come together to deliver a shared set of objectives, which includes commitment to a single system improvement plan to restore and improve service quality, performance and financial health. We are establishing a new way of working

together, with providers and commissioners increasingly taking collective responsibility for population health and resources. We have 5 programmes in the system that include elective care, new models of community care, children and families and mental health The immediate priority is to deliver significant improvements in urgent and emergency care performance. The priorities for mental health are to create a new emergency front door alongside the physical health emergency services at Portsmouth Hospitals NHS Trust, and a collaborative approach to the management of service users needing acute bed admission.

We are engaged in a Multi-speciality Community Provider (MCP) transformation programme within Portsmouth, underpinned by a partnership agreement between the Trust, the Portsmouth Primary Care Alliance, the local authority and Clinical Commissioning Group (CCG). The programme builds on work already started to integrate community health and social care services at locality level, centred around primary care. Similar work is underway in Southampton, where, as a key partner in the Better Care Southampton transformation programme we are working with partner organisations to formulate a more robust out of hospital operating model that seeks to underpin the STP strategy. By delivering better integrated out of hospital services we will be able to deliver even better patient outcomes, while also operating more efficiently, establishing a new way of working together with common objectives and accepting collective responsibility for the health and care of the people in the areas we serve.

We acknowledge that the future organisational form for Solent, as we are currently constructed, is unclear and that there is significant uncertainty in relation to the medium and long-term configuration of health and social care services within Hampshire and the Isle of Wight STP. We do know that services will need to be radically transformed in order to ensure services are fit for the future – in terms of ensuring enduring quality and safety, meeting demand as well as achieving efficiencies. Whilst the front line services we offer will predominantly remain the same, it is likely that, in the future, we will increasingly be providing these via integrated models with key partners, supported by effective governance models and new contractual arrangements.

We also know that during times of change we are open to risk. These include risks concerning ensuring we are able to maintain ‘business as usual’, attract and retain an engaged workforce, remain a credible partner and continue to strive to achieve excellence in all we do. We must not get distracted.

The Board has oversight of our strategic risks, many of which are interdependent, via our Board Assurance Framework and also ensures we have appropriate mitigations in place to manage these, particularly during periods of such significant transformation. Ensuring that Solent provides great care, is a great place to work and provides great value for money remain our priorities.

There have been fewer tender opportunities in 2017/18, but we have continued to respond to those that are aligned to our core business and remain committed to exploring innovative models of integration and contract extension mechanisms to provide continuity for organisations and people who use our services.

Budget pressures and cost efficiency requirements remain a risk and any loss of key services will increase our financial pressure and also potentially destabilise other service contracts where there are significant interdependencies.

Details of our key risks in year are included within the Annual Governance Statement, page [n]

Working with our partners and alliances

As described previously, we continue to be committed to a future of integrated services wherever it makes sense to do so, and will always seek opportunities to work with other organisations to build robust and sustainable out of hospital services, delivering the best possible care to our people at, or close to, their own homes. In the following sections you can read more about our partnership working within our operational care groups.

Southampton and County Services

We remain a key partner in Better Care Southampton, a transformation programme which involves key stakeholders from across the Southampton health and social care community, including the voluntary sector.

The programme aims to:

- put individuals and families at the centre of their care and support, meeting needs in a holistic way
- provide the right care, in the right place, at the right time, enabling individuals and families to be independent and self-resilient wherever possible
- make optimum use of the health and care resources available in the community
- intervene earlier and build resilience in order to secure better outcomes by providing more coordinated, proactive services and
- focus on prevention and early intervention to support people to retain and regain their independence.

During 2017/18, we have continued with our work to design and evolve an operating model to achieve these aims. The model is focussed on wrapping services around the patient. This will allow teams to support more people, with complex needs, to help them to live as independently as possible in their own home, reduce non-elective admissions, as well as lower rates of re-admission post spells of acute care.

We made a number of changes in year which move us towards providing even more joined up services - some examples are illustrated:

Within social care

The Integrated Southampton Urgent Response Service and Community Independence teams bring together teams from the city council and our Solent services under a single management structure. Together they provide reablement and rehabilitation services co-located in bases across the city.

We have made good progress integrating our service provision for children and their families, focussing on 0-19 early help services. We have established a joint leadership team who are working together to deliver a more collaborative service. We have already established partnership arrangements with the council for children with special educational needs, and for services delivering child and adolescent mental health services for looked after children.

Within primary care

Our links with primary care are of key importance as we strive to deliver more community based care. We work very closely with colleagues from Southampton Primary Care Limited, particularly in supporting cluster level work.

Together with colleagues in primary care, we are working on a number of areas to improve the support provided to people in care homes. We are also working in partnership with Southampton Medical Services, supporting them in delivering a Community Wellbeing Service. This service is focussed on prevention and wellbeing in our communities.

Within the secondary sector

We work as a key system partner, supporting colleagues in University Hospital Southampton NHS Foundation Trust (UHS). By establishing strong relationships and transparent partnership working, as well as working in a more integrated way with social care colleagues, we have contributed to the improving position with regards to delayed transfers of care.

Our In- reach Coordinator, based in the hospital actively seeks out service users for discharge and our Community Emergency Department Team works closely with the emergency department and frailty partners to prevent admission through advice and information.

Within our community hospital wards based at the Royal South Hants Hospital, we have implemented a weekly Care Act compliance meeting, which includes colleagues from social care. Together, by sharing information, we evaluate delays to facilitate discharge.

We have also helped to develop the Southampton Integrated Discharge Bureau to become a hub for discharges across the community and acute sector.

Within the voluntary sector

We are working in partnership with Social Care in Action (SCA) Group and Southampton Voluntary Services to provide Southampton Healthy Living, a behaviour change service. The team focus on targeted interventions in smoking cessation, weight management, increasing physical activity and alcohol interventions, as well as provision of mini NHS Health checks and public health campaigns.

We continue to work with our partners to deliver our Homeless Healthcare team, a multi-disciplinary primary care team providing care to homeless people in Southampton.

Portsmouth and South East Hampshire

The priority in 2017/18 has been to further develop partnership arrangements within the city with primary and social care, and to support the creation of the Local Delivery System (LDS).

Multi- specialty Community Provider (MCP)

The Portsmouth MCP Programme is a partnership between the Portsmouth Primary Care Alliance (PPCA), Solent NHS Trust, NHS Portsmouth CCG and Portsmouth City Council (PCC). We have committed to working together to meet the challenges facing the health and care services in the city, through the development of new models of care that dissolve the traditional boundaries between the delivery of primary care, community health, social care and hospital services.

Key transformation programmes include:

Key transformation programme	Description
Community/neighbourhood model	An integrated service based on geography, rather than organisation
Integrated 24/7 primary care	Delivery of round the clock service with consistent capacity and capability provision
Care home team	Provision of regular planned support and improved urgent response
Musculoskeletal triage, emotional wellbeing, paediatric triage	Supporting primary care to help service users access the right services
Unified point of access / clinical assessment service	to simplify access points to services
Pharmacy support	Medicines management support to care homes
Long-term conditions hub	Developing a model of proactive community based
Information and IT	Further expanding the opportunities of the shared care record system support
Organisational development/ Workforce development	Developing shared opportunities for learning and development and designing a new workforce
Communications and engagement	Ensuring our stakeholders and communities are involved in what we do

Within social care

During 2017/18, we worked with Portsmouth City Council to bring together our early help and prevention services. A single leadership structure is now in place, and we are working to integrate our health visiting and family nurse teams, focused on families with children under the age of 5. We are also integrating our school nurses with teams in the local authority who provide services to young people, aged 5-19, and their families.

Services are provided in the community and through Family Hubs, previously known as Children's Centres. These have been rebranded so that they meet the needs of young people up to the age of 19, as well as their families.

As part of the remodelling and integration of the 0-19 services, our Health Visiting Service has been refreshed to offer a targeted response to families who are most in need. We continue to also provide the universal service delivery to everyone; this is core to the health visiting offer.

Our adults teams, who are already collocated, have been working together to provide a single approach to the delivery of adult services. The new neighbourhood model pilots this approach. The model brings together all care delivery, including social care and primary care, to focus on the needs of the population in the neighbourhood. Our integrated approach is not new; we already have this operating in our step down service which has recently partnered with a key domiciliary care provider to make a step change in early supportive discharge from the acute hospital.

Within our mental health services, we continue to operate a successful partnership agreement with social care to ensure we provide joined up care. The team continue to have a positive impact on our clients, and in particular

ensure that they receive services close to home.

Our teams work with teams in Portsmouth City Council to jointly deliver learning disability services in Portsmouth. Through integration, the service has been able to realise its ambitions of providing 'named workers' to all service users, involving people in service design and jointly managing safeguarding adult concerns. The joint team have also developed a housing and support strategy. The changes, brought about by the integration of services, have been really well received by service users and their carers. The achievements of the teams have been noted locally, regionally and nationally.

Within the voluntary and community sector

To ensure people benefit from the wide variety of services available and best suited to their needs, we continue to work in contractual arrangements with a number of community and voluntary organisations, including Society of St James, Solent Mind and No Limits. As an example, we work in close partnership with Solent Mind delivering support and recovery services, helping people to access our mental health services to achieve improved mental health and wellbeing. We also work together with organisations who support children and their families, including Barnardo's and Homestart.

Our role in the Portsmouth and South East Hampshire Local Delivery System

Solent plays an active role in the Integrated Care System which is focussed on four transformation programmes including:

Transformation Programme	Description
Urgent care	Working with our partners, we are providing services to help prevent emergency admissions into hospital and to support people to return home as soon as possible.
Elective care	We are creating local services for the management of long term conditions, and changing pathways to ensure people are triaged before they are referred for surgery.
Community health and care programme (New models of care)	Transforming services to provide an accelerated approach to providing new models of integrated primary and community care.
Mental health	Working with the acute hospital to provide a mental health assessment unit within the emergency department, and working with partners in the provision of mental health services to manage the number of beds available.

Working in the community

Engagement with local people

We always try to ensure that people who use our services and the public are at the heart of everything we do, in line with the NHS Constitution. We believe that by listening to the people who use our services we can understand what matters to people most, and can create, develop and transform services in response. We work with service users and the public to improve services, enhance patient experience and improve quality and safety.

Patient and public involvement (often referred to as engagement or participation) can take place in a variety of ways, for example through social media, formal consultations and meetings. Below you'll find a flavour of some of our involvement activities during the past year;

- The environment in which we provide our services is of the utmost importance to the patient experience. We always seek to ensure that the buildings we provide our services from are fit for purpose. Within the year we asked service users and their families to comment on some of our estates plans, including the proposed move of The Kite Unit (our specialist neuropsychiatric rehabilitation service) to the Western Community hospital and proposed relocation of Podiatry Services from Woolston Clinic to Thornhill Centre for Healthy Living and Bitterne Health Centre. Feedback we received helped shape and inform our plans.
  We have also asked people who use our services to work with us to develop aesthetically pleasing and pyshcologically beneficial surroundings. Recent decoration at both the St Mary's Community Health Campus and The Limes reflects patient feedback we received.
- To help establish a Trust standard for dementia friendly care environments, we asked service users at The Limes, our older person's mental health unit, to help us develop wayfinding that meets their needs. The new signage has been well received and now forms part of our Estates signage portfolio.
- As part of their Quality Improvement project, to reduce the number of HIV patients who do not attend their clinic appointments, our Sexual Health team worked with service users to understand what helps or hinders people from attending appointments and what they could do to make it easier for people to attend. The service will use this information to explore potential changes they can make to better support people to attend.
- Our Homeless Health team have been working with service users to understand why people do not attend their secondary care appointments at hepatology for hepatitis C. Speaking with service users, the team identfied the need to offer additional assistance to help them book appointments. Thanks to feedback, the team are also exploring establishing a mentorship group to offer people peer support.
- Side-by-Side is the name given to a partnership between the Solent Academy of Research and Improvement team and a dedicated group of individuals that give a patient and public perspective to our work. The group meet regularly to help make sure everything that the team do has a patient perspective embedded at the heart of it. This collaboration has been extremely successful and continues to grow. In 2017 Side-by-Side was instrumental in helping us to become one of the first NHS Trusts to gain the internationally recognised 'Patients Included' accreditation for our annual conference. This accreditation is awarded to events which go the extra mile to include service users and ensure that their voice is heard and valued.
- The Board also seeks views directly from service users. Last year we heard service users share their stories from services across the Trust including children's services, Musculo-Skeletal (MSK) physiotherapy, podiatry, sexual health and the falls service – after each story the Board reflects on any learning that could be taken.

You can find more about how we have engaged with people who use our services and our 'Side by Side' Group in our research and quality improvement agenda within our Quality Account, which includes our Research and Improvement Annual Report 2017/18 as an appendix.

Engagement with our Membership

Although we stepped off the Foundation Trust (FT) application pipeline in 2015, and have not held any active recruitment campaigns in the last year, we have remained engaged with our registered membership.Our membership constituencies, as defined when we were on the FT journey, are as follows;

- **Public constituency** – people aged over 14 based in Southampton, Portsmouth and wider Hampshire and includes service users and carers. We have a total of 7,041 public members.
  The public constituency consists of three geographies including Portsmouth City (1,803), Southampton City (2,031) and wider Hampshire(3,207).
- **Staff constituency** –all permanent members of staff, as well as bank staff over 12 months and temporary staff on a contract of over 12 months, unless they opt out. We have a total of 4,080 staff members. You can find more about our Employee Engagement initiatives on page [n].

Over the last year we continued to explore opportunities to engage with our members.
During the year we:

- continued with our programme of Health and Mind events with topics focussing on falls prevention and dementia awareness
- published four, quarterly editions of Shine, our newsletter for both staff and public members
- invited members to attend our Annual General Meeting 2017 and health fair
- shared information on key topics, including our Care Quality Commission inspection and Sustainability and Transformation Plans
- offered members the opportunity to volunteer with us, or to join us as an apprentice
- shared information about various health campaigns including Stoptober and Cover up Mate.

Our volunteers

We recognise the significant contribution volunteers can make to our services; they help to enhance the patient experience and enable communities to participate in the community health agenda. Our volunteers enhance and enrich the work of our employees.

Providing volunteer opportunities and supporting volunteering helps promote active citizenship and social inclusion. In addition, developing volunteer opportunities enables us to foster our relationships and profile with local people.

We continue to actively recruit volunteers into clinical and non-clinical roles. They help to enhance our services by:

- meeting, greeting and directing service users
- gathering patient feedback
- providing clerical assistance
- befriending

- providing peer support
- gardening and tending to flowers

As well as offering traditional volunteer opportunities we also ask people to become volunteers by experience (also known as experts by experience or peer volunteers). Volunteers by experience are recruited to share their own life experience of a health condition or of using a service.

Engagement with Health Overview and Scrutiny Forums

We have continued to regularly attend scrutiny panel/committee meetings in Portsmouth, Southampton and Hampshire.

During the year we provided updates and answered questions on the following subjects:

Southampton (Health Overview and Scrutiny Panel)

- Update on Kite Unit relocation, following some planning delays
- Telephony - moving from BT/Virgin voice phones to free 0300 numbers
- Woolston clinic closure
- Reprovision of services at Thornhill Community Health Centre
- Quality Account
- Substance misuse service (Solent stopping provision of service in the city)

Portsmouth (Health Overview and Scrutiny Panel)

- Update on Kite Unit relocation, following some planning delays
- Telephony - moving from BT/Virgin voice phones to free 0300 number
- St Mary's Community Health Campus redevelopment plans
- CQC inspection update
- CQC National Review of Mental Health Services for Children and Adolescents
- The Trust's Financial Position and Forecast
- Quality Account

Hampshire (Health and Adult Social Care Select Committee)

- Update on Kite Unit relocation, following some planning delays
- Telephony - moving from BT/Virgin voice phones to free 0300 numbers
- Quality Account

The future - our Community Engagement Framework

We know there's a lot more we can do to actively, and meaningfully, engage with our community and to ensure a more consistent approach across our services and interactions with people. During 2018/19 we will be developing a framework for Community Engagement which will focus on four main dimensions for engagement. This will incorporate how we will use our previously registered membership (a requirement of our former Foundation Trust application process) , changes to our Members Council and how we use volunteers.

Investing in our future

We have continued to invest in our infrastructure and in our people. Making the most from our resources will help us deliver great value for money.

Our investment in our estate has been significant during the year, with the single biggest project completed being the move of the Kite Ward from the St James' Hospital site in Portsmouth to the Western Community Hospital in Southampton. This project involved a multi-disciplinary team of people. We have also invested heavily in backlog maintenance to improve the physical condition of our buildings and in anti-ligature adjustments to our mental health facilities; significant spend is earmarked for future years to continue on both these areas.

Having spent significant sums over the last few years on IT equipment, we continue to look at how we can work differently, considering the cultural aspects of change as well as the use of physical assets.

We value our people and recognise that an engaged workforce will deliver great care; we therefore invested significantly in our Organisational Development Programme in year, particularly focusing on our leadership capability and our 'Leading with HEART Programme' for our senior leaders. We recognise the importance of leadership development as being key to creating a great place to work, providing great care and ensuring great value for money. During the year ahead we will be extending our programme to the next tier of leadership.

Charitable funds

Beacon, Solent NHS Charity, raises money for areas not covered or fully supported by NHS funds and aims to make a difference to the experience people have when they come to us. This can be anything from improving a waiting area, buying a more comfortable chair to creating a multi-use outdoor sports area for those staying with us on a longer term basis. Sometimes it is the smallest things that can make the biggest difference.
Whilst we are a relatively small and unknown charity, we are immensely grateful to everyone who has donated money. The donations we received during 2017/18 amounted to £7,081. During the year ahead we will be considering how the charity can make linkages with 'in kind' support opportunities to maximise the social impact and outcomes.

Whole system response and emergency preparedness

The Emergency Preparedness, Resilience and Response (EPRR) for Solent NHS Trust is an ongoing identified work stream which has developed over the past three years.

In 2017/18 we continued to review all of our emergency plans. These are validated as part of the testing schedule within the Trust, often in partnership with the wider health community.

We continue to work with other organisations to prepare for a critical or major incident. Our Chief Operating Officer for Southampton continued to represent us at the Health Resilience Partnership (LHRP), whilst our Emergency Planning Practitioner (EPP) continues to regularly attend local health resilience meetings, sharing information with our Emergency Planning Group.

During 2017/18 we have:

- participated in an incident outbreak planning exercise
- held business continuity exercises to test service business continuity plans
- participated in an exercise in Portsmouth, involving the acute trust and partners
- providing regular training for on call staff
- participated in system wide task and finish groups for flu planning and mass casualty response.

We also implemented a new training plan. The plan, which has been built around the training needs of our employees, using lessons identified from incidents and previous training and included at least one training session for each on-call member of staff during the year.

In preparation for a difficult winter, we reviewed and updated our winter plan ensuring that contingency plans for increased capacity were developed and documented for use during high capacity system challenges.

Each year NHS England (NHSE) assesses us for assurance against the EPRR core standards. In 2017/18, NHSE concluded that we were 'fully compliant' with the EPRR assurance assessment. NHSE acknowledged the work we had undertaken during the year, commending our work to achieve an 'excellent level of compliance'.

Solent news

In the following sections you can read a few examples of our promotional stories.

Southampton and County care group

Helping the homeless for 25 years

Our Homeless Healthcare Team hosted a tea party to mark their 25th birthday in July. The event was attended by service users, stakeholders, staff, the Mayor of Southampton as well as former Southampton Football Club Manager and FA Cup winner, Lawrie McMenemy. The event took place at the self-referral Two Saints Day Centre in Southampton, from where our service is run.

Artwork created by Primary school pupils

Pupils from Thornhill Primary School created a healthy living montage, which takes pride of place in our new children's hub at Thornhill Healthy Living Centre's reception area and upstairs waiting area.
The school's 360 children, with support from local artist Joe Ross and a project officer from Southampton Solent University's School of Art and Design, sketched, modelled and painted their idea of healthy living.

New location for the Kite Unit

In January 2018 our specialist neuropsychiatric rehabilitation service, known as the Kite Unit, moved from St James' Hospital in Portsmouth to a new, purpose-designed area within Western Community Hospital in Southampton. The move followed a £1m investment, which included a complete refurbishment and the creation of bespoke features designed for service users by Solent's Estates team. Specialist features include:

- a 'quiet room', enabling service users to sit in a relaxing space looking out over the unit's gardens
- a fully equipped gym to help service users maintain their fitness and reduce symptoms of depression
- a therapy room and kitchen, enabling service users to re-learn essential life skills, such as cooking, and develop new ones to improve their wellbeing including painting and gardening.

HIV webchat launched

In July our Sexual Health Services launched an online live chat service for people living with, or affected by HIV. HIV Live Chat, funded by Public Health England, is accessible at www.letstalkaboutit.nhs.uk/livechat and is believed to be the first of its kind in England, allowing users to talk directly online with an HIV clinical specialist. The user, whether they are someone diagnosed as HIV positive or someone affected by another with the virus, is given appropriate and confidential clinical guidance, counselling and signposting over the course of the chat.

Elf fundraising

The Special Care Dental Service in the north of the service ran a fundraising event as part of the Alzheimer's Society ELF day in December. The day was arranged to raise vital funds and awareness of the condition.

Portsmouth

Diabetes event

Our Diabetes Specialist Nursing Teams, together with Southern Health NHS Foundation Trust, held an event in May 2017. Attended by over 100 people, information was shared about how to keep healthy while living with diabetes. The teams talked with people about the importance of foot and dental care, and the importance of maintaining a balanced diet.

Praise from parents

Our staff in Children's Services were awarded the 'Parent Appreciation Award' from Portsmouth Parent's Voice (PPV), a forum to support parents and carers find services and support for 0-25 year olds with additional or special needs and/or disability. Sian MacLoed, Specialist Health Visitor, Dr Soha Mina, Dan Bevan, Austism Liaison and Support Worker, and Deborah Burness, from CAMHS, were praised for the difference they have made.

Pulmonary Rehabiliation Week

To mark Pulmonary Rehabilitation Week in June, our Pulmonary Rehabilitation Service teamed up with Breathe Easy, a local British Lung Foundation support group ,and demonstrated exercises in the main reception at the Queen Alexandra Hospital in Portsmouth. The team work with people on the best exercise techniques and education to help them manage their condition on their own.

Trust wide

Baby Buddy App

In November, our health visitors launched a mobile app to help parents and health professionals through pregnancy, birth and the first six months of a baby's life.

The free app,'Baby Buddy', was created with mums, midwives and doctors and is supported by midwives at Portsmouth Hospitals NHS Trust and University Hospitals Southampton NHS Foundation Trust. It acts as a tool to provide people with information that is reliable, accurate and available 24 hours a day.

Solent Mindfulness workshops

Talking Change, a team of psychotherapists and researchers who specialise in the understanding and treament of common mental health conditions, developed mindfulness opportunities for Solent employees. During the year, the team have offered a number of one off sessions, as well as an 8-week mindfullness based stress reduction course.

Premises and Facilities Management (PFM) Awards 2017

Together with Kier Workplace Services, we were shortlisted as finalists for the Premises and Facilities Management Awards at the event held in November.

Research league tables

In August we were named as the top recruiting research Care Trust in England by the National Institute for Health Research. The research was conducted between April 2015 and March 2016 and over 1,800 participated. This was an increase of 48% on the previous year.

Solent regional collaboration housing summit

Sue Harriman, our CEO, hosted a regional housing, health and care summit in September 2017. Senior public sector leaders from housing, health, voluntary sector and care organisations across Hampshire and the Isle of Wight met to agree how they could better work together to consider alternative delivery models and opportunities to:

- use collective assests (including buildings, properties and land to improve the mental health and wellbeing of communities
- utilise and lever greater value from joint workforces to keep people safe and well at home
- building grass-roots community resilience to change and build mental health friendly communities.

Making a difference to employee mental wellbeing

As part of our employee health and wellbeing programme, we worked with people who have experience of mental health problems to develop the OWLES (Optimising the Wellbeing and Lived Experience of Staff) group. The role of the group is to help create a culture where our employees feel comfortable and inspired to talk about mental health, and to encourage everyone to support one another. The group worked together to design and develop a week of activities to help people think about mental wellbeing. As well as ‘Power Hour’ bite size learning sessions and an online activity pack, the group organised a number of mindfulness workshops, stress buster sessions and roadshows.

Going concern

Our statement on Going Concern can be found in Section 4.

Performance Analysis

Performance Measurement

We record and report a range of data on a monthly basis for all of our services, including team level data in some instances. The information is used to help us provide internal intelligence and assurance that our services are delivering safe, effective and efficient care.

In addition to these internal measures, during 2017/18 we also reported against 550 Key Performance Indicators (KPIs) as well as an additional 952 individual reporting indicators – together these help commissioners monitor our performance against the standards of care expected and services commissioned.

On a monthly basis we hold monthly Performance Review Meetings with our service lines and corporate directorates. At these meetings progress against specific agreed indicators is scrutinised and challenged. Any areas of significant risk that are not appropriately mitigated or where assurances are lacking are escalated to our Performance Subcommittees for additional oversight and scrutiny, before being escalated to our Trust Management Team, if appropriate.

Whilst we seek to address areas of exception, where performance is less than expected, we do of course promote and share performance successes and achievements so that we can spread learning.

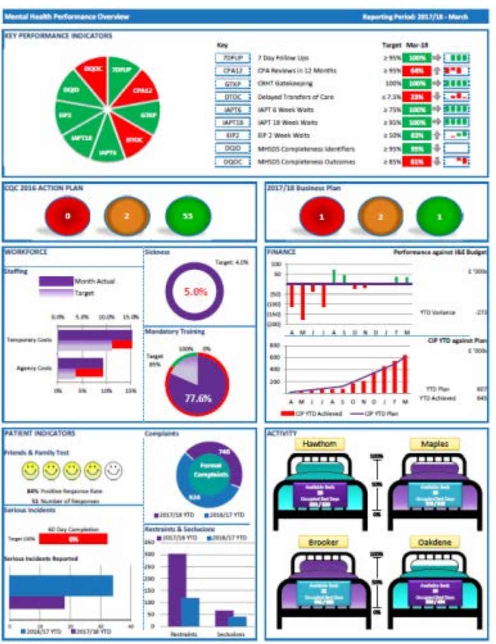
The key core areas reviewed at our monthly performance meetings across all of our clinical services are illustrated below – we also scrutinise other service specific information and reports.

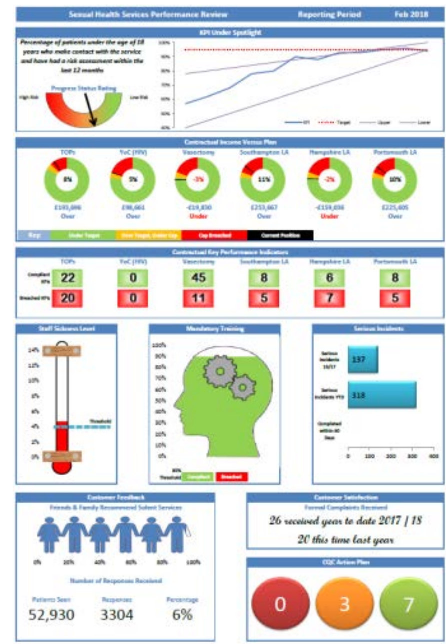
Performance Dashboards

During 2017/18 we introduced a new form of performance dashboard which triangulates information enabling us to enhance our intelligence. The new dashboards incorporate infographics to simplify data presentation and increase accessibility of the information presented with the aim of enabling managers to better engage in performance reporting.

Our dashboards have been co-created with each of our individual service lines to ensure that the information presented is the most relevant to them. During the year ahead we will further embed our dashboards in our formal performance reports.

Examples of our innovations are below:





NHS Improvement Single Oversight Framework

The NHS Improvement Single Oversight Framework (SOF) provides the framework for overseeing organisations and identifying potential performance concerns. We continued to assess ourselves against the standards set out and have maintained our 'Level 2' organisational grading, where Level 1 is the best and Level 4 indicates an organisation that is most challenged. We believe this is a positive position for us and our inability to achieve a Level 1 rating has predominately been caused by our forecasted in-year financial deficit.

The framework covers five themes:

1. Quality of care
2. Operational performance
3. Finance and use of resources
4. Strategic change
5. Leadership and improvement capability (well-led)

Currently NHSI has defined metrics associated with the first three themes listed above; as such our performance is summarised as follows. Thresholds highlighted in grey are internal, aspirational thresholds, whereas all others are national targets. NHSI is working to develop the performance metrics associated with the additional themes, aligning approaches to the CQC Domains where possible.

Quality of Care

Under this domain we monitor ourselves against metrics relating to:

- Organisational Health
- Caring
- Effective and
- Safe

Organisation health

We set ourselves some internal ambitious targets and our performance against these is summarised below. Staff sickness showed a gradual increase through 2017 into the winter period but then fell sharply after the flu season had passed. Staff turnover has gradually decreased over the year which is positive and we hope to continue this trend during the year ahead. The utilisation of temporary staffing has been a challenge at times throughout the year, due to a number of reasons including, difficulties in recruiting due to national staff shortages (particularly within our mental health services and band 5 nurses[1] within our community services) as well as supporting system pressures during the challenging winter period. We are however continuing to actively recruit and aspire to be an employer of choice.

Organisational Health — Internal aspirational thresholds are highlighted in grey

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Staff sickness (in month)	4%	4.0%	4.1%	4.1%	4.3%	4.8%	4.6%	4.9%	5.2%	5.1%	5.2%	4.3%	4.2%
Staff turnover (rolling 12 months)	12%	15.2%	15.3%	15.1%	14.8%	14.8%	14.5%	14.2%	14.3%	14.4%	14.1%	14.4%	14.2%
NHS Staff FFT	40%			64.4%			64.1%						
Proportion of Temporary Staff (in month)	6%	6.9%	5.9%	6.1%	6.1%	6.4%	5.8%	5.7%	6.0%	6.1%	6.0%	5.9%	6.0%

[1] Band 5 nurses are also known as 'staff nurses'

Caring

Our performance against the caring metrics was strong throughout the year with only the Mental Health Patient Friends and Family Test under-achieving[2]. Despite this being a very challenging target, due to the nature of the service provided, we have consistently achieved 80% or more which benchmarks positively nationally.

Caring													
Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Written Complaints		7	21	22	14	16	17	11	19	16	18	22	20
Staff Friends and Family Test Percentage Recommended - Care	80%	-	-	83.0%	-	-	82.3%	-	-	-	-	-	-
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Scores from Friends and Family Test - % positive	95%	96.8%	95.7%	95.1%	97.8%	95.2%	95.0%	96.0%	97.0%	96.6%	96.2%	96.2%	95.9%
Mental Health Scores from Friends and Family Test - % positive	95%	97.2%	88.1%	87.1%	100.0%	90.5%	83.3%	85.4%	91.3%	83.3%	95.6%	84.3%	80.5%

Effective

We performed strongly against the effective domain and metrics throughout the year with the relevant indicators all achieved by our Mental Health Services. Only one month's performance slipped just under the target all year.

Effective													
Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	100%	100%	100%	100%	92%	100%	98%	100%	100%	100%
% clients in settled accommodation		69%	69%	68%	69%	70%	72%	72%	71%	71%	71%	70%	71%
% clients in employment	5.0%	5.6%	6.6%	6.0%	6.0%	5.0%	5.0%	6.0%	6.0%	5.0%	5.0%	5.0%	5.2%

Safe

We also performed positively against the safe domain. During the second half of the year NHSI introduced 2 new indicators for monitoring – including; the number of incidences of Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias and Escherichia coli (E.coli) bacteraemia bloodstream infection. We met the target of zero for both of these indicators.

Safe													
Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-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	1	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95%	91%	100.0%	97.0%	99.0%	98.0%	97.0%	100.0%	97.0%	97.0%	96.0%	95.0%	92.0%
Clostridium Difficile - variance from plan	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile - infection rate	0	0	0	0	0	0	0	1	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA)	0							0	0	0	0	0	0
Escherichia coli (E.coli) bacteraemia bloodstream infection	0							0	0	0	0	0	0
MRSA bacteraemias	0	0	0	0	0	0	0	0	1	0	0	0	0
Admissions to adult facilities of patients who are under 16 yrs	0	0	0	0	0	0	0	0	1	0	0	0	0

[2] The 2016-17 NHS Benchmarking Network: Friends and Family Test results: 85% mean and 88% median

Operational Performance

We performed excellently throughout the year against indicators focussing on our access times, mental health service placements and data quality.

Operational Performance Indicators

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	99.3%	100.0%	100.0%	99.9%	99.8%	99.5%	99.7%	99.6%	99.7%	99.4%	99.4%	99.7%
Maximum 6-week wait for diagnostic procedures	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Inappropriate out-of-area placements for adult mental health	0							0	0	0	0	0	0
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	30.0%	71.0%	50.0%	86.0%	67.0%	83.0%	80.0%	88.0%	50.0%	40.0%	83.0%	100.0%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%							97.7%			98%		
Improving Access to Psychological Therapies (IAPT) / Talking Therapies													
- Proportion of people completing treatment who move to recovery	50%	61.8%	60.2%	57.4%	57.3%	56.5%	61.1%	60.4%	57.8%	53.4%	57.8%	57.6%	58.2%
- Waiting time to begin treatment - within 6 weeks	75%	100.0%	99.8%	99.0%	100.0%	100.0%	100.0%	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%

Finance

The SOF also measures our financial performance via a set of indicators which calculate a ‘finance score’.

Finance Score

Indicator Description		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Capital service capacity	Financial Sustainability	0.0	1.1	1.5	1.4	1.6	1.7	1.7	1.6	1.8	1.7	1.8	2.5
Score		4	4	3	3	3	3	3	3	2	3	2	2
Liquidity (days)	Financial Sustainability	-13.0	-12.9	-12.5	-13.0	-12.9	-13.3	-12.7	-14.4	-15.4	-14.7	-10.7	-6.7
Score		3	3	3	3	3	3	3	4	4	4	3	2
I&E Margin	Financial Efficiency	-0.02%	-1.9%	1.3%	1.4%	1.1%	0.9%	1.0%	-1.0%	-1.0%	-0.9%	-0.7%	0.4%
Score		3	4	2	2	2	2	2	4	3	3	3	2
Distance from financial plan	Financial Efficiency	-0.02%	-0.5%	0.0%	0.1%	0.2%	0.3%	0.1%	0.0%	0.1%	0.1%	0.2%	1.3%
Score		2	2	1	1	1	1	1	1	1	1	1	1
Agency spend	Financial Controls	0.3%	25%	24%	25%	47%	40%	38%	38%	42%	42%	43%	38%
Score		2	3	2	2	3	3	3	3	3	3	3	3
	Finance Score	3	3	2	2	2	2	2	3	3	3	2	2
	RAG	R	R	G	G	G	G	G	R	R	R	G	G

Our score fluctuated through the year between 2 and 3, where 1 is the best rating and 4 the worst. The two main areas of variance in the year were caused by our liquidity and our income and expenditure margin. However, as we achieved better than our agreed deficit control target set at the beginning of the year, we have showed a strengthened financial position on recent years.

There have been no important events since the end of the financial year that have affected our overall performance.

Strategic Objectives Achievement

We began the year with 163 strategic objectives planned for delivery against our 2 year Operating Plan (2017-19). These objectives were further split into 669 respective milestones managed locally by service lines and corporate teams - progress is monitored against agreed objectives.

Solent NHS Trust Priorities and the Solent Story

As part of our business planning process for our Operating Plan, service lines and corporate directorates aligned their own strategic objectives to our 9 organisational priorities to ensure there is a direct relationship between the service we provide and our strategic direction - these are mapped in the following tables.

To provide great care		
Improve Quality in line with CQC Requirements	Provide Safe Staffing	Use Technology to work differently
24	16	16

A great place to work		
Plan for long term sustainable staffing	Enhance our leadership throughout the Organisation	Provide training that enables us to deliver great care
22	19	23

To deliver great value for money		
Further Pathway Integration with other providers	Benchmark our services to improve productivity	Change front line and corporate services to live within our income
24	22	19

Our key successes

The following section illustrates some examples where we can demonstrate we have made a difference.

Service line: Adults Southampton
Objective: To develop inpatient services in line with changing health demands of our community

As a result of reviewing patient pathways into our inpatient services based at our community hospitals we have identified opportunities for service users within Acute Medical Units to be safely transferred to the Royal South Hants Hospital – protocols have subsequently been drafted. We have also promoted access to our sister services including the Community Emergency Department Team (CEDT), Urgent Response Service (URS) and primary care. We are now exploring further opportunities to develop IV antibiotic administration in the community, led by the URS with our acute partners.

Service line: Sexual Health
Objective: Grow our local/regional/national reputation as an innovative provider of integrated sexual health services by expanding our digital offer and research capability

The Sexual Health service has improved the digital services available to our service users in order to help raise the profile and awareness of the services that we offers. This was successfully achieved through an increase in posters, oral presentations and journal articles which helped improve our engagement with our service users. The service also successfully developed a web-chat facility for our service users with HIV, improving access for service users who required advice. Due to the success of the web-chat facility, the Sexual Health service are now looking to roll this out in 2018/19 to the wider service so that this facility is available for all Sexual Health service users.

Service line: Child & Family
Objective: To develop options on how services can deliver differently using interactive platforms, new technologies and intelligent use of patient record systems

By engaging with almost 200 service users, the service ran a digital innovation project to re-develop how our staff engaged with service users, what communication methods we offered and what our current patient facing website offered. Consequently, a new website was launched in November 2017 with reliable up to date information, contact details and interactive media. The service is also planning to commence live question and answer events from May 2018. We will also be launching a new messaging service allowing direct contact with a qualified nurse enabling service users to choose phone, email or text as their method of preferred communication. We have also promoted reliable Apps which we believe will benefit service users.

NHSI Well Led Framework and licencing requirements

You can find more about our compliance with the Well Led and Licencing requirements within our Annual Governance Statement. Any risk to licencing non-compliance would be appropriately reflected within our Board Assurance Framework and appropriate mitigations would be implemented.

There were no confirmed Human Rights violations by us during 2017/18 and the Trust has an agreed Anti-fraud, Corruption & Bribery Policy and procedures. Our policies are available on our public website www.solent.nhs.uk .

Environmental Reporting

We have developed a Sustainable Development Management Plan that aligns with the NHS Standard Contract, specifically the Service Contract item SC18 – Sustainable Development.

On an annual basis we complete the Sustainable Development Unit report, supported by ERIC returns (Estates Return Information Collection) and from data provided through our energy bureau. This is in line with our Carbon Reduction Action Plan, to meet our mandatory sustainability reporting requirements.

In addition, on a monthly basis, we monitor our waste disposals and utilities consumption. Our utilities consumption is compared with previous year's usage to ensure economic efficiencies and to track consumption in line with our carbon reduction targets. Our waste disposal locations are monitored to ensure minimal waste to landfill, and to track increasing recycling rates. We work with our waste contractor to increase segregation to improve recycling rates, and with their subcontractors to increase clinical waste residues to R1[3] recovery facilities, instead of previous landfill sites. With the agreement of the Environment Agency, the waste contractors permit has been enhanced allowing offensive waste to also be disposed of and recovered, via R1 facilities. In accordance with the HM Treasury Sustainability Reporting Guidance, our Carbon Reduction Action Plan addresses the minimum requirements concerning Green House Gases (GHG) both Scope 1, (direct GHG emissions), Scope 2 (energy indirect GHG emissions), and Scope 3 (Other Indirect GHG emissions) as well as Finite Resource Consumption including estates water consumption, via our ERIC return (measured in cubic meters).

We are committed to sustainable procurement practices and all new contracts are issued in accordance with NHS Terms and Conditions. By ordering our goods via a supply chain we minimise fleet mileage, deliveries, congestion and associated pollutants. During the year we improved the analysis of our environmental information and data across our estate footprint more thoroughly through the use of data available from our energy bureau that will support the ERIC process and requirements under the Sustainable Development Unit, as well as more broadly ensuring sustainability is embedded within business practices across the organisation.

Further information about our environmental responsibilities can be found within the Annual Governance Statement.

The Performance Report is signed by

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

[3] R1 recovery facilities use waste to generate energy

Section 2: Accountability and Corporate Governance

Directors' report

Governing our services

Our Board of Directors

Accountable to the Secretary of State, the Board is responsible for the effective direction of the affairs of the organisation, setting the strategic direction and appetite for risk. The Board establishes arrangements for effective governance and management as well as holding management to account for delivery, with particular emphasis on the safety and quality of the trust's services and achievement of the required financial performance as outlined in its Terms of Reference.

The Board leads the Trust by undertaking the following key roles:

- ensuring the management of staff welfare and patient safety
- formulating strategy, defining the organisation's purpose and identifying priorities
- ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
- seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- shaping a positive culture for the Board and the organisation.

The business to be conducted by the Board and its committees is set out in the respective Terms of Reference and underpinned by the Scheme of Delegation and Reservation of Powers.

The Board meets formally every other month In-Public. Additional meetings with Board members and invited attendees are held following In-Public meetings to discuss confidential matters. The Board also holds confidential seminar (briefing) meetings every other month and development days every other month. All non-executive directors take an active role at the Board and board committees.

Balance, completeness and appropriateness of the membership of the Board of Directors

The Board of Directors comprises six non-executive directors (NEDs) including the Chairman and five voting executive directors. The executives with voting rights include the Chief Executive Officer, the Deputy CEO and Director of Finance and Performance, the Chief Medical Officer, Chief Nurse and Chief People Officer. Together with the Chief Operating Officer for Portsmouth and Commercial Director and the Chief Operating Officer for Southampton and County Services they bring a wide range of skills and experience to the Trust enabling us to achieve balance at the highest level. The structure is statutorily compliant and considered to be appropriate. The composition, balance of skills and experience of the Board is reviewed annually by the Governance and Nominations Committee.

Appointments

Executive director appointments

In year there were a number of changes to the Executive team as follows;

- Helen Ives was appointed as Chief People Officer in April 2017
- Lesley Munro was appointed as Interim Chief Operating Officer for Southampton and County services between February 2017 and May 2017. From June to November 2017 Lesley was the Interim Chief Nurse.
- From December 2017 Jackie Ardley was appointed as Interim Chief Nurse. A substaintive recruitment process commenced in Quarter 4 2017/18 and following an assessment centre in mid April 2018 we substantively appointed Jackie into the Chief Nurse role permanenty.
- David Noyes was appointed as Chief Operating Officer Southampton and County Services in July 2017.

Executive recruitment consultants, Odgers Berndston, provided executive search assistance with our executive director appointments.

Non-executive director appointment

During 2017/18 Stephanie Elsy was appointed as a Non-executive director supported by Odgers Berndtson. Interview panels were convened of representatives of NHS Improvement, an independent Trust Chair, the Trust's Lead Governor and the Trust's Chairman.

The people

Non-executive directors

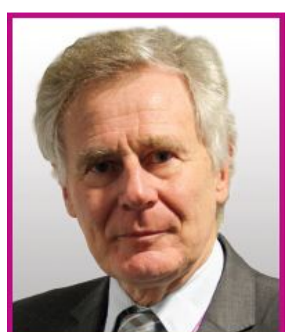
Dr Alistair Stokes, Chair

Alistair was appointed to the Trust in April 2011. He has had a wide ranging career in marketing, business development and administration in the chemical and pharmaceutical industries including working as Commercial Director with Monsanto Company and as Managing Director for UK operations and subsequently Regional Director for the Far East and South East Asia for Glaxo PLC. From 2007, Alistair served as Chairman of the Ipsen Group's UK companies, retiring from that role in 2010. Alistair also served as Regional General Manager for the NHS in Yorkshire and for several years as a member and Vice Chairman of a District Health Authority and from 1992 until 1998 as Chairman of an NHS Trust. He is a Fellow of the Institute of Directors and a Chartered Director. Alistair is the lead NED for Health & Safety (including Local Security Management).

Mick Tutt, Deputy Chair and Non-executive Director

Mick was appointed to the Trust in April 2011. He has more than 40 years NHS experience, including 20 years in Senior Management and more than a decade at Executive Director (and equivalent) level. As a qualified nurse Mick has managed mental health and learning disabilities services in a number of different Trusts and has experience of working with the CQC and its predecessors, including chairing comprehensive inspections and taking part in the new Well Led regime during the last year. Mick has also acted as the Nurse/Manager representative on several independent inquiries and has undertaken many investigations into disciplinary and grievance matters and serious incidents. Mick was a former lay member of the Portsmouth Community and Mental Health Service Board before being appointed as Non-Executive Director for Solent NHS Trust. He now acts as a manager for appeals against Mental Health Act detentions and also chairs the Mental Health Scrutiny Committee and Assurance Committee. Mick is also the lead NED for Patient Safety (including mortality).

Jon Pittam, Senior Independent Director and Non-executive Director



Jon was appointed to the Trust in June 2012. Since 1997 until his retirement in 2010, Jon was the County Treasurer for Hampshire County Council as well as being Treasurer for the Hampshire Police and Fire Authorities. In these roles, Jon provided financial and strategic advice in support of the authorities' corporate strategies and was the chief financial officer for budgets approaching £2 billion. Jon was an elected council member of his chartered accountancy body and the national spending convenor for local government finance during several public expenditure rounds. Jon is an Associate Hospital Manager, the chair of the Audit & Risk Committee and the lead NED for procurement.

Mike Watts, Non-executive Director

Mike grew up and went to school in Southampton. He is a Hampshire resident and has an extensive and wide ranging track record in organisational design and development that has driven business performance. Mike is currently the lead consultant with Capability and Performance Improvement Ltd of which he is a co-owner. He has previously held senior HR roles at Southampton City Council, and the Chartered Institute of Professional Development; Cabinet Office; Lloyds TSB and Scottish Widows. During his time in the Cabinet Office, Mike was recognised by HR Magazine as one of top 30 influencers of HR practice. He has also held a previous Non Executive Director role with the Scottish Executive. Mike was appointed in October 2016 and Chairs the People and OD Committee as well as the Remuneration Committee. He is also the lead NED for Medical and Professional Fitness to Practice issues.

Professor Francis Davis, Non-executive Director

Francis was appointed to the Trust in October 2016. Francis is currently Professor of Communities and Public Policy at the University of Birmingham where he publishes on inclusion, disability, cohesion and teaches post graduate policy and politics. He has, for 20 years, been active in founding, chairing and supporting community groups, voluntary organisations and social enterprises in health and social care. He helped to launch the 'Hampshire Festival of the Mind' and also the first UK 'Mental Wealth Festival'. Formerly a private sector CEO Francis has chaired industry bodies for the South and South East, worked as a senior civil servant at Cabinet level and is an advisor to CIPFA Consulting. He chaired both the Mayor of London's and the Mayor of the West Midlands cohesion summits and has been a member of the Department of Health's cross government Independent Advisory Group on Carers. Francis chairs the Finance Committee and the Charitable Funds Committee and is also an Associate Hospital Manager.

Stephanie Elsy, Non-executive Director

Stephanie has worked in the delivery of public services for over 30 years . She was a CEO in the charity sector for 15 years managing community and residential services for people recovering from substance misuse, people with disabilities and people living with HIV and AIDS. She then entered local politics as a Councillor in the London Borough of Southwark in 1995, becoming Chair of Education in 1998 and then Leader of the Council in 1999. After retiring from local government in 2002 Stephanie served on the Board of Southwark Primary Care Trust which had pooled its resources with the Social Services Department and had a joint Director. She also started a consultancy business providing services in health, local and regional government. Serco Group PLC became one of her clients, and in 2004 she was invited to join the company as a senior Director to support its Board and Senior Executives in raising the company's profile in government and business. She was a member of the company's Global Management Team and helped shape the company's business strategy and supported new market entry in the UK and internationally. Stephanie left Serco in 2012 to establish a new consultancy business, Stephanie Elsy Associates, an advisory consultancy specialising in public sector services and the government contracting markets. She lives in Emsworth where she is Chair of the local Neighbourhood Forum which is developing a Neighbourhood Plan for the town. She also sits on the Board of the Responsible Finance Association, who represent Fair Finance providers that provide finance to customers not supported by mainstream lenders. Stephanie joined the Trust in September 2017 and is the lead NED for Patient Experience and Emergency Planning, Resilience and Response.

Non-executive directors who left in year

Jane Sansome

Jane was appointed to the Trust in June 2015. Jane had an extensive and highly successful 21 year career in the NHS before joining the Ministry of Defence in 2000 to lead the operational planning and delivery of the strategy to transform Defence Medical Services. In 2004 with the first stage of the strategic plan delivered, Jane moved to the private sector to become the Chief Executive Officer of the project company delivering the £1.2billion redevelopment programme for Barts and the London Hospitals. In 2012 Jane joined Skanska UK as a Non-Executive Director where she supported the Managing Director of Skanska Facilities Services to develop the strategy, resource and contract delivery plans for the company. Jane left Skanska at the end of February 2015 to become a freelance management consultant. Whilst at Solent NHS Trust Jane chaired the Finance Committee and Remuneration Committee and was the lead NED for patient experience and oversight of medical fitness to practice issues. Jane left the Trust in May 2017.

Executive Directors

Sue Harriman, Chief Executive

Sue trained as a nurse in the Royal Navy. During her 16 year military career, she worked in both primary and secondary care, including spending five months on board a hospital ship during the 1990 Gulf War conflict.
Sue was a trained critical care nurse for a number of years, and after completing a BSc in Infection Prevention at the University of Hertfordshire, joined the NHS in 2002 to become a Nurse Consultant in Infection Prevention. Sue has developed a management and leadership portfolio that includes attending Britannia Royal Naval College, Dartmouth, and gaining Masters level Management and Leadership qualifications at the University of Southampton. Sue has been an Executive Board Director for 10 years. Her executive roles have included Director of Nursing and Allied Health Professions, Chief Operating Officer and Managing Director. Sue was appointed to lead Solent NHS Trust as Chief Executive in September 2014.
Sue has lived and worked, locally, in Hampshire since her military career brought her here nearly 30 years ago. She is committed to bringing health and care services together so they work in partnership with the community, and those who use and work with them.

As the Chief Executive, Sue believes her role is to empower the Trust to provide the best care possible, for its team of staff to feel supported and happy at work, whilst ensuring the Trust always offers best value for money.
Sue says, "I feel very privileged to be leading Solent NHS Trust at this time, I will never forget my roots as a nurse, caring for people and their families and friends at such important times in their lives. I became a nurse because I cared deeply about helping others, now as a Chief Executive I will do everything I can to make sure our team at Solent can always continue to care with compassion, and be the best they can whilst providing the care their service users want and need."

Andrew Strevens, Director of Finance and Performance and Deputy Chief Executive

Andrew is the Director of Finance and Performance and joined the Trust in August 2015. He has worked within the health service since 2009 and brings a whole system view, having worked in senior positions for providers (Hampshire Community Health Care and Southern Health) and as a commissioner (NHS England South Region). He also has a commercial background, having worked for KPMG and B&Q Plc.

Chief Medical Officer, Dr Daniel Meron

Dan joined the Trust in January 2016. Dan studied Medicine at the University of Southampton, and completed psychiatry training in Wessex. He went on to become a consultant in general adult psychiatry in Avon & Wiltshire, where he held consultant posts in community teams, Crisis Resolution and Home Treatment, Acute Inpatient, Assertive Outreach, and Primary Care Liaison. Over the years he developed a management and leadership portfolio and continued to combine senior management roles with active front-line clinical work. He is actively engaged in research at the School of Medicine, University of Southampton, where he completed a Doctor of Medicine higher research degree. He has special interest in mood and anxiety disorders, trauma, addiction, recovery, and mindfulness. Dan undertook an Executive-MBA degree at Hult International Business School and graduated with distinction in 2014. Dan believes that integration between mental and physical, primary and secondary, and between health and social care in a community-based system, is the way to improve the lives of the people we are here to serve.

Sarah Austin, Chief Operating Officer Portsmouth and Commercial Director

Sarah originally trained as a nurse in London and specialised in renal care in Portsmouth, undertaking both a teaching qualification and a BSc. Her career to date includes 17 years in Portsmouth Hospitals Trust latterly working as Director of Strategic Alliances leading the merger with Royal Hospital Haslar, five years as Director of Central South Coast Cancer Network and three years in South Central Strategic Health Authority focusing on strategy, system reform and market development. Sarah joined Solent NHS Trust in autumn 2010 as Transforming Community Services Programme Director before being appointed as Director of Strategy in November 2011. Sarah is now COO for Portsmouth and South East Hampshire (PSEH) and Commercial Director for Solent, and has additional responsibilities for the Integrated Care System as Director of System Delivery.

Jackie Ardley, Interim Chief Nurse[4]

Jackie has over 40 years experience in the NHS as a nurse. She commenced her career in Critical Care, working across the health system in General Nursing, Primary Care and Mental Health and Community Services. In 2001 Jackie spent seven years working on national service redesign programmes, leading a number of successful initiatives within a number of roles including Director of Service Improvement and a Regional Director post in Improvement Partnerships. Jackie has worked as Chief Nurse in Leicestershire Partnership NHS Trust. She is passionate about improving service users and their families experience across health and social care. Jackie joined us in December 2017.

David Noyes, Chief Operating Officer Southampton and County Wide Services

Prior to his life in the NHS, David spent 28 years in the Royal Navy, as a Logistics Officer, serving at sea and ashore in a wide variety of roles, including during hostilities in both the Gulf and in support of operations in the former Yugoslavia. His professional responsibilities spanned a broad range of operational disciplines including all support related operational matters, such as logistics, catering, HR, cash/budgets, medical, equipment support, infrastructure and corporate support functions. During his career, he also served in major Headquarters undertaking strategic planning roles, and also twice worked in the Ministry of Defence in London, directly supporting members of the Admiralty Board, including the First Sea Lord. Towards the end of his military career, David was seconded to the Army, and served with 101 Logistics Brigade, during which time he served as Deputy Commander in the Joint Force Support Headquarters deployed for six months in Helmand province, Afghanistan. Having left the Royal Navy in 2013, David joined the NHS, and initially worked as Director of Planning, Performance and Corporate Services for Wiltshire Clinical Commissioning Group, before joining Solent NHS Trust as Chief Operating Officer for Southampton and County wide services in July 2017.

Helen Ives, Chief People Officer

Helen Ives joined us in May 2016 to lead our organisational development programme and was appointed to the role of Chief People Officer in April 2017. Helen is an organisational psychologist and an HR professional. She is a fellow of the Chartered Institute of Professional Development and member of the British Psychological Society. Prior to joining the NHS, Helen worked in a variety of business sectors, including: technology, logistics and professional services. Helen also runs her own business as an independent consultant, working with organisations to develop their culture and people. As Chief People Officer, Helen is accountable for the development, and successful implementation, of the People and Organisational Development Strategy. She works with our people and teams to develop our culture – our vision, mission and how we create a working environment in which people can thrive, make a difference to the communities we serve and deliver great care. She is also the executive lead for workforce planning, ensuring we have a sustainable workforce plan that enables us to deliver our services.

[4] Jackie was appointed in December 2017 – April 2018 as our Interim Chief Nurse. In April 2018 following an external recruitment process and assessment centre , Jackie was appointed as our substantive Chief Nurse.

Executive directors who left in year

Mandy Rayani, Chief Nurse

Mandy trained in Swansea as a Registered Mental Health Nurse (RMN) and subsequently worked in mental health services for approximately 20 years. In 2005, Mandy became Regional Nurse for Mid and West Wales Regional Office working with the Welsh government, before taking up the role of Deputy Nurse Director at Cardiff and Vale NHS Trust, one of the largest teaching hospitals in the UK in 2007. Following the NHS Wales reorganisation in 2009, she was appointed Deputy to the Executive Nurse Director of Cardiff and Vale University Health Board, a fully integrated healthcare organisation providing primary, community, secondary mental health and tertiary services. Mandy joined Solent NHS Trust in September 2014 as Chief Nurse and left in June 2017 to join Hywel Dda University Health Board in Wales as the Director of Nursing Quality and Patient Experience.

Board development and performance evaluation

The Board of Directors keeps its performance and effectiveness under on-going review.
The Board holds workshops every two months to focus on developmental and strategic topics.

During 2017 the Board commissioned a specialist firm of business psychologists and consultants to support the delivery of the on-going Board Development Programme. This work focused on values and behaviours and the critical role of the Board in ensuring that Solent is a well-led organisation and is able to respond to the varied and complex demands of system working. A comprehensive internal Board appraisal was also conducted in year, the results of which support the on-going development work of the Board.

The Trust also conducted a self- assessment against the NHS Improvement (NHSI) Well Led Framework and in support of the forthcoming CQC Well Led inspection - consequently a robust action plan has been developed to address any areas requiring attention. The Board acknowledges the requirements of the Well Led Framework to conduct an independent assessment and will do so with the prescribed timeframe.

In addition, an annual governance review is conducted by the Governance and Nominations Committee and each Board committee completes a mid-year review against its agreed annual objectives and, at year end, presents an annual report to the Board on the business conducted.

The Board also reflected on the recommendations following external governance reviews, including a review of Risk Management. The Trust is implementing the recommendations identified.

Individual Board members are appraised annually and mid-year reviews are conducted.

Declaration of interests and Non-Executive Director Independence

The Board of Directors is satisfied that the Non-Executive Directors, who serve on the Board for the period under review, are independent, with each Non-Executive Director self-declaring against a 'test of independence'.

The Board of Directors are also satisfied that there are no relationships of circumstances likely to affect independence and all Board members are required to update their declarations in relation to their interests held in accordance with public interest, openness and transparency.

Name	Interest registered
Dr Alistair Stokes Chairman	No interests to declare
Jon Pittam Non-executive director	No interests to declare
Mick Tutt Non-executive director	• Specialist Advisor /Bank Inspector – Care Quality Commission • Pelican Consulting - sole trader offering management advice and support to health and social care organisations
Francis Davis Non-executive director	• Employed by University of Birmingham and St Mary's University , Twickenham • Working with Minister of State at Department for Work and Pensions for Disabilities to enhance and develop the disability and enterprise policy. No financial interest or political affiliations (ending 31st March 2018) • Advisor to CIPFA Directorships • Vivo Care Choices (ended September 2017) • Holocaust memorial Day Trust • Near Neighbours • Power 2 Inspire • St Ethelburga's Centre (ended September 2017) • Aequus International • Chair of Metro Mayor of West Midlands Community Cohesion Process and Conference (1st September to 30th November) • Trustee Cathedral Innovation Centre
Stephanie Elsy	Directorships • Stephanie Elsy Associates Ltd • Emsworth Forum Ltd • Community Development Finance Associate Ltd Ownership of business • Stephanie Elsy Associates Ltd
Mike Watts Non-executive director	• Director: Capability & Performance Improvement Ltd • Project work for various external clients
Sue Harriman Chief Executive Officer	Gifts and hospitality – Women in Leadership lunch at the House of Lords 15th March 2018
Helen Ives Chief People Officer	No interests to declare
Andrew Strevens Director of Finance and Performance	No interests to declare

Name	Interest registered
Dan Meron Chief Medical Officer	• University Hospitals Southampton NHS Foundation Trust (UHSFT) – Honorary Deputy Medical Director • Southern Health NHS Foundation Trust (SHFT) – Honorary Consultant Psychiatrist • University of Southampton – Honorary Senior Clinical Lecturer at School of Medicine • Care Quality Commission (CQC) – Secondment for occasional CQC inspections • Pinstriped Sandals Consulting Ltd – sole Director. Offering training, research and consultancy services • Member Royal College of Psychiatrists • All non NHS activities conducted outside of NHS contracted time • No shares or direct financial interest in any pharmaceutical company
Jackie Ardley Chief Nurse	• 0.2 WTE Dartford, Gravesham, Swanley and Swale CCG
Sarah Austin Chief Operating Officer - Portsmouth &Commercial Director	• Close family friend works for Capsticks • Close friend works for CGI • Close friend is owner of ExForcesNet and I am co-author of Forces4Change Charter
David Noyes Chief Operating Officer – Southampton	• Vice Chair of Southampton Connect • Trustee of Southampton Healthy Living
Members that have left in year	
Jane Sansome Non-executive director	• Director of Sansome & Co Ltd • Interim Managing Director of MYFM Limited.

Information Governance

Incidents concerning personal data are formally reported to the Information Commissioners Office, in accordance with Information Governance requirements. Further information can be found within the Annual Governance Statement, pg [n].

Statement of Accountable Officers Responsibilities

The Statement of Accountable Officers Responsibilities is located on pg [n].

The Board's committees

The Board has established the following committees:

Statutory committees

- Audit and Risk Committee
- Governance and Nominations Committee
- Remuneration Committee
- Charitable Funds Committee

Designated committees

- Assurance Committee
- Finance Committee
- Mental Health Act (MHA) Scrutiny Committee
- People and OD Committee

Composition of Board committees at 31 March 2018

Director	Position	Board	Finance Committee	Remuneration Committee	Assurance Committee	MHA Scrutiny Committee	Governance & Nominations Committee	Audit and Risk Committee	Charitable Funds Committee	People and OD Committee
Alistair Stokes	Chairman	Chair	-	Member	invited	Member	Chair	-	-	-
Mick Tutt	Deputy Chair/ Non-Executive Director	Member	-	Member	Chair	Chair	Member	-	Member	-
Jon Pittam	Senior Ind. Director / Non-Executive Director	Member	(to attend when available)	Member	Member	Member	Member	Chair	-	-
Francis Davis	Non-Executive Director	Member	Chair	Member	Member	Member	-	-	Chair	-
Mike Watts	Non-Executive Director	Member	Member	Chair	Member	Invited	-	Member	-	Chair
Stephanie Elsy *Started Sept 2017*	Non-Executive Director	Member	Member	Member	(invited initial 6 months)	invited	-	Member	-	Member
Sue Harriman	Chief Executive	Member	Member	Member			Member	Invited	-	-
Andrew Strevens	Deputy CEO & Director of Finance and	Member	Member			-	-	Member	-	-
Dan Meron	Chief Medical Officer	Member	-	-	Member	Member	-	Invited	-	-
Jackie Ardley *Started Dec 2017*	Interim Chief Nurse	Member	-	-	Member	Member	-	Invited	-	-
Helen Ives *Started April 2017*	Chief People Officer	Member	-	-		-	-	-	-	Member
David Noyes *Started July 2017*	COO Southampton & County Wide	Non – voting member	-	-	Member	Member	-	-	Member	-
Sarah Austin	COO Portsmouth & Commercial Director	Non – voting member	-	-	Member	Member	-	-	-	-
Members that left this year										
Jane Sansome *Left May 2017*	Non-Executive Director	Member	Previous chair	Previous chair	-	-	-	Member	-	-
Mandy Rayani *Left June 2017*	Chief Nurse	Member		-	Member	Member	-		-	-
Lesley Munro *From June 2017 – November 2017*	Interim Chief Nurse	Member		-	Member	Member	-	-	-	-

Membership of Board committees at 31 March 2018

Director	Position	Board (6 meetings)	Finance Committee (12 meetings)	Remuneration Committee (4 meetings)	Assurance Committee (10 meetings)	MHA Scrutiny Committee (4 meetings)	Governance & Nominations Committee (2 meetings)	Audit and Risk Committee (4 meetings)	Charitable Funds Committee (4 meetings)	People and OD Committee (3 meetings)
Alistair Stokes	Chairman	5/6	3/12	3/4	5/10	2/4	1/2	-	-	-
Mick Tutt	Deputy Chair/ Non-Executive Director	6/6	4/12	4/4	10/10	4/4	2/2	-	4/4	-
Jon Pittam	Senior Ind. Director / Non-Executive Director	6/6	2/12	2/4	8/10	3/4	2/2	4/4	-	-
Francis Davis	Non-Executive Director	5/6	11/12	4/4	8/10	1/4	-	-	4/4	1
Mike Watts	Non-Executive Director	6/6	11/12	4/4	8/10	-	-	4/4	-	3/3
Stephanie Elsy *Started Sept 2017*	Non-Executive Director	3/4	3/7	1/1	2/6	-	-	2/2	0/2	0/3
Sue Harriman	Chief Executive	6/6	8/12	2/4	7/10	1/4	2/2	4/4	-	-
Andrew Strevens	Deputy CEO & Director of Finance and	6/6	12/12	2	1	-	-	4/4	-	-
Dan Meron	Chief Medical Officer	6/6	1	-	7/10	3/4	-	-	-	-
Jackie Ardley *Started Dec 2017*	Interim Chief Nurse	2/2	-	-	2/3	0/1	-	1/1	-	1
Helen Ives *Started April 2017*	Chief People Officer	6/6	-	3	2/9	-	-	-	-	3/3
David Noyes *Started July 2017*	COO Southampton & County Wide	3/5	7/9	-	7/7	2/3	-	-	3/3	-
Sarah Austin	COO Portsmouth & Commercial Director	4/6	4/12	-	7/10	0/4	-	-	-	-
Members that left this year										
Jane Sansome *Left May 2017*	Non-Executive Director	1/1	2/2	2/2	-	-	-	1/1	-	-
Mandy Rayani *Left June 2017*	Chief Nurse	1/1	-	-	2/2	0/1	-	1/1	-	-
Lesley Munro *From June 2017 – November 2017*	Interim Chief Nurse	3/4	-	-	6/7	2/3	-	-	1/1	-

Key – blue figures indicate where Board member attended as an invitee, rather than being a member of the Committee.

Audit and Risk Committee

Frequency of meeting: At least quarterly (plus private meeting with External Auditor). During 2017/18 the committee met four times and separately in private.

The purpose of the Audit & Risk Committee is to provide one of the key means by which the Board of Directors ensures that effective internal control arrangements are in place. The Committee operates in accordance with Terms of Reference set by the Board, which are consistent with the NHS Audit Committee Handbook. All issues and minutes of these meetings are reported to the Board. In order to carry out its duties, Committee meetings are attended by the Chief Executive, the Director of Finance and Performance and representatives from Internal Audit, External Audit and Counter Fraud on invitation. The Committee directs and receives reports from these representatives, and seeks assurances from trust officers. The Committee's duties can be categorised as follows:

- Governance, Risk Management and Internal Control
- Internal Audit
- External Audit
- Other Assurance Functions – including Counter Fraud
- Financial Reporting

In year the Committee has received progress reports against recommendations identified by Internal and External Auditors, committee specific health sector updates, and received updates on financial governance processes, including single tenders, losses and special payments, whistleblowing, as well as receiving briefings on clinical audit and counter fraud investigations.

[*any*] significant issues in relation to the financial statements of 2017/18, operations or compliance were raised by the Audit and Risk Committee during the year. AUDIT COMMITTEE TO CONFIRM AT MAY 2018 MEETING

Audit and Risk Committee composition and attendance 2017/18 is previously summarised.

Details of other committees of the Board are described in the Annual Governance Statement, page [n].

Internal audit

Our Internal Auditors during 2017/18 were PricewaterhouseCoopers LLP, PwC.

Internal Audit provides an independent assurance with regards to the Trust's systems of internal control to the Board. The Audit and Risk Committee considers and approves the internal audit plan and receives regular reports on progress against the plan, as well as the Head of Internal Audit Opinion which provides an opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The Committee also receives and considers internal audit reports on specific areas, the opinions of which are summarised in the Annual Governance Statement, page[n].

The cost of the internal audit provision for 2017/18 was £57,300 (excluding VAT).

As a result of a tendering exercise PwC were reappointed as our internal auditors from 1st April 2018.

External audit

Our External Auditors are Ernst & Young LLP (appointed from August 2012 following the transfer of audit function from the Audit Commission to private organisations). The main responsibility of External Audit is to plan and carry out an audit that meets the requirements of The Code of Audit Practice and the NHS Manual for Accounts.
External Audit is required to review and report on:

- Our financial statements (our accounts)
- Whether the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

The Audit and Risk Committee reviews the external audit annual audit plan at the start of the financial year and receives regular updates on progress. The Committee also receives an Annual Audit Letter.
The cost of the external audit for 2017/18 was £63k (including VAT).

Our external auditors did not conduct any non-audit services in year.

As a result of a tendering exercise Ernst & Young LLP were reappointed as our external auditors from 1st April 2018.

Disclosure of information to auditors

Please refer to the statement of directors responsibilities in respect of the accounts pg [n]

Countering fraud and corruption

A Local Counter Fraud Specialist (LCFS) is provided by Hampshire and Isle of Wight Fraud and Security Management Service. The role of the LCFS is to assist in creating an anti-fraud, corruption and bribery culture within the Trust; to deter, prevent and detect fraud, to investigate suspicions that arise, to seek to apply appropriate sanctions; and to seek redress in respect of monies obtained through fraud. The Audit and Risk Committee receives regular progress reports from the LCFS during the course of the year and also receives an annual report. Our Counter Fraud provision has received an overall rating of Green (the highest possible rating) from NHS Counter Fraud Authority.
We have implemented agreed policies and procedures, such as the Fraud, Corruption and Anti-bribery Policy as well as a Freedom to Speak Up Policy and issues of concern are referred to the LCFS for investigation. We also ensure that there are various routes through which staff can raise any concerns or suspicions.

Remuneration

Full details of remuneration are given in the remuneration report on page [n].

Members Council

Elections to our inaugural Council of Governors were announced in August 2013. However, further to the announcement to step off the Foundation Trust pipeline back in December 2015, the Governors and Board previously took the opportunity to review their Terms of Reference. Under the revised Terms of Reference agreed in 2016 the name of the Council was amended to reflect the strengthening engagement with the membership to 'Members Council'.

The responsibilities of the Members Council and Governors as previously agreed were to:

- act as a critical friend and advisor, representing the interests of the organisation, staff, members and wider public
- support the Board in the development of the organisation's strategic plans (including the Annual Plan) seeking assurance and continued transparency on its delivery and implementation
- play a role in promoting integrated and partnership working and in assessing its effects
- provide third party expertise and advice, on invitation from Officers of the Trust
- be an advocate for the Trust providing support and bringing to the attention of the Trust any matters of broad concern (not individual cases) raised by constituent members in relation to standards of care, safety, performance, value for money or any matter contrary to the Trust's values and in the spirit of the 'See something, say something' campaign.
- work with the Board to establish a process for handling issues such as; the removal of Council members, dealing with disputes, tenure and other 'constitutional' matters

In addition, Governors have previously been invited to participate in the Board level appointments process and observe a number of Board Committees.

The original Council comprised 14 publicly elected governors and five staff elected governors representing the constituencies of Portsmouth, Southampton and Hampshire, as well as six appointed governors from partner organisations.

The future

During the last year, in light of the council vacancies, the changing external context including the Sustainability and Transformation Partnerships and developing Integrated Care Systems we embarked on a journey, in collaboration with our governors, to further reconsider their role, the Members Council, as well as that of our wider membership. These considerations have been incorporated into the development of our emerging wider Community Engagement Framework, which will be finalised during Quarter 2 of 2018/19.

Composition of Members Council

Constituency		Name	Council Attendance 10th March 2017	Council Attendance 19th October 2017	Declarations of Interest
Staff	Southampton	Debra O'Brien	✓	X	• Nil
		Sarah Oborne	X	X	• Member of St John Ambulance
	Portsmouth	Jenny Ford	X	X	• Branch Secretary of Unison Portsmouth Health Branch
		Vacancy			
	Hampshire	Vacancy			
Public	Southampton	Clive Clifford	✓	X	• Nil
		Jon Clark	✓	X	• Wife works for Faculty of Medicine at the University of Southampton
		Vacancy			
		Vacancy			
		Vacancy			
	Portsmouth	Narcisse Kamga	✓	X	• The Sickle Cell Society • MENCAP
		Michael North	✓	✓	• Chair of a Patients Participation Group – Drayton, Portsmouth • Chair of a Patients Participation Group – Wootton Street Surgery, Cosham
		Sharon Ward	X	X	• Nil
		David Stephen Butler	✓	✓	• Portsmouth Royal Dockyard Historical Trust
		Vacancy			
	Hampshire	Sharon Collins	✓	X	• Director – Collins Corporate Solution Ltd • Director – Shared Ventures Ltd and facilitator of Solent Region Collaboration Hub – enabling conversations and collaboration opportunities across health, housing and social care across Hampshire, Portsmouth, Southampton and Isle of Wight • Volunteer on the Committee of Hampshire Hornets Wheelchair Basketball (a fully constituted, not-for-profit accessible basketball club with charitable aims)
		Harry Hellier	✓	X	• Nil
		Robert Blackman	✓	✓	• Nil
		Vacancy			
Nominated Governors	Portsmouth City Council	David Williams	X	X	• Board member of Portsmouth CCG • Director of University Technical College Portsmouth (UTC Portsmouth)
	Southampton City Council	Cllr. Warwick Payne	✓	✓	• Labour Party membership
	Hampshire County Council	Cllr. Peter Latham	X	X	• Member of Conservative Party
	NHS Southampton City CCG	Beccy Willis	X	X	• Partner works for Southampton City Clinical Commissioning Group and is involved in the Solent contract
	University of Southampton *	Vacancy			
	NHS Portsmouth City CCG	Vacancy			

**(rotational seat with University of Portsmouth)*

You can read how we engaged with our membership during the last year on page [n].

Governance Statement

Annual Governance Statement 2017/18

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *Accountable Officer Memorandum.*

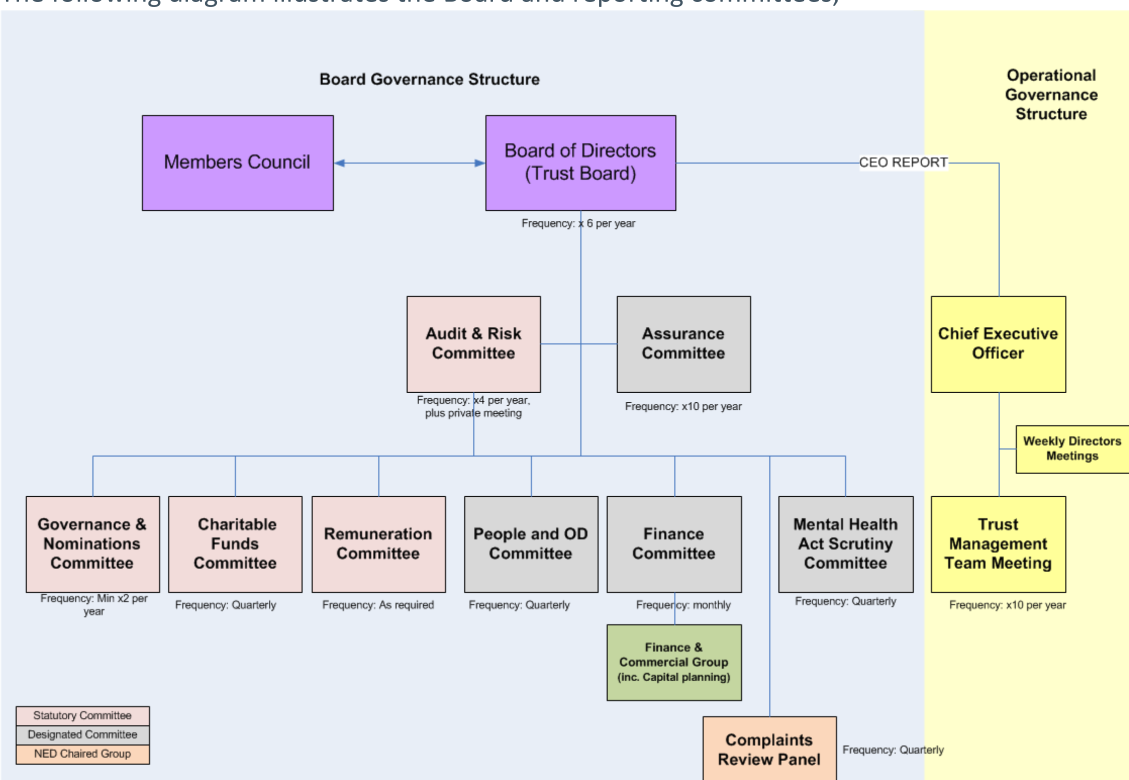
The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Solent NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Solent NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

The Governance Framework of the Organisation

The role of the Board and its duties are explained on page [n] of the Annual Report.
The individuals who serve on the Board and changes to appointments can be found on pg [n] of the Annual Report.

The following diagram illustrates the Board and reporting committees;



A summary of the role of the Audit & Risk Committee is found on page [n] of the Annual Report and internal audit opinions for the audits carried out in year are as follows:

Audit title	Opinion
Key financial systems	Low risk – Fixed Assets
	Low risk – Capital Expenditure
	Low risk – Cash
	Low risk – Budget Control
General Data Protection Regulations	Medium Risk
Information Governance Toolkit	Medium risk
Clinical Data Quality	Low risk
Clinical Supervision	High Risk[5]
Review of the Assurance Committee	Medium Risk

Significant progress has been made in respect of responding to recommendations made by our internal auditors, as reflected within their Head of Internal Audit Opinion. In particular in response to the Clinical Supervision audit we have reviewed our policy, which will be implemented in Q1 2018/19, and have enhanced our processes.

Governance and Nominations Committee

Frequency of meeting: At least twice a year and as required. During 2017-18 the Committee met 2 times.

The Committee's main purpose is to lead in the identification and recommendation of candidates to executive vacancies to the Trust Board. The Committee also considers and keeps under review governance arrangements for the Trust including Fit and Proper Person processes, Committee Structure and Committee Terms of Reference and to make proposals to Trust Board as appropriate. The Committee also approves recommendations regarding Associate Hospital Manager appointments and renewals of tenure.

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

The Committee is responsible for assessing the size, structure and skill requirements of the Board, and for considering any changes necessary or new appointments. If a need is identified, the Committee will consider if external recruitment consultants are required to assist in the process and instruct the selected agency, shortlist and interview candidates. If the vacancy is for a non-executive director the recruitment process is handled by NHS Improvement. The Chairman, Non-Executive Directors and the Chief Executive (except in the case of the appointment of a new chief executive) are responsible for deciding the appointment of executive directors. The Chairman and the Non-Executive Directors are responsible for the appointment and removal of the Chief Executive. All new appointees received an appropriate induction.

Remuneration Committee

Frequency of meeting: At least annually and as required. During 2017-18 the Committee met 4 times.
The Remuneration Committee is comprised of the Non-Executive Directors (and others by invitation). The Committee reports to Confidential Board meetings regarding recommendations and the basis for its decisions. The Committee makes decisions on behalf of the Board about appropriate remuneration (including consideration of performance related pay and to ratify decisions of the Clinical Excellence Awards Panel), allowances and terms of service for the Chief Executive and other Executive Directors.

Charitable Funds Committee

Frequency of meeting: Quarterly (or as required). During 2017-18 the Committee met 4 times.
The Corporate Trustee (Solent NHS Trust), through its Board, has delegated day to day management of the charity (Solent NHS Charity) to the Committee. The Committee ensures that funds are spent in accordance with the original intention of the donor (where specified), oversees and reviews the strategic and operational management of the Charitable Trust Fund as well as ensuring legislative requirements in accordance with the Charity Commission are met. The Committee is also responsible for developing and managing policies and procedures in relation to the management of Charitable Funds, monitoring the investment portfolio and the development of the fundraising strategy.

Assurance Committee

Frequency of meeting: Ten times a year. During 2017-18 the Committee met 10 times.
The Committee is responsible for providing the Trust Board with assurance on all aspects of quality of care. This includes quality governance systems, ensuring regulatory standards of quality and safety are met and that risk across the organisation is mitigated. In particular the Committee provides assurance to the Board regarding:

- Regulatory compliance (including CQC requirements and Safeguarding) and the provision of services in accordance with statute, best practice and guidance
- High standards of healthcare governance and high quality service provision.
- Risk – ensuring that risks are identified, prioritised and appropriately managed.
- A culture of continuous improvement across the Trust exists and learning is shared and embedded

The Committee also seeks assurance that the development of all clinical governance activities within the service lines improve the quality of care throughout the Trust. A programme of annual assurance reporting and deep dives are scheduled annually. Deep dives conducted in year included oversight of CQC actions, Medicine Management (which reports by exception to the QIR Group and Assurance Committee), Health and Safety, Research and Development and Safeguarding.

Finance Committee

Frequency of meeting: Monthly. During 2017-18 the Committee met 12 times.
The Finance Committee is responsible for ensuring appropriate financial frameworks are in place to drive the financial strategy, and provide assurance to the Board on financial matters as directed. The Committee focuses on the following areas; strategic financial planning, business planning processes, annual budget setting and monitoring, treasury management and financial control, business management as well as conducting in depth reviews of aspects of financial performance as directed by the Board. The Finance Committee has been integral to the Board in providing scrutiny and oversight concerning the delivery of the financial plan.

Mental Health Act Scrutiny Committee (MHAS Committee)

Frequency of meeting: Quarterly. During 2017-18 the Committee met 4 times.
The central purpose of the Committee is to oversee the implementation of the Mental Health Act (MHA) 1983 functions within the Trust principally within Adult and Older Persons Mental Health, and Learning Disabilities services. The Committee has primary responsibility for seeing that the requirements of the Act are followed. In particular, to seek assurance that service users are detained only as the Mental Health Act 1983 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, on an annual basis the Trust's external legal advisors provide update training in relation to the Mental Health Act. The Committee also seeks assurance on the appropriate application for Deprivation of Liberties Safeguards (DoLS) as well as seeking assurance regarding adequacy of training and development opportunities provided for front-line practitioners and of the monitoring of competence regarding the application of the MHA and DoLS.

People and Organisational Development Committee

Frequency of meeting: Quarterly unless the Chair of the Committee decides it necessary to alter the frequency of the meeting based on the volume or complexity of business that the Committee is asked to consider. During 2017-18 the Committee met 3 times.
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.

Attendance records at the Board and its committees are included within the Annual Report pg [n].

Highlights of Board Committee Reports

The Board has an agreed annual cycle of business and receives exception reports via the relevant Chair in relation to recent meetings of its committees. The Board, as a standing item at each meeting, also considers whether additional assurance is sought from its committees on any items of concern. The Chief Executive Report to Board includes commentary on significant changes recorded in the Board Assurance Framework and Corporate Risk Register. Progress on corporate and strategic objectives is reported quarterly within the performance report. In addition, a number of internal audits were completed, as described on page [n] and annually each Board Committee presents an annual report to the Board detailing a summary of business transacted and achievements against the agreed Committee objectives. The Committee annual reports will be available via the Trust website.

Performance Evaluation of Board

Details can be found within the Annual Report of the processes undertaken in year in relation to Board Effectiveness, pg [n].

Capacity to Handle Risk

Risk management and quality governance arrangements, accountability and leadership

As Chief Executive, I am ultimately accountable for governance and risks relating to the operational delivery of all clinical and non-clinical services provided by the Trust including its subcontracts. The Board sets the Trust's risk appetite and is briefed through the CEO report on all significant risks.
The Trust has a range of arrangements in place which provide monitoring and assurance on matters relating to quality, safety and regulatory matters. Each service line has an identified lead for quality safety and assurance who is responsible for supporting the service line Clinical Director in the delivery of the quality, safety and governance agenda. The service line Professional Leads for Quality Safety and Assurance also liaise with the Trust Quality Risk and Professional Standards team to support cross organisational work streams and learning arising from incidents. Each Service Line has a governance structure in place which reports through to the Quality Improvement & Risk Group and the Assurance Committee.

Key roles in relation to risk management and quality governance include;

- Chief Nurse - nominated Executive Lead Director for risk management, quality governance and health and safety compliance
- Chief Medical Officer - Lead director with responsibility for Learning from Deaths (mortality) agenda (Patient Safety Director as defined by national guidance on learning from deaths, National Quality Board 2017)
- Director of Finance and Performance – nominated Executive Lead Director for health and safety compliance
- The Head of Patient Safety working with the Clinical Risk Manager is responsible for ensuring the development and oversight of implementation of the Trust Risk Management Framework, risk procedures and administration of the Corporate Risk Register
- Clinical Directors - accountable for risk and clinical governance within their respective service lines, supported by the Operational Directors and Professional Leads for Quality Safety and Assurance .
- Operational Directors and Heads of Service – responsible for managing operational risks originating within their service areas.
- Executive oversight, via the Chief Operating Officer for Southampton and County Services, ensuring emergency planning and disaster recovery plans are established and regularly tested.

Specific Trust wide arrangements are in place which support robust assurance include:

- Care Group Meetings , chaired by Chief Operating Officers, general performance of quality and other operational issues
- Service Line Clinical Governance Groups, chaired by the Clinical Director - responsible for the oversight of quality and risks, triangulating performance information to monitor and address service quality. The groups provide exception reporting to the Quality Improvement and Risk Group which is chaired by the Chief Nurse and these are then scrutinised at the Assurance Committee. The service line structure provides high levels of autonomy increasing the effectiveness and accountability of the clinical services.
- Trust Management Team - oversees operational responses to risks contained in the Corporate Risk Register. The roles of the Assurance Committee and Audit and Risk Committee are described previously.

- Contract, Quality & Risk Management Meeting (CQRM) monthly meetings with commissioners
- Care Group and corproate team monthly Performance Reviews Meetings (PRM) are held to seek assurance regarding the management of operational risk. In addition, we monitor quality indicators through service line performance sub-committee meetings.
- Each service line has a documented local Annual Governance Statement which outlines the internal control and risk management processes under the leadership of each Clinical Director, and underpins the Trust wide Annual Governance Statement with regard to the internal control and clinical governance processes within our clinical services.
- Serious Incident requiring investigation (SI) process including Root Cause Analysis (RCA) investigation and SIRI panel arrangement
- Learning from Deaths process for unexpected deaths (mortality reviews)
- An audit programme (Trust wide and service level covering standards and topic specific issues)
- Board to Floor visits (includes executives, non-executives and governors) to engage with frontline staff and service users
- Service review visits by commissioners
- Announced and unannounced visits to clinical areas/teams by the Quality Risk & Professional Standards Team
- Patient and service user feedback (Friends and Family Test and other local mechanisms)
- Patient-Led Assessments of the care environments
- Patient and carer stories to Board
- Monthly reporting and publication of safe staffing status (with sign off by matrons and oversight by the Quality Risk and Professional Standards Team)
- The Board is apprised of any key quality and safety matters at the beginning of each Board meeting
- Our Quality Account is produced annually which outlines the progress made and action taken to improve and maintain quality and safety within and across Trust services. The Annual Quality Account is developed in consultation with key stakeholders and serves as an additional validation mechanism for determining the quality of services. More information on the Quality Account is provided on page[n] (of the Annual Report).
- Our Patient Experience Strategy was approved following consultation with a wide range of service users and partner agencies. The Trust Patient Experience forum continues to meet quarterly and oversees the delivery and implementation of the strategy.
- We also have an established processes to formally assess Cost Improvement Plans (CIPs) and other transformation schemes through a Quality Impact Assessment (QIA) process. Within the QIA process, foreseeable or potential risks which could impact on quality are considered and key leading indicators are identified to help highlight the realisation of any actual risks. A gateway approach to the agreement of CIPs and QIAs has been embedded with sign-off by the applicable service line Clinical and Operational Directors in consultation with services prior to review by the Chief Medical Officer and Chief Nurse. The Service Line Clinical Governance Groups are responsible for the management and monitoring of the leading indicators identified within signed off QIAs and for ensuring that in collaboration with the Chief Medical Officer and Chief Nurse, risks associated with QIAs are escalated to the Assurance Committee.

Risk Management Training

We provide a range of risk management training including;

- At Corporate Induction – where an introduction to risk management, Serious Incidents (SI) and Duty of Candour is provided.
- Risk management refresher training will be provided every two years to all staff from 1 April 2018. The training includes; risk management principles, escalation processes, accountability, risk assessment and hazard identification.

- Risk Register training – for all staff who have responsibility in using the Trust's on line risk register
- A two day training package for SI Investigators - provided in collaboration with neighbouring organisations. This training provides in depth training on root cause analysis, identification of hazards and the SI process.
- Formal Incident reporting and reviewers training, as well as;
- Bespoke training provided by the Quality and Risk Team.

Risk Assurance

The Board Assurance Framework (BAF) provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been identified and where gaps exist, that appropriate mitigating actions are in place to reduce the risk to a tolerable level. The Audit and Risk Committee tests the effectiveness of this system annually.

The Risk and Control Framework

I am assured that risk management processes are continuing to be increasingly embedded within the Trust and incident reporting is openly and actively encouraged to ensure a culture of continuous improvement and learning. I am also assured that there are appropriate deterrents in place concerning fraud and corruption. The organisation understands that successful risk management requires participation, commitment and collaboration from all staff. A new Risk Management Framework has been developed in 2018 to replace the former Risk Management Strategy and provides a clear overarching framework for the management of internal and external risk and describes the accountability arrangements, processes and the Trust's risk tolerance. The Framework is underpinned by a new step by step guide to the Risk Management Process for frontline staff, and revised induction and refresher training for all new and existing staff.

The Trust's approach to risk management encompasses the breadth of the organisation by considering financial, organisational, reputational and project risks, both clinical and non-clinical. This is achieved through:

- an appropriate framework; delegating authority, seeking competent advice and assurance
- a risk culture which includes an agreed risk appetie, as outlined within the framework
- the integration of risk management into all strategic and operational activities
- the identification and analysis, active management, monitoring and reporting of risk across the Trust
- the appropriate and timely escalation of risks
- an environment of continuous learning from risks, complaints and incidents in a fair blame/non-punitive culture underpinned by open communication
- consistent compliance with relevant standards, targets and best practice
- business continuity plans and recovery plans that are established and regularly tested; and
- fraud deterrence including the proactive work conducted by the Local Counter Fraud Service, policies on fraud, corruption and anti-bribery , debt recovery and the threat of prosecution. Fraud deterrence is integral to the management of risk across the organisation especially as there could be clinical or health and safety implications which could then impact upon the organisation. Staff are encouraged to report any potential fraud using the online incident reporting process appropriately including anonymous reporting if necessary. We are not aware of any specific areas within the organisation that are at risk of material fraud, however we cannot be complacent. One incident of fraud with an immaterial financial impact was handled during the year. Notifications from the Counter Fraud team improve our knowledge and awareness of the risk of fraud.

Equality impact assessments are carried out to assess the impact of the Trust's decisions and design of services as part of the Trust's legal duty under the Equality Act 2010 – we also use assessments in the development of policies

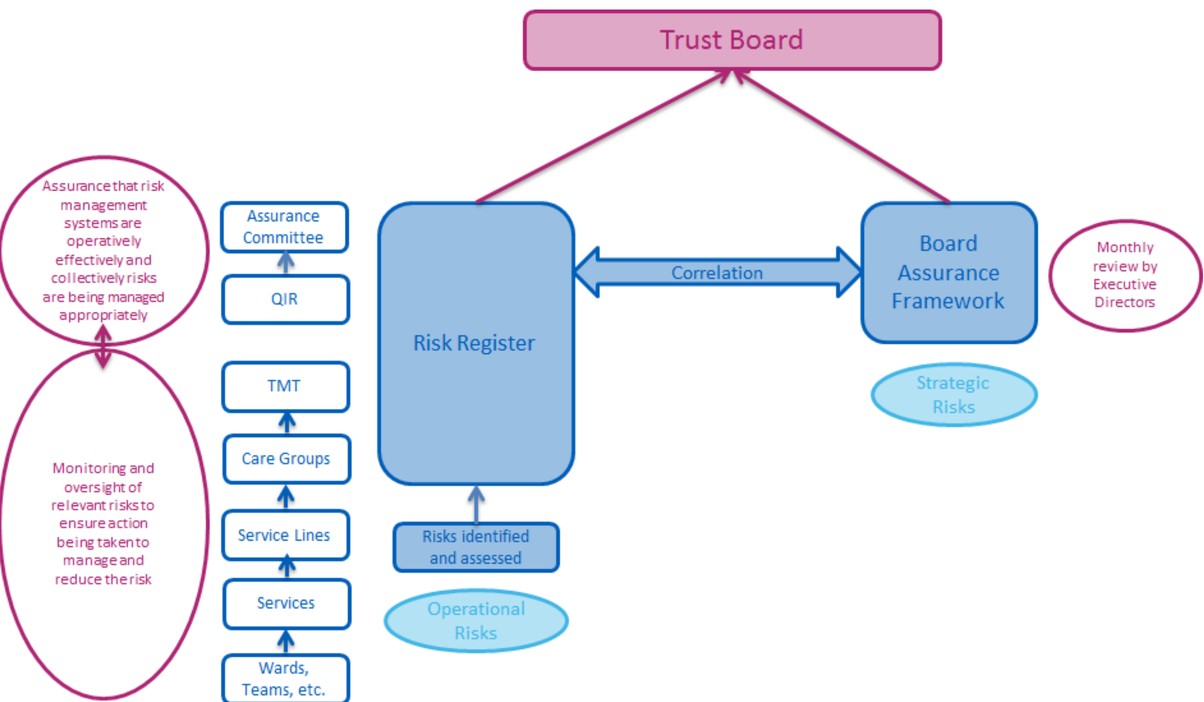
and in consideration of cost improvement plans.

Risk Assessment Process

The organisation has structured risk assessment and management processes in place as set out in the Risk Management Framework. This also includes having trained, service-based risk assessors in place to undertake assessment to support local management. Managers are responsible for managing action planning against identified risks and for escalating those risks with additional resource implications via service risk registers. The Risk Management Team receives and centrally records risk assessments to identify commonalities for organisational risk treatment and escalation.

Risk registers operate at service line level for all identified risks. Risks assessed as scoring 12[6] or above have increased oversight and monitoring by formal committees including the Trust Management Team for all risks scoring 15 or greater. This is in accordance with the risk appetite, agreed by Board and set out in the Risk Management Framework.

The below diagram illustrates the assessment, reporting and oversight process:



Risk identification and measurement

Risk identification establishes the organisation's exposure to risk and uncertainty. The processes used by the Trust include, but is not limited to; risk assessments, adverse event reports including trends and data analysis, Serious Incidents requiring investigation (SI), learning from deaths, claims and complaints data, business decision making and project planning, strategy and policy development analysis, external/internal audit findings /recommendations and whistle blowing in accordance with the Trusts Freedom to Speak Up policy.

The online Risk Register is now fully embedded and has provided the ability for real time reporting and escalation; it also aligns existing systems used for incident, complaints and claims reporting. In turn this has enabled the Quality &

[6] Risks are scored against the NHS National Patient Safety Agency risk matrix, which scores risks on a scale of consequence 1-5 (with a score of 5 being catastrophic) and a scale of likelihood 1-5 (with a score of 5 being almost certain)

Risk Team (and service managers) to provide swift response and support to services. The use of the online system supports the triangulation of data from incidents, claims and complaints for further analysis and assurance.

The Trust uses the National Patient Safety Agency likelihood and severity matrix to assign a risk score and we recognise that in all cases it is vital to set the risk into context for evaluation. Risks which fall outside of the remit of routine clinical assessment or are potentially significant for the organisation are approached and managed in line with the Risk Management Framework. The Trust is aware and encourages a proactive safety culture, good communication and teamwork, all of which are inherent in the improvement of risk and the implementation of good clinical risk assessments. To ensure clinical risk assessments are appropriate they are always reviewed as part of all serious or high risk investigations so that lessons can be learnt and assessments improved if necessary.
The positive risk management culture and risk management processes have enabled the Trust to proactively identify, assess, treat and monitor significant risks in year.

Strategic Risks

The organisations strategic risks (scoring 12 or over), at the end of the current financial year and as detailed within the Board Assurance Framework relate to:

- Workforce Capacity – as described within the operational context. In addition work continues to develop alternative career and learning pathways to support news models of care.

- Quality Governance and quality improvement – the Trust continues to implement action plans to address issues raised as a consequence of the comprehensive CQC inspection and subsequent inspections , and further embed the Solent Quality Improvement Programme.

- Future organisational function – clarification on structure, leadership and multi-agency accountability will be required as the organisation responds to the Sustainability & Transformation Partnership (STP) plans, local delivery systems and associated work streams as a consequence of the rapidly changing external environment.

As these are strategic risks they have longevity and will pose as risks to the Trust into the future – we are actively mitigating these to an agreed tolerable level and, as with operational risks, ensure that any learning is disseminated to reduce the chance of reoccurance .

There is clear alignment between the Board Assurance Framework and operational risks.

Operational Risks

The highest operational risks in year are identified below, however, each are being managed by the Executive Lead to reduce the risk to an acceptable level:

- Workforce Sustainability - there is a risk that we are unable to recruit and / or retain sufficient numbers of clinical staff with the skills and experience required. Particular pressures in our Adult Mental Health, Adults Services Southampton and Children's services have existed throughout the year which pose a risk to service delivery and the quality of patient care. We remain committed to ensuring that staffing levels are appropriate to meet the identified needs of patient/service users. Nursing and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for our service users. Where we have staff shortages we are developing solutions including providing additional training to new and existing cohorts of staff, for example including the introduction of Associate Nurse Practioner roles within our Mental Health Services. In accordance with national requirements we monitor the appropriateness of nursing staffing levels and skill mix to ensure we provide safe and effective care that reflects the acuity and dependency needs of individual patient groups. However, we recognise that safe staffing must also acknowledge the contribution of other disciplines and professions within the overall staffing establishment to ensure that clinical teams deliver safe, effective and high quality care in an increasingly complex environment.
- Telephony – we currently operate out of a number of locations where we do not manage the IT for the site but where staff report telephony issues which could impact on clinical care. This is being actively addressed by IT services with the premise owner so that faults can be effectively reported howeverservice business continuity arrangements are in place should the risk materialise.
- Estates – we are aware that some of our services are operating out of sub optimal sites impacting on service provision. Services have implemented mitigation plans and our estates team continue to actively seek alternative sites.

We will continue to monitor and mitigate all significant risks associated with Cost Improvement Plans identified via the Quality Impact Assessment process.

Well Led

In year we have completed self –assessments against the NHSI Well Led Framework and CQC Key Lines of Enquiry and have implemented action plans to address areas where we know we can improve.
We also assess ourselves monthly against the requirements of the NHS Provider Licence to ensure compliance, in accordance with the NHSI Single Oversight Framework requirements – the details of which are incorporated into our Board Performance Report.

Information Governance Toolkit and Data Security

Data Security is a significant part of the national Information Governance (IG) Toolkit requirements as well as ensuring that at least

95% of staff have completed IG training annually, which is nationally recognised as an extremely challenging standard. We achieved Level 3 compliance with these requirements.

IG serious incidents are reported and monitored via the Toolkit and to the Information Commissioner's Officer as described below.

In March 2018 we achieved Level 3 (the highest level in compliance) in 42 out of the 45 requirements outlined in the IG Toolkit. We achieved the mandated minimum Level 2 in the remaining three requirements, and our overall compliance level is 97%. We continue to monitor all incidents and risks associated with IG matters and ensure we learn as a consequence.

Serious Incidents Requiring Investigation

A total of 78 Serious Incidents requiring investigation (SI) were raised 36 of which related to incidents concerning pressure ulcer management/care. Other SIs concerned unexpected deaths (20), slips/trips and falls (4), as well as treatment delays, surgical errors, safeguarding adults and children. As part of the SI process we actively identify learning opportunities.

We also investigated and responded to six Information Governance (IG) SIs, all of which are categorised as:

- Staff Breach – investigated through disciplinary processes
- Personally Identifiable Data sent to wrong person / address
- Security of information – changes in processes made

None of the above SIs resulted in data loss.

Our Caldicott Guardian and Senior Information Risk Officer are consulted with whenever there is an IG Serious Incident and our commissioners provide scrutiny to our SI process and confirm closure on investigations once appropriate assurance has been sought.

The Information Commissioner's Officer are also advised of every incident and have confirmed that they are happy with the immediate actions taken and have closed their investigations into all six incidents.

Care Quality Commission (CQC) Compliance

The Trust has reported full compliance with the registration requirements of the Care Quality Commission through the year and routinely receives visits and inspections from the CQC. There are no outstanding issues recorded against the Trust. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

After the comprehensive inspection of the Trust by the CQC in June 2016, the CQC re-visited a number of services that had been identified as 'Inadequate' and re-rated them. Whilst this did not affect the overall rating, all of our services are now either rated as 'Good' or 'Requires Improvement' with the Learning Disability service rated as 'Outstanding'.

There remains a small number of actions associated with the Inspection that are managed though normal governance arrangements. This feeds into the Quality Improvement & Risk Group through to the Assurance Committee. This is supplemented by Board oversight through activities such as Board to Floor visits, Quality Review

Visits, review of performance management information and Friends and Family Test feedback.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employers contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Environmental responsibilities

We reviewed the impacts of climate change for delivering our services back in 2015/16 and in response to the Sustainable Development Unit Guidance, implemented a Sustainability and Carbon Management Strategy. The strategy incorporates a Sustainable Development Management Action Plan and a Carbon Reduction Action Plan, which are reviewed at least annually to ensure they remain relevant and reflect the changing estate.

We have developed a Sustainable Development Management Plan that aligns with the NHS Standard Contract, specifically Service Contract item SC18 – Sustainable Development, this is due for submission to our Board for approval in May 2018.

This plan recognises the challenge in meeting our carbon reduction targets and sets out the measures to be taken and establishes our commitment in meeting carbon reduction obligations. A number of initiatives are already in place delivering improvements as part of our management plan, and regular monitoring against our baseline is in place to record the achieved reductions against target.

We are committed to being a leading sustainable healthcare organisation, and to carrying out our business with the minimum impact on the environment. Our Sustainable Development Management Plan (SDMP) priorities are:

- To reduce our carbon footprint by a minimum of 2% year on year, through a combination of technical measures and staff behaviour change.
- To embed sustainability considerations into our core business strategy.
- To work collaboratively with our key contractors and stakeholders to deliver a shared vision of sustainability.
- To comply with all statutory sustainability requirements and implement national strategy.

During 2017/18, across the Trust we:

- Invested over £150K in energy efficiency measures.
- Involved staff in a Green Impact campaign to raise awareness and generate environmental improvement actions.

- Reduced total waste volumes compared with 2016/17, our target for 2018/19 is to achieve zero waste to landfill.
- Improved our mixed waste recycling, our target for 2018/19 is to separate out our waste streams where possible to enable independent recycling of waste paper and cardboard.
- Introduced initiatives to make our procurement more sustainable.

Through the implementation of a new Access & Transport Policy our target for 2018/19 is to effectively monitor travel and identify actions that can be supported to encourage staff to consider alternative means of transport. This will enable us to reduce single occupancy car travel and increase cycling in conjunction with our Sustainable Travel Plan.
We are undertaking risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that our organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The following key processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers, Standing Orders and Standing Financial Instructions approved by the Board. These key governance documents include explicit arrangements for:
    - Setting and monitoring financial budgets;
    - Delegation of authority;
    - Performance management; and
    - Achieving value for money in procurement.
- A financial plan approved and monitored by the Board.
- The Trust operates a hierarchy of control, commencing at the Board and cascading downwards to budget managers in relation to budgetary control, balance sheet reconciliations, and periodic review of service level income with commissioners. In addition, the Finance Committee provides scrutiny and oversight which has been supplemented this year by independent commissioned reviews.
- Robust competitive processes used for procuring non-staff expenditure items. Above £5,000 procurement involves competitive tendering. The Trust has agreed procedures to override internal controls in relation to competitive tendering in exceptional circumstances and with prior approval obtained.
- CIPs, which are assessed for their impact on quality with local clinical ownership and accountability
- Strict controls on vacancy management and recruitment
- Devolved financial management with the continuation of service line reporting and service line management
- The Trust participated in the National Benchmarking Network's Children's & Adolescent Mental Health Services (CAMHS) project, with separate submissions for our Southampton and Portsmouth services, Corporate Services, Learning Disabilities, Intermediate Care (NAIC), Mental Health, Delayed Transfers of Care, Community Services and Pharmacy and Medicines Optimisation and Diagnostic projects. In addition, Solent NHS Trust has been part of the monthly community indicator workstream and are part of the Model Hospital application.
- The Trust Board gains assurance from the Finance Committee in respect of ensuring appropriate financial frameworks are in place to drive the financial strategy and provide assurance to the Board on financial matters as directed, including to review the impact of CIPs on forward financial planning.
- The Audit and Risk Committee also receives reports regarding losses and compensations, SFI breaches, financial adjustments and single tender waivers. The Board gains assurance from the Assurance Committee regarding the quality of services and compliance with regulatory control. The Audit & Risk Committee test the effectiveness of

these systems.

Performance Reporting

During 2017/18 the performance governance structure has continued to mature to optimise escalations of significant performance to the senior leadership team and Trust Board. The meeting structures in operation are described as follows;

- Concerning our clinical service lines: Chief Operating Officers meet with their service line senior managers on a monthly basis and review performance against quality, workforce, finance, business plans, operations, data quality and any other issues pertinent at that time. The exceptions form the agenda at a later monthly meeting chaired by the Director of Finance and Performance where these are discussed in-depth, necessary mitigations implemented, and assurance sought where appropriate.
- Concerning our non-clinical functions: Monthly Corporate Performance Subcommittees meetings review and scrutinise the performance under executive respective areas of responsibility
- A summary of all operational and corporate exceptions are then submitted through to the monthly Trust Management Team Meeting ensuring oversight.

In addition to standard performance monitoring, other significant areas of risk can be requested for review at the performance meetings, for example, progress against the CQC Action Plan, agency spend and contract performance notice remedial action plans. Similarly, the Chief Operating Officers and Director of Finance and Performance have discretion to include agenda items, where appropriate, to ensure all necessary and required items for performance assurance are considered. Specialised forums are also held periodically to provide additional scrutiny and support to managers where escalation is required on finance, quality and workforce.

We have implemented an internal data quality tool that is validating incorrectly reported waiters due to front end data entry issues. In 2017/18, the Trust reduced the number of incorrectly reported 52 week breaches by 1000s across the Trust. During 2018/19, a similar process will be implemented and monitored to validate incorrectly reported waiters between 18-52 weeks.

Our Data Quality Team works collaboratively with our services to validate data including waiting time performance indicators and continue to systemically review all service users on waiting lists to ensure they are accurate and appropriately recorded. Regular reporting and oversight is shared with services and senior management to ensure validations and outcomes are being recorded correctly.

As stated within the Annual Results Report for the year ended 31 March 2018, our external Auditors anticipate issuing an *[unqualified Value for Money opinion and an unqualified opinion concerning the Trust's financial statements].* *[To be updated when auditor opinion known]*

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to Trusts on the form and content of annual Quality Reports – we have produced our annual Quality Account in compliance with these requirements, and in doing so has consulted with key stakeholders.

The Account includes a summary of the arrangements in place to assure the Board that the reporting of quality

presents a balanced view and that appropriate controls are in place to ensure the accuracy of data.

The Trust has in place a number of systems and processes to ensure that we are focusing upon the right quality indicators and that quality reports are integral to the overall performance monitoring of the Trust. This is led by executive leadership to ensure that quality and other performance information is triangulated and presented in a balanced view.

Quality indicators are based upon a range of sources, including regulatory, national, best practice and locally agreed improvement targets. Many indicators are established internally in collaboration with clinical services to help achieve the highest possible standards of quality and care.

All quality metrics have systems to appropriately capture the information, analyse and onward reporting to the applicable stakeholders, including internally (the Board, Care Group Performance Subcommittees) or externally (for example NHS Improvement and local commissioners). Our Quality Account is available in section [n] of the Annual Report.

The Quality Improvement Strategy is currently being reviewed to reflect the refreshed value statements being developed within the organisation and work is planned for 2018/19 in supporting an enhanced focus on quality improvement linked to embedding cultural change.

Significant Issues during 2017/18

As part of its role in ensuring effective direction of the Trust, the Board continuously seeks assurances on the detection and management of significant issues. As Accountable Officer, I ensure that Board members are apprised of real or potential significant issues on a no-surprises basis, both within formal Board meetings and as required between meetings. Electronic briefings are circulated to non-executive directors to inform them of any emerging issues in between Board meetings. The Board Assurance Framework is updated to reflect significant issues and the mitigation thereof.

In year the following significant issues occurred:

- Like many NHS organisations, a number of our services experienced **staffing pressures** due to sickness, vacancies and difficulties recruiting due to national staff shortages, such as community adults and children staff and mental health nurses. This has resulted in the over reliance on agency staff and the breaching of the mandatory spending cap despite significant development in recruitment and retention approaches and a Solent managed bank. Workforce controls continue to be implemented including ensuring the vast majority of temporary staff are sourced through our in house bank, and where necessary block booking agency which has provided additional assurance in terms of the quality of temporary staff supply.

- We continued to constructively support **system working** as part of our involvement with the Sustainability and Transformation Partnerships (STP) and developing Integrated Care Systems (ICS), particularly in the support of hospital admission avoidance and discharging medically fit patients from the acute sector. However, the system is not yet in financial balance resulting in pressures in some community services - this was particularly evident during the period of the national and well publicised winter pressures.
  We also recognise that despite our increased joint working arrangements with partners we have more to do in relation to developing **robust integrated governance arrangements** across sectors and organisations. We continue to participate in the development of associated governance frameworks to ensure appropriate risk management and internal control arrangements are established relating to the Hampshire and Isle of Wight STP

and Local Delivery Systems (LDS).

- **Serious incident reporting** arrangements have been enhanced during the last year to reduce a backlog of closures - the number of serious incident investigation reports that breach the closure deadline has been actively managed with few/minimal breaches of late.

- We were unsuccessful in securing the **necessary funding** from the Department of Health for the redevelopment of the **St James Hospital and St Mary's Health** Campus in the first and second waves of funding application which delayed strategic plans associated with our estates and capital programmes. We have however been successful in the wave 3 application. The delay in securing the necessary funding has resulted in circa £1.7m annual savings not being achieved by the Portsmouth health system and the release of land for housing development being later than expected; operationally it has meant our services being delivered from sub-optimal premises.

- We continued to operate in **challenging financial times** with a deficit target of £1.5m. In year we encountered a number of financial related risks as summarised below:
    - in relation to **VAT partial exemption calculations** concerning changes due to commissioning moving from NHS organisations to local authorities; consequently we are actively working with experts and advisors and the Finance Committee and Board have been fully apprised.
    - In relation to the Hampshire & IOW STP and **related system financial pressures** including expectations to work together to reduced costs which could significantly destabilise Solent services and impact on neighbouring system partners as well as adversely affecting the quality of our service offer
    - there have been a number of contract challenges which have been inspired by the significant financial challenges faced by certain Clinical Commissioning Groups, which we have dealt with robustly.

- **Areas rated by CQC as Requires Improvement** – we continued to actively address areas rated by the CQC in their comprehensive inspection as requiring improvement. Whilst significant progress has been made, it is acknowledged that a small number of actions require complex resolution and/or assistance from partner agencies. The areas that remain being actively addressed include;
    - Statutory and mandatory compliance
    - Wheelchair provision – we are actively working with our CCG partners (as the commissioner of the service) and with the independent provider to ensure systems and processes are in place to ensure a responsive and timely service
    - The environment within our Pschiatric Intensive Care Unit
    - Spiritual support for our service users

  We continue to strive to improve services using a Quality Improvement (QI) approach which supports our continuing learning from investigations. You can read more about our QI programme within the Quality Account.

- Having invested significantly in new IT systems and hardware for our staff, and a complete transfer from a complex fragile network to a new and resilient infrastructure, national benchmarking data identified us as an outlier in relation to **IT related expenditure**. Consequently we proactively reviewed our IT programme and agreed to further explore opportunities for cost, efficiency and service improvement whilst continuing to work cooperatively with our outsourced IT provider. We were hit by the **national IT cyber-attack**, Wannacry, however our security systems proved robust resulting in minimal business and service interruption.
- **Operational Performance** was also impacted in year as summarised as follows:

- **Looked after Children out of area placements** - statutory health assessments and reviews for Looked after Children continued to breach timescales in year. Although the responsibility for the breaches is multi-organisational, it is still a concern and our Children and Families service line continue to review possible actions to help mitigate this issue.

- **Wheelchair provision delays** - we continue to see delays in the provision of wheelchairs for our patients, particularly our 0-19 service users, from the externally commissioned provider. We are actively engaged with commissioners and the wheelchair provder in seeking resolutions, moving forwards.

- **Dental General Anaesthetic Waiting Lists** - waits are still longer than desirable due to a shortage of available theatre space to undertake our procedures and we continue to work with partners to seek theatre capacity.

Demand on our services at times does create longer than acceptable waiting times in areas such as Child & Adolescent Mental Health services (CAMHs), Speech & Language Theraphy and Psychological Therapies. In all cases, we implement clinical prioritisation processes, continue to monitor this via our monthly performance review meetings and performance reports to the Board, as well as ensuring an issues of a quality nature are escalated via our Quality Improvement & Risk Group through to the Assurance Committee. We are also in constant dialogue with our commissioners via contract review meetings.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit & Risk Committee, Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The following key processes have been applied in maintaining and reviewing the effectiveness of the system of internal control:

- a review of committee governance by the Governance and Nominations Committee. The Board consider recommendations made by the committee and is ultimately responsible for approving and monitoring systems to ensure proper governance and the management of risk
- reviews of key governance documentation such as Standing Orders, SFIs, Scheme of Delegation and the Board Assurance Framework
- the oversight by the Audit & Risk Committee of the effectiveness of the Trust's systems for internal control, including the Board Assurance Framework (BAF). In discharging their duties the committee takes independent advice from the Trust's internal auditors (PwC) and external auditors (Ernst & Young). The BAF is also reviewed and challenged by the Board and updates are presented monthly via the Chief Executive's report to the Board
- the internal audit plan, which has been adapted in year to address areas of potential weakness in order that the Trust can benefit from insight and the implementation of best practice recommendations - and the findings of relevant internal audits.
- the scrutiny given to the Clinical Audit Programme by the Audit and Risk Committee

- the Trusts assessment against NHSI's Well Led Framework and associated action plan
- the scrutiny given by the Mental Health Act Scrutiny Committee in relation to the implementation of the Mental Health Act and
- the review of serious untoward incidents and learning by SI and , Learning from Death Panels and Service Line Clinical Governance Groups.

The Head of Internal Audit Opinion (HOIA) concluded an opinion of 'Generally satisfactory with some improvements required'. Update once confirmed HOIA known.It was noted however, that there are some areas of weakness and as such the Trust is actively addressing these; particularly concerning those raised within the Clinical Supervision Audit Report (which was rated as 'High Risk'). The HOIA also highlights areas of good practice identified as a consequence of our auditors reviews.

I therefore believe that the necessary arrangements are in place for the discharge of statutory functions, that the Trust is legally compliant and there are no irregularities.

Conclusion

In conclusion, and in acknowledgment of the referenced significant issues, I believe Solent NHS Trust has a generally sound system of internal controls that supports the achievement of its objectives.

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

Statement of Chief Executive's responsibilities as the Accountable Officer of Solent NHS Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum.

These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors and I consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the trust's performance, business model and strategy. A statement regarding the going concern position in relation to the accounts can be found on page [n]

Disclosure of information to auditors

The directors and I confirm that, so far as we are aware, there is no relevant audit information of which the trust's external auditors are unaware. We also confirm that we have taken all steps that we ought to have taken as directors in order to make ourselves aware of any relevant audit information and to establish that the auditors are aware of that information.

By order of the Board

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

[signed]
Andrew Strevens
Deputy CEO and Director of Finance and Performance

Date: xxxxx

Remuneration and Staff Report

Remuneration report

Remuneration of the Chief Executive and Directors accountable to the Chief Executive is determined by the Remuneration Committee. The terms of reference of this Committee comply with the Secretary of State's "Code of Conduct and Accountability for NHS Boards".

The Remuneration Committee met 4 times during 2017/18.

The committee considers the terms and conditions of appointment of all Executive Directors, and the appointment of the Chief Executive and other Executive Directors.

All Non Executive Directors and the Chairman are members of the Committee. Although the Chief Executive, Director of Human Resources, and Director of Finance & Performance attend the meetings by invitation, they are not members of the Committee.

The attendance by members is detailed below:

Member	15th May 2017	30th May 2017	22nd June 2017	14th December 2017
Jane Sansome *Left 31/05/2017*	✓	✓		
Alistair Stokes	✓	✓	x	✓
Jonathan Pittam	x	x	✓	✓
Mick Tutt	✓	✓	✓ *	✓
Mike Watts (Chair)	✓	✓	✓	✓
Francis Davis	✓	✓	✓	✓
Stephanie Elsy *Appointed 01/09/2018*				✓

**Chaired the meeting*

Although the Remuneration Committee has a general oversight of the Trust's pay policies, it determines the reward package of Senior Managers only. All Senior Managers are Executive Directors. Other staff are covered either by the national NHS Agenda for Change pay terms or the national Medical and Dental pay terms.

In year the Committee:

- were kept briefed on appointment processes to executive team vacancies and preferred candidates following assessment centre outcomes
- discussed and agreed remuneration matters concerning executive pay

- considered Mutally Agreed Resignation Schemes (MARS)
- considered the CEO appraisal
- ratified the recommendations made by the Clinical Excellence Awards Panel

Senior Managers Remuneration Policy

Our policy on the remuneration of senior managers for the current and future financial year is based on principles agreed nationally by the Department of Health taking into account market forces and benchmarking. During 2017/18 NHS Information undertook a benchmarking exercise on Executive Director and Non-Executive Director pay, which has been used to review remuneration of the Chief Executive and Executive Directors.

Senior managers pay includes the following elements as set out by the Department of Health: Basic Pay, Additional Payments in respect of Recruitment and Retention, and Additional Responsibilities. All Recruitment and Retention additions are subject to benchmarking, whilst additional responsibilities additions are awarded in line with the requirements of the Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts. All elements of the executive directors' remuneration package are subject to performance conditions and achievement of specific targets. No Directors are currently being paid a performance bonus.

Two Directors' receive a salary in excess of £150,000. Paying a salary above this threshold has been agreed by the Trust Remuneration Committee and the NHS Improvement Remuneration Committee for one Director. The other Director is paid in accordance with the relevant national Medical and Dental terms as they also perform clinical duties.

Individual annual appraisals assess achievements and performance of Executive Directors. They are assessed by the Chief Executive and the outcome is fed back to the remuneration committee. Individual executive performance appraisals and development plans are well established with in the Trust and follow agreed Trust procedures. This is in line with both Trust and national strategy.

The Chair undertakes the performance review of the Chief Executive and Non-Executive directors.

Our Non-Executive Directors, including the Chairman, are paid the rates set by the Secretary of State and NHS Improvement.

There were no senior managers seconded into the organisation during the year 2017-18.

Service Contract Obligations

All senior manager contracts require them to meet the Fit and Proper Persons requirements specified in Section 7 of the Health and Social Care Act 2008. Failure to do so would be considered a breach of their contractual terms.

Loss of office payment for Senior Managers are determined in accordance with Sections 14-16 and 20 of the NHS Terms and Conditions of Employment. For the year 2017-18 there was no loss of office payments made.

Duration of Contracts

All Executive Directors are employed without term in accordance with the Trust Recruitment and Selection Policy.

All Executive Directors are required to give six months' notice in order to terminate their contract. Termination payments are on the grounds of ill health retirement, early retirement, or redundancy on the same basis as for all other NHS employees as laid down in the National Terms and Conditions of Employment and the NHS Pension scheme procedures.

Within the 2017-18 financial year there have been no early terminations of an Executive Director and no non-contractual payments have been made.

The Chairperson and Non-Executive Directors are appointed on a term set by the Secretary of State. They are office holders and as such are not employees, so are not entitled to any notice periods or termination payments.

Awards made to previous Senior Managers

There have been no awards made to past Senior Managers in the last year and therefore no provisions were necessary.

The Trust's liability in the event of an early termination will be in accordance with the senior managers' terms and conditions.

Off payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Trusts must publish information on their highly paid and or senior off-payroll engagements

In accordance with the Manual of Accounts Annual Reporting Guidance 2017-18, all public bodies are required to publish the following information within their 2017-18 Annual Report.

Off payroll engagements in place as at 31/03/18, for more than £245 per day that last longer than six months	
Total number of off pay scale engagements in place as at 31st March 2018	4
Of which, the number that have existed for:	
less than one year at the time of reporting	3
between one and two years at the time of reporting	1
between two and three years at the time of reporting	0
between three and four years at the time of reporting	0
four or more years at the time of reporting	0

A review of all off-payroll engagements has been undertaken, and assurance has been sought on all contracts to ensure the individual is paying the right amount of tax. As a result the Trust believes it is fully compliant with the requirements.

All new off-payroll engagements or those that reached six months in duration between 01/04/17 31/03/18, at a rate of £245 or more per day and that last longer than six months	
Number new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3
Of which number assessed as:	
within scope of IR35	3
not within the scope of IR35	0
Number engaged directly (via PCS contracted to trust) and on the trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	3
Number of engagements that saw a change to IR35 status following the consistency review	0

Notes: All contracts in place prior to the 01/04/17 were reviewed in the light of the Review of the tax arrangements of public sector appointees introduced in the Finance Bill of 2017 relating to off-payroll working (IR35) within the Public Sector.

For all new appointments an IR35 assessment has been undertaken prior to commencement of a contract.

Off payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 01/04/17 and 31/03/18.	
Number of off-payroll engagements of board members, and or senior officers with significant financial responsibility, during the year	0
Number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility during the financial year. This figure includes both payroll and off-payroll engagements	8

Period and details of the exceptional circumstances that led to this appointment and period of appointment: There were no off payroll engagements of board members and or senior managers.

Expenditure on consultancy

During the 2017-18 financial year £1,251k was sent on consultancy.

Expenses

During the 2016-17, and 2017-18 financial years, subsistence and travel costs were paid as follows:

	Number	Number making a claim	2016-17 £00	2017-18 £00
Executive Directors	8	8	80-90	111-112
Non-Executive Directors	7	7	30-40	66-67
Shadow Governors	16	2	8-9	2-3
		Total	131-132	180-182

The salary, emoluments, allowances, exit packages, and pension entitlements of the Trust's Senior Managers are detailed in the following sections.

Fair pay multiples (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director/Member in Solent NHS Trust in the financial year (£000), 2017-18 was £155-£160 (2016-17, £155-160). This was 5 times (2016 - 17, x5), the median remuneration of the workforce (£28,746), which was £28,101 (2016–17, £28,101).

In the 2017-18 one (2016 - 17, two) employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £14k to £185k (2016–17, £15k-£180k)

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind, but does not include severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

When calculating the median figure, individuals employed via a bank contract who did not work on the 31st March 2018 have been excluded; together with employees who left prior to the April 2017, honorary appointments, Non-executive directors who receive allowances only, individuals who are undertaking training in receipt of a training allowance only and individuals who were not directly employed by the Trust.

Exit packages (audited)

Changes have continued to take place within the organisation in the 2017-18 financial year and whilst we endeavour to do all we can to ensure the continued employment of our staff there have been 4 severance payments totalling £147k made in the year. All of these payments relate to compulsory redundancies. None of these payments relates to senior managers as detailed in the accounts and all payments have been made in accordance with the NHS Pension Scheme procedures and National Terms and Conditions, as a result Treasury Approval has not been required.

Exit Packages agreed in 2017-18								
								2017-18
Exit Package cost band (including and special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	1	6,816	0		1	6,816	0	
£10,000 - £25,000	2	37,950	0		2	37,950	0	
£25,001 - £50,000	0		0		0		0	
£50,001 - £100,000	0		0		0		0	
£100,001 - £150,000	1	102,667	0		1	102,667	0	
£150,001 - £200,000	0		0		0		0	
>£200,000	0		0		0		0	
Totals	**4**	**147,433**		**0**	**4**	**147,433**		

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS redundancy arrangements. Exit costs in this note are accounted for in full in the year of departure. Other departures have been paid in accordance with the Mutually Agreed Resignation Scheme (MARS). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

The table below reports the number and value of exit packages agreed in the year.

Analysis of Other Departures	2017-18	
	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	
Mutually agreed resignations (MARS) contractual costs	0	
Early retirements in the efficiency of the service contractual costs	0	
Exit payments following Employment Tribunals or court orders	0	
Non-contractual payments requiring HMT approval **	0	
Total	**0**	

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total number in table 1 which will be the number of individuals.

*: any non-contractual payments in lieu of notice are disclosed under "non contractual payments requiring HMT approval".

**: includes any non-contractual severance payment made following judicial mediation, and no amount relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary. The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Salaries and allowances (audited)

Name and Title	2017-18						
	(a)	(b)	(c)	(d)	(e)	(f)	Total
	Salary and fees including R&R (bands of £5,000)	Expense Payments (taxable) (total to nearest £100	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other payments (bands of £5,000)	All pension-related benefits (bands of £2,500	(a to f) (bands of £5000
	£000	£00	£000	£000	£000	£000	£000
S Harriman – Chief Executive	155-160	0.2-0.3	0	0	0	22-22.5	175-180
A Strevens – Director of Finance and Performance	120-125	0.1-0.2	0	0	0	17.5-20	135-140
H Ives – Chief People Officer	100-105	0-0.1	0	0	0	12.5-15	115-120
D Meron – Chief Medical Officer*	135-140	0-0.1	0	0	0	17.5-20	155-160
M Rayani – Chief Nurse Resigned 17/06/17	20-25	0-0.1	0	0	0	2.5-5	25-27.5
S Austin – Chief Operating Officer Portsmouth	105-110	0	0	0	0	15-17.5	102-125
D Noyes – Chief Operating Officer Southampton & County Commenced 03/07/17	80-85	0.1-0.2	0	0	0	10-12.5	90-95
J Ardley – Chief Nurse Commenced 18/12/17	30-35	0.1-0.2	0	0	0	0	30-35
A Stokes – Chairman, (Non- Executive Director 01/01/18-31/03/18)	25-30	0	0	0	0	0	25-30
M Tutt – Non Executive Director (Acting Chairman from 01/01/18 to 31/03/18)	10-15	0.4-0.5	0	0	0	0	10-15
F Davis – Non Executive Director	5-10	0	0	0	0	0	5-10
J Pittam – Non Executive Director	5-10	0.2-0.3	0	0	0	0	5-10
M Watts – Non Executive Director	5-10	0-0.1	0	0	0	0	5-10
J Sansome – Non Executive Director Resigned 31/05/17	0-5	0-0.1	0	0	0	0	0-5
S Elsy – Non Executive Director Commenced 01/09/17	0-5	0-0.1	0	0	0	0	0-5

For individuals who joined or left the Trust part way through the year, the full time equivalent salary plus any additional remuneration, excluding severance payments have been used to calculate the rate of payment.

The expenses shown column (b) are different to those shown in the Expenses section as column (b) relates solely to taxable expenses, compared to all expenses shown in the Expenses Section.

* The Chief Medical officer role is combined with clinical duties. These figures include £45k-50k (expressed in bands of £5,000) relating to clinical duties.

Previous year salary and allowances

Name and Title	2016-17						
	(a)	(b)	(c)	(d)	(e)	(f)	Total
	Salary and fees including R&R (bands of £5,000)	Expense Payments (taxable) (total to nearest £100	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other payments (bands of £5,000)	All pension-related benefits (bands of £2,500	(a to f) (bands of £5000
	£000	£00	£000	£000	£000	£000	£000
S Harriman – Chief Executive	155-160	0.2-0.3	0	0	0	20-22. 5	175-180
J Pennycook- Director of Human Resources & Organisational Development Resigned 31/12/16	75-80	0-0.1	0	0	40-45	10-12.5	125-130
A Strevens – Director of Finance and Performance	100-105	0.1-0.2	0	0	0	12.5-15	115-120
D Meron – Chief Medical Officer*	135-140	0.2-0.3	0	0	0	17.5-20	155-160
A Whitfield – Chief Operating Officer Southampton and Hampshire Wide Resigned 12/03/17	100-105	0.1-0.2	0	0	0	12.5-15	115-120
M Rayani – Chief Nurse	105-110	0.2-0.3	0	0	0	15-17.5	120-125
S Austin – Chief Operating Officer Portsmouth	105-110	0	0	0	0	15-17.5	120-125
A Stokes – Chairman	15-20	0	0	0	0	0	15-20
D Batters – Non Executive Director Resigned 31/07/16	0	0	0	0	0	0	0
F Davis – Non Executive Director Commenced 01/10/16	0-5	0	0	0	0	0	0-5
J Pittam – Non Executive Director	5-10	0.2-0.3	0	0	0	0	5-10
J Sansome – Non Executive Director	5-10	0-0.1	0	0	0	0	5-10
M Tutt – Non Executive Director	5-10	0.4-0.5	0	0	0	0	5-10
M Watts – Non Executive Director	0-5	0	0	0	0	0	0-5

* The Chief Medical officer role is combined with clinical duties. These figures include £45k-50k (expressed in bands of £5,000) relating to clinical duties.

Pension benefits 2017-18 (audited)

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash equivalent Transfer Value at 1 April 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension to nearest £100 £000
S Harriman – Chief Executive	0.0 -2.5	(2.5) - 0.0	30 - 35	70 - 75	489	52	540	
A Strevens – Director of Finance and Performance	2.5 -5.0	0	15-20	0	151	53	203	
D Meron – Chief Medical Officer*	0.0-2.5	2.5 -5.0	30 -35	100-105	612	76	688	
D Noyes – Chief Operating Officer Commenced 03/07/17	0.0 -2.5		5-10		78	27	105	
M Rayani – Chief Nurse Resigned 17/06/17	5.0-7.5	22.0-22.5	50-55	160-165	852	217	1,069	
S Austin – Chief Operating Officer Portsmouth	0.0- 2.5	(2.5) – (5.0)	50 -55	95-100	784	67	852	

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 the Occupational Pension Schemes (transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Note:

[signed]
Sue Harriman
Chief Executive Officer
Date: xxxxx

Staff Report

Our Staff

Last year, we employed 4,086 clinical and non-clinical members of staff (including part time and bank staff) which equates to 2,899 whole-time equivalents (WTE), all of whom contribute to providing high quality patient care across our local communities. Our team members work hard to improve efficiency, to meet national and local quality targets and to bring innovations in care to people who use our services. Most people are permanently employed in clinical roles and directly deliver patient care. We also employ a significant number of scientific, technical and administrative staff who provide vital expertise and support. The following table provides a breakdown of our workforce at the end of the year (March 2018).

Staff Group	Female FTE	Female %	Male FTE	Male %	Total FTE
Admin & Estates	559.07	88.26%	74.37	11.74%	633.45
Director	4.00	57.14%	3.00	42.86%	7.00
Healthcare Assistants and Other Support Staff	562.11	80.82%	133.43	19.18%	695.54
Managers and Senior Managers	42.28	60.13%	28.03	39.87%	70.31
Medical & Dental	98.32	71.26%	39.65	28.74%	137.97
Nursing & Midwives	702.55	92.05%	60.68	7.95%	763.23
Scientific, Therapeutic & Technical	528.44	89.26%	63.55	10.74%	591.99
Total	**2496.77**	**86.11%**	**402.72**	**13.89%**	**2899.49**

Our workforce is predominately female (86%) and this is the predominant gender in all of the staff groups, except for the managers and senior managers group/Directors. We published our Gender Pay Gap reporting (available on our website) and remain committed to the Equality and Diversity agenda working to strengthen inclusive people practices across the Trust.

The following tables provide detail on staff numbers and expenditure. The expenditure is for the full year and the staff numbers represent average figures for the year.

Employee Benefits – Gross Expenditure (audited)	**Permanent £000s**	**Other Agency £000s**	**Total £000s**
Salaries and wages	94,757	4,960	99,717
Social security costs	8,784		8,784
Apprenticeship Levy	465		465
Employer Contributions to NHS BSA Pensions division	12,211		12,211
Other pension costs	5		5
Termination benefits	148		148
Total employee benefits	**116,370**	**4,960**	**121,330**
Employee cost capitalised	95		95
Gross Employee Benefits excluding capitalised costs	**116,275**	**4,960**	**121,235**

Average Staff Number	**Permanent Number**	**Other Agency Number (inc. Bank Staff)**	**Total Numbers**
Medical & Dental	141	4	145
Admin & Estates	700	33	733
Healthcare Assistants and Other Support Staff	691	85	776
Nursing, midwifery and Health Visiting Staff	751	56	807
Nursing, midwifery and Health Visiting Learners	13		13
Scientific, Therapeutic & Technical	590	9	599
Other			
Total	**2886**	**187**	**3,073**

Despite on-going challenges with regards to recruitment in certain professional disciplines and particular areas such as specialist nursing and mental health, the overall level of vacancies are around 2.8% of the total workforce. The demand for bank and agency staff remains high and the amount of spend on bank and agency is 8% of the total pay bill. This is reflective of demand for Mental Health and Community services and national staffing shortages in some key roles.

The Trust Agency ceiling is £3.6 million and our spend for the year is above our threshold at £4.9 million. There is an improvement plan in place to continually drive down the use of Agency, however, winter pressures have created significant challenges that have impacted our progress.

Our in house bank continues to fill 68% of requested shifts with internal bank staff and works hard to ensure that we use as little Agency as is possible.

Staff retention programme

As part of the work we are doing around Quality Improvement, we have been working with service lines and engaging with groups of staff across the organisation to understand the biggest issues and root causes of staff turnover. This activity has highlighted the following areas as the prioritised delivery areas for focus and action planning:

- Recruitment - attraction and brand: Employer Value Proposition & Distinctive Brand
- Flexible working arrangements
- Training for our managers in people development
- Reward and recognition
- Career progression: defined progression routes
- Induction – the root into Solent

In addition, we have a strategic initiative underway to implement the 6 step methodology for workforce planning. This is a critical success factor for recruitment and retention, and much more broadly, organisational effectiveness.

Although we will continue to improve in our day to day operational delivery, we have a strategic action plan in place that focuses on the above 6 areas, with the aim of delivering a significant reduction in turnover by the end of 2019.

Equality and Diversity

Every effort is made to ensure that all our staff are treated fairly, inclusively and equitably regardless of their individual characteristics and circumstances. All new employees are given training in relation to our values and the principles of treating others with dignity and respect. Robust arrangements are also in place to deal with any reports of non-compliance and we continue to monitor trends and take action where necessary.

With regards to disabled employees or those who become disabled whilst working for us, we provide support, training and make reasonable adjustments as necessary to ensure our staff can enjoy a fulfilling career with us. We continue to encourage and support applications for employment from all individuals. For applicants who disclose a disability, reasonable adjustments are put in place upon request and all appointments are based on merit.

Progress continues with the implementation of our Equality and Diversity Strategy. We annually review our performance against the Workforce Race Equality Standards and are working through our action plan for the Equality Delivery System. We have participated in the NHS Employers Diversity & Inclusion Partners Programme. We are engaging through our internal and external networks on the Workforce Disability Equality Standard and the Sexual Orientation Monitoring Standard. We ensure that all of our policies are developed with equality and diversity as one of the main considerations.

During the year ahead we are also planning on establishing closer links with our veteran community. Working with Forces4Change, we will be holding an event in April 2018 to launch our initiatives bringing together a passion for supporting veterans and for enabling military to civilian transition and creating a network of colleagues within the organisation who can support veterans and their families.

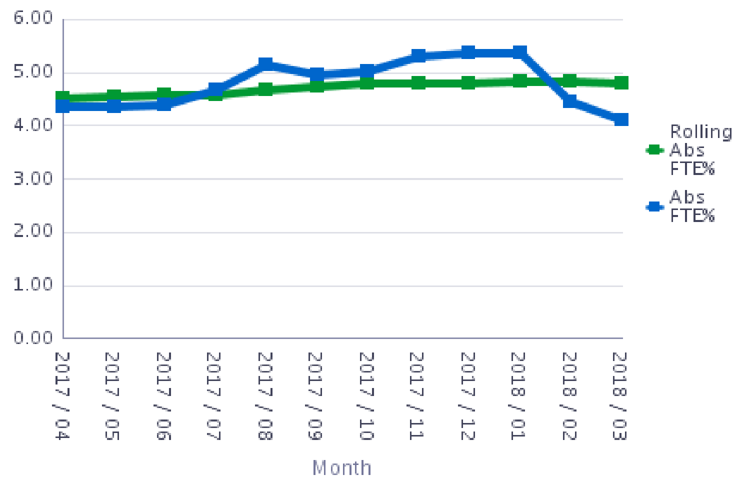
Partnership Working

We pride ourselves on having developed excellent partnership arrangements with our staff side representatives. This is formally supported within the Joint Consultative Committee (JCC) and the newly introduced Joint Consultative and Negotiating Committee (JCNC). The local Doctors and Dentists Negotiating Committee (DDNC) specifically deals with matters for medical staff. We also have a Policy Steering Group to ensure that we continue to develop partnership arrangements when renewing and considering new policies that affect the workforce and wider external environment to ensure fairness and equity.

Sickness Absence

We have seen our annualised sickness absence rise during the year from 4.51% to 4.80%. Mental health-related conditions are the main cause of sickness at 28.4%; this is up 5% on the previous 12 month period. The following graph shows sickness absence rates for April 2017 to March 2018. Sickness rates have fluctuated throughout the period, with a peak of 5.38% in Jan 2018. The average for community and mental health trusts for the same period was 4.53%.

The graph below represents data between April 2017 and March 2018

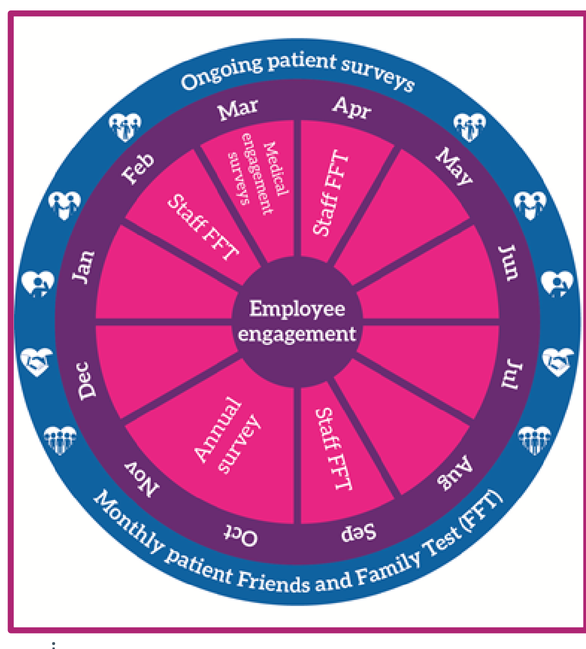


In response to sickness absence data, various initiatives have been implemented and evaluated to improve staff health and wellbeing. The 2017 staff survey shows that people's satisfaction with action taken around health and wellbeing has improved by 5% since the 2015 survey. More on specific action taken to improve levels of organisational health and wellbeing can be found in the Occupational Health section of this report, on page [n].

Employee Engagement

There is a clear relationship between employee satisfaction and patient satisfaction and we recognise that the highest quality of care for people who use our services is delivered through a high quality and engaged workforce where staff feel empowered to really make a difference. We operate a number of employee engagement and patient care measures throughout the year as demonstrated in figure [n], all with the primary purpose of measuring and enhancing employee engagement.

We have a variety of employee engagement initiatives in place within our Great Place to Work programme, which was launched in 2016, the elements of which are illustrated below.



i

Figure [n] – Employee Engagement

Figure [n] – Great place to work

A summary of each element is outlined as follows:

Leading with Heart

- Leading with Heart Senior Leadership and Board development programme
- Management development programmes and workshops
- Back to the Floor – members of the Board spend time working with teams
- Director drop-in sessions – Executive Directors join teams informally to listen and learn

At the Heart

- Engagement Forums – organised by Occupational Group to explore key workforce issues
- Focus Groups – in response to specific concerns raised by employees
- At the Heart team sessions – team engagement programme to strengthen the Heart values
- Communications Champions – employee communication and engagement network
- Power Hours – hour-long webinars to share knowledge and expertise

The Way Forward

- Strategy communications - connecting employees with our vision, priorities and progress
- Monthly "Ask Sue" forums – staff are invited to contact the CEO in an online Q&A

The Difference

- Communication and Engagement programme – using the power of storytelling to involve people and recognise the difference our care makes
- Weekly Employee newsletter and regular Manager newsletter

People First

- We are working to continually improve our employee experience from the moment people express an interest in joining Solent throughout their entire career with us, see Figure [n].

Figuren [n] Employee experience model

Being Agile

- Continual quality improvement and innovation are supported through Dragon's Den (where staff can apply for funds to fast track new initiatives) and the Quality Improvement (QI) Programme (development to support teams on their own quality improvement projects).
- Involvement and consultation with employees facing or affected by change is integral to the way we lead the organisation. With adherence to our Organisational Change Policy we seek to ensure our consultations are meaningful, fair, transparent and consistent. Our consultations are carried out in partnership with our staff side colleagues and we adhere to our policies throughout.

Staff Survey

The 2017 Annual Staff Survey was carried out by Quality Health with a total of 1876 people taking part. This is a response rate of 56% which is above average for combined mental health / learning disability and community trusts in England (45%), and compares with a response rate of 55% in 2016.

Trust engagement shows a marginal increase of .3% when compared with last year, as detailed below. However, this is still .7% higher than the national average for community trusts.

Figure x: Overall Staff Engagement

(The higher the score, the better)

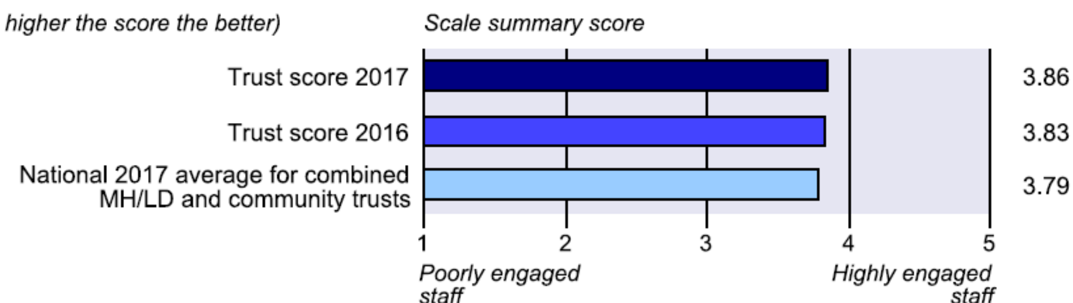


Table X. Top 5 ranking scores compared with combined Mental Health, Learning Disabilities and Community Trusts in England

Key findings	Solent 2017	Average MH /LD / Community Trusts
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	9%	14%
Staff confidence and security in reporting unsafe clinical practice	3.9	3.72
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.92	3.76
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	16%	20%
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	92%

In addition to the above improvements, there are a number of areas where we have maintained a positive level of engagement over the year;

- Effective team working
- The quality of our non-mandatory training
- The provision of Equal opportunities for progression regardless of background
- Positive action taken around health and wellbeing

Table x: Bottom 5 ranking scores compared with combined Mental Health, Learning Disabilities and Community Trusts in England

Key findings	Solent 2017	Average MH /LD / Community Trusts
Staff satisfaction with resourcing and support	3.33	3.33
Staff satisfaction with the quality of work and care they are able to deliver	3.82	3.85
Percentage of staff working extra hours	71%	71%
Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	58%	57%
Percentage of staff / colleagues reporting most recent experience of violence	89%	88%

There is still more work to do around satisfaction with levels of resource and support; action around sustainable staffing levels, safe staffing and productivity improvement remains an on-going priority for the coming year. Each service line business plan has clear deliverables against these priority areas which will be monitored through the Board Performance Reporting process

We will also continue the work we have been doing around our Great Place to Work programme, specifically the further development of our leaders, teams and culture through the HEART values.

2017 NHS Staff Survey headlines

55.8% of people took part

3.86* Engagement score (increase from 3.83* in 2016 and above the average of other comparable trusts: 3.79*)

Out of 22 NHS key findings we had:

better than average | worse than average

The majority of the questions show an improvement on last year

Here are some areas where the improvement is significant

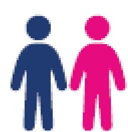
The care of patients/ service users is my organisation's top priority
79%
Increase of 4%

I would recommend my organisation as a place to work
59%
Increase of 3%

The team I work in have a shared set of objectives
77%
Increase of 3%

My organisation takes action around errors, near misses or incidents
79%
Increase of 3%

I am satisfied with the support I get from my immediate manager
76%
Increase of 4%



My immediate manager can be counted on to help me with difficult tasks
78%
Increase of 3%

I have had training, learning or development in the last 12 months
77%
Increase of 5%

My immediate manager asks for my opinion before making decisions that affect my work
63%
Increase of 3%

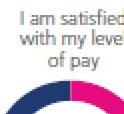
My immediate manager is supportive in a personal crisis
80%
Increase of 3%

Areas which people scored the same:

- The way we work together in our teams
- The quality of our non-mandatory training
- The opportunities we give for career progression, regardless of background
- The difference you feel you make to patients
- The action we take to help you manage your health and wellbeing

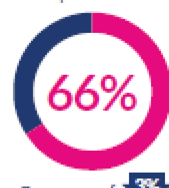
Areas which people scored lower:

I am satisfied with my level of pay



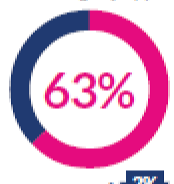
Decrease of 6%

I am working additional unpaid hours



Decrease of 3%

I had the opportunity to talk about the Trust values and my development needs during my appraisal



Decrease of 2%

Next steps

Look out for your team reports. Your manager will talk with you about next steps and the actions you can take as a team.

Over the coming weeks we will be communicating the Trust results with you in more detail. You can find all the survey reports on SolNet within Staff Zone.

Exit Packages

Details of exit packages can be found on page [n]

Off payroll engagements

Details of off payroll engagement can be found on page [n]

External consultancy

At times it is necessary for us to make use of the skills of external consultants and at these times, we ensure that the arrangements comply with our standing financial instructions and offer good value for money. External consultancy is used within the Trust when we require objective advice and assistance relating to strategy, structure, management of our organisation, for example. This year we have sought advice and assistance from external consultants relating to Organisational Development and property related issues. The cost associated with consultancy can be found within the Remuneration Report on page [n].

Occupational Health and Wellbeing Service

Our Health and Wellbeing Steering Group is held bi-monthly and is attended by key stakeholders involved in supporting staff and who take an active role in supporting the delivery of our health and wellbeing plan. In support of employee experience, we have a robust Occupational Health and Wellbeing service in place that proactively supports the health of our employees through initiatives. These initatives include; the Global Challenge - a 100 day step challenge, health and wellbeing events as well as our Optimising Wellbeing & Lived Experience of Staff (OWLES) group, aimed at spreading the word on mental health. This year we held a launch event to promote the active participation in this group and spread the word on support available to our people.

Our physiotherapy service has worked proactively with services to support staff with musculoskeletal (MSK) problems and to work with managers to review and consider the challenges associated with our people working in some of our community environments that pose higher levels of risk in terms of MSK injury.

In response to sickness absence data, various initiatives have been implemented to improve staff health and wellbeing. These include easy access to occupational health and fast track physiotherapy services. Targeted support has been made available for services with high sickness rates and health and wellbeing support programmes to include; emotional resilience workshops and self-care support and resource material designed to motivate and empower staff to promote self-care approaches that will help them to improve their lifestyle. Managers are supported by HR, Occupational Health and our Employee Assistance Programme (EAP) to manage sickness absence in line with our policy and to support staff in attending work regularly or to sustain their return to work following a period of absence.

NHS Constitution

The NHS Constitution was established in 2009 and revised in summer 2015. The constitution sets out the principles and values of the NHS. It also sets out the rights to which patients, service users, the public and staff are entitled, a range of pledges to achieve and the responsibilities which patients, service users, the public and staff owe to one another to ensure that the NHS operates fairly and effectively. We operate in accordance with the principles and pledges as set out in the NHS Constitution and undertake an annual review of our compliance, which is reported to our In-public Board meeting.

Health and Safety

We are committed to the health, safety and welfare of our colleagues, and third parties that work within our operational footprint and have remained compliant with Health and Safety legislation in year. We have not had any investigative proceedings being undertaken in regards to breaches of health and safety legislative requirements, Regulatory Reform (Fire Safety) Order or the Environmental Protection Act and have not received any external visits from any external regulatory agency, as a result of a specific incident or complaint. The executive lead for the Health and Safety portfolio is the Deputy CEO and Director of Finance & Performance. The Associate Director of Estates and Facilities chairs the Health and Safety Group, which meets quarterly.

NHS Foundation Trust Code of Governance

Although as an NHS Trust, the NHS Foundation Trust Code of Governance does not directly apply to us, the principles are seen as good governance practice. We have, therefore, applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis, where applicable. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Enhanced quality governance reporting

Care Quality Commission (CQC)

You can find more about our compliance with CQC registration requirements and our response to CQC findings in the Annual Governance Statement and Quality Account.

Quality governance reporting

Our quality governance structure is well-established within the organisation. Each clinical service line has a dedicated forum within which clinical governance matters are discussed. The forum, chaired by a Clinical Director, monitors the progress and impact of local quality improvement schemes, including lead quality indicators, and takes appropriate action to mitigate any areas of clinical risk at the earliest opportunity. This is supplemented by a monthly performance review in each Care Group which undertakes an overall ‘healthcheck’, looking at financial, workforce and activity data alongside quality metrics, and taking remedial action as required. All clinical governance groups

report monthly to the Quality Improvement and Risk Group.

The Trust's Quality Improvement and Risk (QIR) Group is chaired by the Chief Nurse who has lead executive responsibility for quality improvement. This group has oversight of the full quality, safety and risk agenda across the Trust and provides appropriate direction and guidance to care groups and corporate functions, including the dissemination of shared learning within the Trust and with partner organisations. Our Corporate Performance Management Office (CPMO) continues to support the quality team to monitor performance against the action plans developed in response to the CQC inspection findings, enabling escalation to executives and the Assurance Committee and through to Board as necessary.

The QIR group seeks updates and assurance from a range of sub-groups that collectively shape and influence the Trust's quality agenda. This includes, but is not limited to:

- Service-Line Clinical Governance Groups
- Serious Incidents Requiring Investigation (SIRI) Panel
- Learning From Deaths Panel
- Health and Safety Group
- Medicines Management Group
- Clinical Audit and Effectiveness Group
- Safeguarding Steering Group
- Emergency Planning and Resilience Group
- Research and Development Group
- Quality Impact Assessments and review process
- Infection Prevention & Control Group

The QIR group is responsible for ensuring compliance with all statutory and regulatory requirements, including publication of the Quality Account and monitoring of progress against the associated priorities. It reports directly to the Trust's Assurance Committee and will make recommendations on quality improvement requirements in addition to highlighting key areas of risk that need visibility and response at Board level. The Assurance Committee reports to the Trust Board in turn.

The Quality Account provides more detail of the governance arrangements in place and reflects the achievements against the quality priorities set for 2017/2018 as well as outlining our priorities for the year ahead, 2018/19.

The Quality Account can be found on page [n].

You can also read more about our internal control processes associated with clinical governance and risk management within our Annual Governance Statement on page [n]

Quality Improvement

During 2017/2018 we have seen a high level of activity focused on improving patient and service user experience and outcomes. Implementation of the Friends and Family Test (FFT) has continued to be supported across all of our service lines. Overall feedback received through FFT and other local feedback mechanisms has been positive. In

addition, feedback received through the formal complaints process has been used to inform further improvement initiatives such as a review of our Customer Care Training programme.

We run a formal Quality Improvement programme to provide staff with the skills and confidence to identify and deliver improvements in their own services. A core element to this programme is partnership working with patients, service users and colleagues. Teams work in partnership to identify areas for improvement, identify and test changes and share findings. In some instances, service users or carers lead the improvement work.

We were invited to join NHS England's Always Events® as part of cohort five. Always Events® focus on the experiences that our service users, carers and service users identify that they should always have when accessing our services. The emphasis of, Always Events® is focused on relationships rather that clinical processes. The work with NHS England marks an exciting opportunity to focus our learning from patient experience through co-production and we will be progressing this further during the year ahead to working side-by-side and in partnership with our patients, carers and service users.

Our public and patient representative group (Side by Side) support the day to day running of our improvement work. We have jointly developed a charter for joint working and the group support the planning and running of events as well as award schemes to share learning.

A number of our teams and individual staff members have once again received recognition for their work in supporting patient care and progress has also continued to be made against clinical audit, research and development plans at service and corporate levels; the details of which are outlined in the Quality Account. It is particularly pleasing to note that we have continued to be an exemplar organisation in the level and quality of research and development activity being undertaken with contribution recognised through national publications.

Accessible information

The Accessible Information Standard (AIS) applies to service providers across the NHS and adult social care system. The aim of the Standard is to establish a framework and set a clear direction such that patients and service users (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss receive;

- Accessible information - information which is able to be read or received and understood by the individual or group for which it is intended'; and
- Communication support - support which is needed to enable effective, accurate dialogue between a professional and a service user to take place

We conducted an audit during Quarters 3-4 2017/18; and whilst our compliance with the AIS continues to improve, we will be working during the year ahead to further promote the AI Awareness film we have developed, roll out specilaist workshops and guidance across the Trust.

Commissioning for Quality and Innovation (CQUIN)

A proportion of our income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between ourselves and our commissioners through the Commissioning for Quality and Innovation payment framework (CQUIN). You can find more about CQUINs within the Quality Account.

Complaints and compliments

Receiving feedback about the services we provide is really important to us – it's how we learn and make improvements. We have embedded processes in place to allow the people we treat,their families and carers, to provide feedback to us. You can find more about our compliants and compliments procedures via our website at www.solent.nhs.uk and how we learn from complaints within the Quality Account.

Innovation

You can read about our Dragons Den iniative and the innovation projects we have supported within the Research and Improvement Annual Report appended to our Quality Account.

Trade Union (Facility Time Publication Requirements) Regulations 2017

Since the introduction of the Trade Union (Facility Time Publication Requirements) Regulations 2017 the Trust is required to publish the following data.

Table [x] – The total number of employees who were relevant union officials between period 1st April 2017 to 31st March 2018

Number of employees who were relevant union officials between 1st April 2017 to 31st March 2018	Full time equivalent employee number
24	19.80

Table [x] - Percentage of time spent on facility time

Number of employees who were relevant union officials employed between 01/04/17 and 31/03/18 spent a) 0%, B) 1%-50%, c) 51-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	17
1-50%	6
51-99%	0
100%	1

Table [x] - Percentage of pay bill spent on facility time

Cost	£000
The total cost of facility time	£31
The total pay bill	£121,235
Percentage of total pay bill spent on facility time*	0%

*Percentage calculated as (total cost of facility time divided by total cost of pay bill) times 100

Table [x] – Paid trade union activities

As a percentage of total paid facility time hours, the number of hours spent by employees who were relevant union officials between 01/04/17 and 31/03/18 on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours *	100%

* Calculated as (total hours spent on trade union activities by relevant union officials between 1st April 2017 and 31st March 2018 divided by total paid facility time hours) times 100

Note:

Facility time = Total time paid by the employer to undertake Union activities as specified in the Trade Union and Labour Relations (Consolidation) Act 1992 excluding time not paid by employer.

Paid trade union activities = Time take off under section 170(1)(b) of the Trade Union and Labour Relations (Consolidation) Act 1992.

The Accountability and Corporate Governance Report is signed by;

[signed]

Sue Harriman
Chief Executive Officer
Date: xxxxx

Section 3:
The Auditors Report

Independent auditors report to the Accountable Officer of Solent NHS Trust

EY to provide

Section 4:
Our Summary Accounts

Our summary accounts

Foreword and Statement on Financial Performance

We have ended 2017-18 by achieving three of our four financial statutory duties:

- External Financing Limit (EFL) which is an overall cash management control. The Trust was set an EFL of £6.5m cash outflow for 2017-18, actual EFL was £2.1m cash inflow and therefore the Trust achieved the EFL target with a positive variance of £8.6m.
- Capital Cost absorption rate is based on actual (rather than forecast) average net relevant assets and therefore the actual capital cost absorption rate is automatically 3.5%.
- Capital Resource Limit (CRL) which represents investments in fixed assets throughout the year. The Trusts fixed asset investment for 2017-18 was £3.6m a £0.3m underspend against the target of £3.9m.
- Whilst the Trust achieved an in year adjusted surplus of £0.7m, the Trust did not achieve is cumulative breakeven duty, a measure of financial stability, with a cumulative adjusted retained deficit of £8.2m reported in 2017-18.

The 2017-18 financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS. Where the Group Accounting Manual permits choice of accounting policy, the accounting policy which is judged to be the most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

[signed]
Sue Harriman
Chief Executive Officer
Date: xxxxx

Finance Review & Statutory Duties in relation to the Accounts

The statement of directors responsibilities in respect of the accounts can be found on page [n].

Break-even position (a measure of financial stability)

The Trust has a statutory duty to achieve break-even in the year. The Trust has achieved the breakeven duty in year, reporting a £0.7m adjusted surplus in 2017-18. As the Trust has previously reported deficit results, the cumulative breakeven position has not been achieved, with a cumulative adjusted deficit of £8.2m. Our regulators were aware of this position and continue to support us in our delivery of key community and mental health local services.

Capital Costs Absorption Rate (a measure of Statement of Financial Position Management)

The Trust is required to absorb the cost of capital at a rate of 3.5% of actual average relevant net assets. The average net relevant assets exclude balances held in the Government Banking Service bank accounts. The dividend payable on public dividend capital is based on actual (rather than forecast) average relevant net assets and therefore the actual cost absorption rate is automatically 3.5%.

External Financing Limit (an overall cash management control)

The Trust was set an External Finance Limit of £6.5m cash outflow for 2017-18 which it is permitted to undershoot. Actual external financing requirements for 2017-18 were £2.1m cash inflow and therefore the Trust achieved the target with a positive variance of £8.6m.

Capital Resource Limit (Investment in fixed assets during the year)

The Capital Resource Limit is the amount that the Trust can invest in fixed assets during the year; a target with the Trust is not permitted to overspend. The Trust was set a capital resource limit of £3.9m for 2017-18. Our actual fixed asset investment was £3.6m, an £0.3m underspend against target.

Want to find out more?

Included on the previous pages are the 'summary accounts' of the Trust and an overall picture of our fiscal performance. A copy of our full accounts are available in Appendix [X]

Financial Statements

Statement of Comprehensive Income for year ended 31 March 2018

	2017-18 £000	2016-17 £000
Employee benefits	(121,235)	(117,630)
Other costs	(58,276)	(64,454)
Revenue from patient care activities	166,882	162,247
Other Operating revenue	20,122	18,428
Operating surplus/(deficit)	7,493	(1,409)
Investment revenue	24	23
Other gains and (losses)	(4)	(11)
Finance costs	(151)	(159)
Surplus/(deficit) for the financial year	7,362	(1,556)
Public dividend capital dividends payable	(2,305)	(2,314)
Retained surplus/(deficit) for the year	5,057	(3,870)
Impairments and reversals taken to the revaluation reserve	(546)	(4,032)
Revaluations	351	0
Total comprehensive income for the year	4,862	(7,902)

Financial performance for the year

	2017-18 £000	2016-17 £000
Retained surplus/(deficit) for the year	5,057	(3,870)
Impairments (excluding IFRIC 12 impairments)	(4,310)	1,740
Adjustments in respect of donated asset respect elimination	(10)	46
Adjusted retained surplus/(deficit)	737	(2,084)

Statement of Financial Position as at 31 March 2018

	31 March 2018 £000	31 March 2017 £000
Non-current assets	86,435	82,958
Current assets	24,625	19,909
Current liabilities	(26,447)	(24,213)
NET CURRENT ASSETS / (LIABILITIES)	(1,822)	(4,304)
TOTAL ASSETS LESS CURRENT LIABILITIES	84,613	78,654
Non-current liabilities	(5,223)	(4,126)
TOTAL ASSETS EMPLOYED	79,390	74,528
FINANCED BY TAXPAYERS' EQUITY	79,390	74,528

Statement of Changes in Taxpayers' Equity for year ended 31 March 2018

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2017	**6,435**	**59,930**	**8,163**	**74,528**
Changes in taxpayers' equity for 2017-18				
Retained surplus/(deficit) for the year		5,057		**5,057**
Impairments and reversals			(195)	**(195)**
Transfers between reserves		259	(259)	**0**
Net recognised revenue/(expense) for the year	**0**	**5,316**	**(454)**	**4,862**
Balance at 31 March 2018	**6,435**	**65,246**	**7,709**	**79,390**
Balance at 1 April 2016	**6,435**	**63,438**	**12,557**	**82,430**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year		(3,870)		**(3,870)**
Net gain / (loss) on revaluation of property, plant, equipment				**0**
Impairments and reversals			(4,032)	**(4,032)**
Transfers between reserves		362	(362)	**0**
Net recognised revenue/(expense) for the year	**0**	**(3,508)**	**(4,394)**	**(7,902)**
Balance at 31 March 2017	**6,435**	**59,930**	**8,163**	**74,528**

Statement of cash flows for the year ended 31 March 2018

	2017-18	2016-17
	£000	£000
Net cash inflow/(outflow) from operating activities	7,830	4,308
Net cash inflow/(outflow) from investing activities	(3,730)	(4,002)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**4,100**	**306**
Net cash inflow/(outflow) from financing activities	(790)	410
INCREASE / (DECREASE) IN CASH	**3,310**	**716**
Cash at the beginning of the period	6,291	5,575
Cash at year end	**9,601**	**6,291**

Better Payment Practice Code : Measure of Compliance 31 March 2018

	2017-18		2016-17	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	24,989	50,562	28,529	56,003
Total non-NHS trade invoices paid within target	23,479	47,509	26,648	48,637
% non-NHS trade invoices paid within target	94%	94%	93%	87%
Total NHS trade invoices paid in the year	1,230	17,446	1,912	16,365
Total NHS trade invoices paid within target	1,067	16,514	1,589	15,630
Percentage of NHS trade invoices paid within target	87%	95%	83%	96%

*The **Better Payment Practice Code** requires the Trust to aim to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later.*

Challenges ahead

The challenges we face as we head in to the new financial year include ensuring we deliver safe and effective services whilst balancing financial efficiencies and within a financial envelope which is subject to year on year cost reductions. We ended 2017/18 achieving a £0.7m surplus with Board recognition that there are more challenging years ahead.

Our efficiency target for 2017/18 (Cost Improvement plan) was £6.1m and we delivered cost savings of £4.2m (the balance was achieved by other measures) but we recognise that there is more to do – both internally within the organisation and with partners to radically transform health and care pathways in accordance with the ambition and plans of the Hampshire and Isle of Wight STP. Working differently and with our partners as part of a 'system' may, at times, mean we need to make difficult decisions for the greater good of our service users and the wider NHS – we will always endeavour to put our citizens and communities before services, and services before organisations, in accordance with our guiding principles.

We are vulnerable to risk during times of change – we must ensure we are vigilant to ensure that we are able to maintain 'business as usual' and that the quality of care we provide, our performance and ultimately our organisational values are not compromised as a consequence.

The key challenges we face in 2018-19 are as follows:

- Delivery of the deficit target of £1.0m
- Delivery of the efficiency savings programme – including significantly reducing our agency spend in order to be compliant with the agency ceiling cap. However, the quality and safety of our services must always remain our highest priority.
- Delivery of key programmes including estates rationalisation – including significantly the St James Hospital and St Mary's Hospital campus
- Working within the Sustainability and Transformation Programme, developing Local Delivery Systems and Integrated Care Systems

The internal control processes for managing risks are outlined in the Annual Governance Statement found on page [n].

Going Concern

The financial statements have been prepared on a going concern basis, as management have no significant reasons to believe otherwise. This is supported by the recent contract negations with NHS and Local Authority organisations to provide continuing services throughout 2018/19 within an agreed Control Total.

In conclusion, having considered the challenges we face, particularly with reference to our operating plan for the next twelve months, and having reviewed with our external auditors, the Board has a reasonable expectation that the Trust has access to adequate resources to continue in operational existence in the foreseeable future. For this reason the Trust continues to adopt the going concern basis in preparing the annual accounts. However, as the Trust has not achieved a cumulative breakeven position over the last four years, it is acknowledged that our Auditors have referred a matter to the Secretary of State in accordance with Section 30 of the Local Audit and Accountability Act 2014.

The statement of financial position is signed by:

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

Section 5:
Quality report incorporating the Quality Account 2017/18

To be inserted once approved (presented separately)

Appendix 1 – Full Accounts

To be inserted once approved

Solent NHS Trust

Annual Report and Accounts 2017/18

incorporating the Quality Account 2017/18

Solent NHS Trust

DRAFT Annual Report and Accounts 2017/18

incorporating the Quality Account 2017/18

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Appendix 1: Full Accounts	

Statement from the Chairman and Chief Executive Officer

We are pleased to present to you our Annual Report and Quality Account for the 2017/18 financial year. The report provides you with an overview of what we do, how well we have done and the challenges we face going forward, as well as a detailed analysis of our activities and accounts.

We have had another busy and challenging year, and we would like to take this opportunity to say 'thank you' to all of our teams who have continued to work so hard to make a difference to the lives of thousands of people across Hampshire, helping them to stay well and be cared for in the community. Within this report, you will read stories of dedicated people giving great care to service users and delivering best value services. We are proud to lead an organisation full of inspiring people.

We are also incredibly fortunate to have support and input from local people. Feedback from people who use our services is core to our culture of continuous improvement. We actively seek views from people who use and access our services and ask them to tell us when things aren't right. In 2017/18, 95.89% of respondents said that they would recommend our services to their friends and family if they needed similar care or treatment. We know there is more we could do to involve people in our services and we are looking forward to launching a new community engagement framework during 2018/19.

Providing safe effective and quality services remains our top priority and we are very proud of our strong improvement culture. We are always reviewing and improving our systems and processes to ensure that we provide the care people should expect of an NHS organisation. However, there are times when we don't get it right, and when that happens we make sure that we do everything we can to learn and improve. Our positive reporting culture was well recognised by our teams in the 2017 NHS Staff Survey. We encourage our employees to speak up when they believe that we are not delivering the care we aspire to. Together, we review what went wrong and take action to make sure we do better in the future. During 2017/18 we delivered against a wide range of quality targets, including measures of safety, effectiveness and patient experience. You can read more about our quality performance and our quality priorities for the year ahead in our Quality Account on page [n].

We continue to invest in Solent as a great place to work, creating an environment where people feel engaged in their work and motivated to deliver, embedding our HEART values throughout. For the second year running we saw a positive increase in our Staff Survey results, achieving a higher than average overall engagement score. On page [n] you will find a summary of our survey results and the work we are doing to continue to build our levels of engagement.

During 2017/18 we placed even greater emphasis on working with other organisations and have continued to actively participate in the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP), as well as the developing local integrated care systems (ICS). Within this report you will read many examples of how working with others has ensured that care is joined up and is making a difference to the people who use our services. Public sector funding continues to be limited. Despite ongoing financial constraints and ever-growing demand for services, we achieved a better position than our agreed financial control target of £1.5m deficit, with a year-end outturn of

£0.7m surplus; the improvement was aided by an additional £1.9m of Sustainability and Transformation Funding (STF) due to our £0.3m in underlying finances. This is a huge achievement by our teams. You can read more about our financial position within the Performance Report and Summary Accounts sections.
We are constantly thinking about the future, how to improve the quality of our services and what services need to be like in years to come. Our focus for the coming year is on achieving our ambitious plans to make a difference by keeping more people healthy, safe and independent in, or close to, their own homes. To achieve our plans we will continue to invest in our workforce, and work with local people, commissioners and partner organisations to develop seamless care irrespective of organisational boundaries.

Finally, it is thanks to strong leadership and our team of caring and compassionate people that we can proudly say that Solent is truely a place that aspires to provide great care, be a great place to work and provide great value for money.

[signed]

Sue Harriman
Chief Executive Officer

Date: xxxxx

[signed]

Alistair Stokes
Chairman

Date: xxxxx

Section 1: Performance Report

Overview

The purpose of this section is to provide a summary of the organisation including our purpose and activities, and our principle risks and uncertainties facing us during the year head. Our Chief Executive, Sue Harriman, also reflects on how we performed over the past year.

Consideration of the going concern basis can be found on pg [n]

Open & honest	Inclusive and valuing everyone	Accountable for our actions	Showing respect, dignity & compassion	Working together

Statement from the Chief Executive

Our unwavering focus on providing great care, creating a great place to work and delivering great value for money has led to continued improvement in the quality of our services and high levels of performance. This would not have been possible without leadership at all levels throughout the Trust, and by individuals who go above and beyond to make a difference every day, even when faced with significant challenges.

During 2017/18, we were faced with a very difficult winter. By working with partners in the system, we relieved some of the pressures felt by our local acute hospitals. Credit must go to the teams who worked hard to help people remain at, or return, home. Our teams also continued to provide care, and keep people safe and well, whilst faced with challenging weather and working conditions.

Our role in the Southampton and Portsmouth systems has been fundamental in reducing the number of people who are medically fit for discharge from acute care, but who are unable to leave hospital due to other circumstances. By actively transferring these service users to our wards, we have been able to help our acute partners free up beds in their hospitals. At the same time we have been working with our social care colleagues successfully, to reduce the rate of delayed transfers within Solent provided wards, again freeing up beds to allow service users to transfer to us from acute hospitals. Our wards across Portmsouth, including both community and mental health wards, showed a decreased delayed transfer of care rate from previous year, again with an average of 10% in 2017/18. Our Southampton wards also showed improvement over the year and had an average delayed transfer of care rate of 9.6%. This reduces waiting times and helps the flow of service users through the health care system.

We take pride in our commitment to quality, and in our improvement culture. We demonstrated this to our regulators on three separate inspections during the year. On each occasion, we were able to show how learning and action has led to better outcomes for service users. We were proud that the changes made within service were recognised as delivering a better quality of care to people who use our services. Due to the significant improvements made by our teams, two core service ratings were increased to overall ‘Good’ from ‘Requires Improvement’, and to our delight, our child and adolescent mental health services were awarded ‘Outstanding’ in the ‘caring’ domain. We hope to further demonstrate our continued commitment to improvement in future inspections.

The voice of the people we care for is paramount. Their feedback provides insight to help us understand what we are doing well and to make improvements. I am thrilled that our Friends and Family score has increased for the third year running. In 2017/18, 95.89% of respondents said that they would recommend our services to their friends and family. We encourage our teams to deal with concerns and problems at a local level. This means that if issues arise, they can be resolved quickly and in a way that is responsive to the patient’s needs and circumstances. We have seen an increase in the number of concerns raised, and a reduction in the number of formal complaints, received year-on-year.

We have continued to invest in the ways in which we gather feedback. In the year, we introduced more digital methods and have developed the options available for children and young people to share their feedback. You can read more about our performance and achievements in quality, safety and patient experience in our Quality Account

on page [n].

We finished the year financially sound, achieving a surplus of £0.7m against our previously agreed deficit control total of £1.5m. As a result of us performing financially better than our agreed plan by £0.4m, we received £3.0m of Sustainability and Transformation Funding, £1.8m of which related to our improved underlying position. Achieving our financial plan is reliant on the input and support of all leaders and their teams. I am thankful to our team who have been able to make changes, and think innovatively to find savings to help us be as efficient as possible, whilst putting patient care as our top priority. 2018/19 will bring increased financial challenges as further recurrent savings need to be made. In order to realise these, we will need to think differently, working with our partners to deliver major system transformation and safe efficiencies.

I am delighted that, for the second year running, we improved upon our NHS Staff Survey results, and when benchmarked with other Trusts, our scores are higher than average. Listening into Action, who rank trusts based on 32 key findings around culture and leadership, ranked us as the best performing mental health, learning disability and community trust and highlighted that we are demonstrating a positive trend in our results year on year. This reflects our ongoing investment in making Solent a great place to work. The results show that we continue to make service users our most important priority, and I was particularly pleased to read that our team believe we take positive action on their health and wellbeing. We are proud of our many, and varied, health and wellbeing initiatives. Helping people to feel happy and well, whilst at work, and have a positive impact on the care we provide.

I recognise the need to continually invest in our workforce. Our performance measures for staff sickness absence and turnover rate also provide us with a good indication about the health and wellbeing of our staff. Whilst we experienced an increased absence rate towards the end of 2017, through health and wellbeing initiatives we have been able to bring sickness levels back in line with what we would aspire to. Our turnover rate has gradually decreased during 2017/18, meaning that our employee retention rate has steadily improved. However, this is an area we would like to improve further and there is already an improvement programme in place to help with employee retention. Thanks to our culture and reputation as an employer of choice, our vacancy rate is comparatively low against other trusts as a whole. We remain committed to continually valuing, engaging and empowering our people.

We have experienced some performance challenges in our services during the year. Nationally, there is a recognised shortage of band 5 nurses (staff nurses) and, like other providers; we have found it difficult to recruit to these positions in our community nursing teams. In addition, meeting the staffing levels required to safely manage the increasing needs and acuity of some of our service users within our mental health services has been challenging. To ensure we continue to provide a safe level of care we have used temporary staffing solutions which has, in turn, increased our agency rate.

In addition, we have found limiting our access times, for some services, difficult. For instance, limited available theatre space has created longer waiting lists than we aspire to for service users requiring a general anaesthetic in our dentistry services. However, we stringently monitor waiting times for all our services and triage our service users based on clinical need to ensure the best possible quality of care. You can read more about our significant issues in

year within our Annual Governance Statement on page [n].

When our performance is below expected standards, we work with our commissioners, people who use our services and regulatory bodies transparently, openly and collaboratively. Together we resolve any issues as quickly and safely as possible. We learn so that we can do things differently in the future.

What remains clear is the commitment and dedication shown by our team. Year-on-year our people continue to make a difference to those that use our services, often going above and beyond. I end 2017/18 proud of what we have all achieved and the determination our team show when faced with challenges. I look forward to 2018/19, working with the team to keep more people healthy, safe and independent at, or close to, home.

Sue Harriman

Chief Executive Officer

About us

Who are we?

Solent NHS Trust was established under an Establishment Order by the Secretary of State in April 2011.

We are a specialist community and mental health provider with an annual income of over £187m for 2017/18. Last year, we employed 4,086 clinical and non-clinical staff (including part time and bank staff) which equates to 2,899 whole time equivalents (WTE) and delivered nearly 1 million service user contacts.

What do we do?

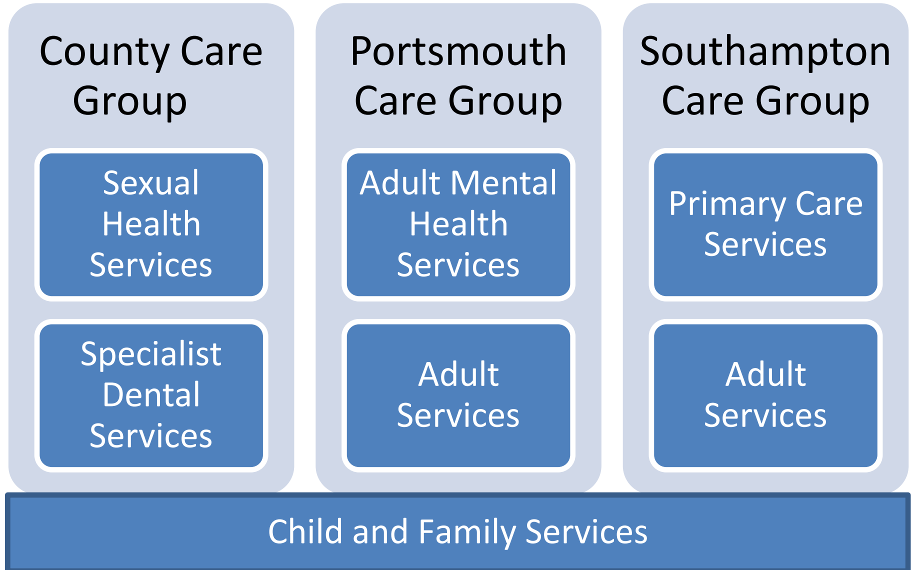
We specialise in providing high quality, best value, community and mental health services to people living in Portsmouth, Southampton and in some parts of Hampshire. Our team of talented staff work from over 100 clinical locations.

We support families to ensure children get the best start in life, provide services for people with complex care needs and help older people keep their independence. We also provide screening and health promotion services, which support people to lead a healthier lifestyle.

We actively promote strong out of hospital services and take an active role in integrating care. Working closely with other trusts, primary care, social care providers and the voluntary sector we make sure care is joined-up and organised around the individual.

We always endeavour to maintain our focus on providing safe, effective and quality services and pride ourselves on being a learning organisation. We are creating a culture of continuous improvement, providing our staff with the tools, capability and capacity to continuously improve to ensure we provide people with the best, and most effective, services we can.

The following diagram illustrates our Care Group Structure:



Who do we serve?

We are the main provider of community health services in Portsmouth and Southampton and the main provider of adult mental health services in Portsmouth. We also provide a number of pan-Hampshire specialist services, including sexual health and specialist dentistry.

We are commissioned by NHS England, Clinical Commissioning Groups and Local Authorities in Southampton, Portsmouth and Hampshire. Southampton and Portsmouth together have more than 450,000 people resident within the cities each covering a relatively small urban geographic area with significant health inequalities, which are generally significantly worse than the England average for deprivation. Hampshire covers a wider geographical area, which is predominantly more rural and affluent, but also has urban areas of higher population density, significant deprivation and health need.

Our story – our vision and goals

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

The best people, doing their best work, in pursuit of our vision.

People dedicated to giving great care to our service users and patients, and great value to our partners.

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

How we deliver our vision…

We know our vision is ambitious, but we have excellent foundations. We will:

Deliver great care

- Involving service users in shaping care and always learning from their experiences
- Working closely with partners to join up care
- Treating people with respect, giving equal emphasis to physical and mental health
- Ensuring we provide quality services which are safe and effective

Make Solent a great place to work

- Supporting people to look after their health and wellbeing
- Improving the workplace by listening to ideas and acting on feedback
- Developing leaders to support and empower people in making a difference

Deliver the best value for money

- Spending money wisely and by working with partners
- Involving people in decisions about spending money
- Enabling services to have more time to provide care

Our values

Our shared values support the development of a strong working culture – guiding and inspiring all of our actions and decisions. They enable us to be better at what we do and create a great place for our people to work, whilst ensuring we provide the highest quality of care to people who use our services.

Our HEART values are meant to reflect the deep belief that we are a caring organisation at the centre of our community.

How do we work together as a values-based organisation?

Our values create the foundation for everything we do – for our employees and our community. During the annual appraisal process, we asked people to reflect on what the values mean to them personally and how they bring them

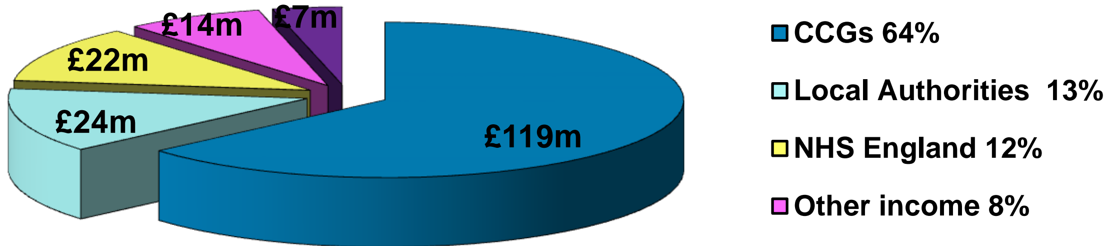
to work. We have also reshaped our recruitment and leadership practices to make HEART a part of our daily culture.

We will continue to develop ways of working that draw our values into all that we do, creating a great place to work and a great experience for people who use our services.

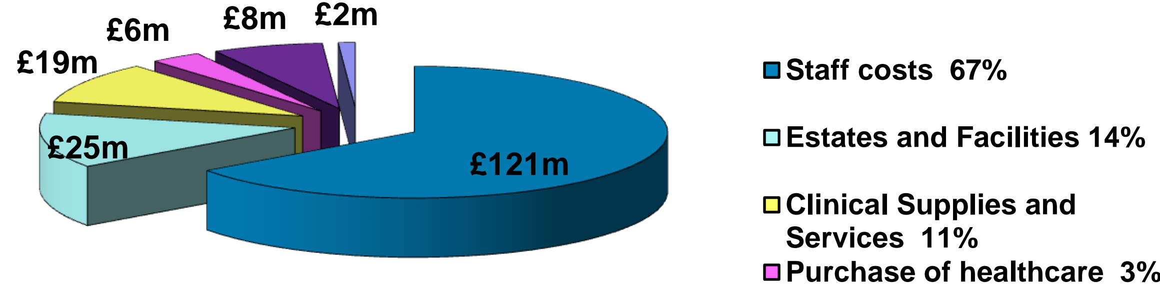
Our finances

During 2017/18 we had an income of over £187m.

Our income is illustrated below:



Our expenditure is summarised below:



Our 2017/18 business priorities

Every year we focus on a small number of priorities. These guide the work of our teams and are used to set individual staff objectives.

Our priorities for 2017/18 are summarised below:

Great care

1. Improve quality in line with CQC inspection requirements
2. Provide safe staffing
3. Use technology to work differently

Great place to work

4. Plan for long term sustainable staffing
5. Enhance our leadership throughout the organisation
6. Provide training that enables us to deliver great care

Great value for money

7. Further pathway integration with other providers
8. Benchmark our services to improve productivity
9. Change front line and corporate services to live within our income

Our performance against our priorities is detailed on pg [n]

The year in review

Summary of financial performance

A summary of financial performance can be found in Section 4.

Principle risks and uncertainties facing the organisation

Our focus during 2017/18, like the previous year, has been on maintaining service quality and sustaining financial recovery. Despite the financial challenges, service performance generally held up well throughout the year.

We achieved a modest adjusted surplus (excluding revaluations and impairments) of £0.7m for the financial year, representing a favourable variance of £2.2m against the deficit control total of £1.5m agreed with NHS Improvement. This compares to a deficit of £2.1m for the previous financial year. During 2017/18, Solent received £3.0m of Sustainability and Transformation funding, £1.8m of which related to the Trust improving its underlying position by £0.4m.

Our efficiency target (Cost Improvement Plan) was £6.1m, of which £4.2m was delivered; the balance was achieved by other measures.

Our plan for 2018/19 is a deficit of £1.0m.

Our business risks

The great majority of our business is with Clinical Commissioning Groups (CCGs), NHS England, and local authorities, as commissioners for NHS patient care services and preventative services. As CCGs, NHS England and local authorities are funded by Government to buy NHS patient care and preventative services; the Trust is not exposed to the degree of financial risk faced by business entities, apart from the normal contract negotiation/renewal that is normal in any organisation. Cumulative deficits have been incurred over the last three years, which have been funded by Department of Health loans with differing repayment dates. It is anticipated that these are rolled over until the Trust returns to making in-year surpluses.

Commissioning budget reductions

There will be risks to our income in the year ahead with commissioning budgets expected to reduce further in line with the national requirement for greater efficiencies, particularly given the financial pressures being exhibited in both the health provider and commissioner sectors. In addition, the financial constraints within local government are such that significant savings will be required, which will require difficult choices to be made.

The risks are such that solutions that are more radical in nature will be required over the next few years, which may mean that we will have to reduce, or stop, the provision of some services due to insufficient funds to deliver them safely and effectively. In addition, we will need to work more creatively with our partners to find solutions which may involve merging resources and teams, looking differently at our joint estate.

Changes to the commercial environment - Sustainability and Transformation Partnerships (STP)

The commercial environment continues to evolve and the Trust is working in collaboration with our health and social care partners to develop and implement system-wide plans to enable local providers and commissioners improve and manage services within collective budgets.

This includes exploration of integrated care system (ICS) models across our geography, in line with latest national guidance within the 2018/19 joint national planning guidance from NHS England and NHS Improvement.

All organisations with responsibility for health and care in Portsmouth and South East Hampshire (PSEH) have come together to deliver a shared set of objectives, which includes commitment to a single system improvement plan to restore and improve service quality, performance and financial health. We are establishing a new way of working

together, with providers and commissioners increasingly taking collective responsibility for population health and resources. We have 5 programmes in the system that include elective care, new models of community care, children and families and mental health The immediate priority is to deliver significant improvements in urgent and emergency care performance. The priorities for mental health are to create a new emergency front door alongside the physical health emergency services at Portsmouth Hospitals NHS Trust, and a collaborative approach to the management of service users needing acute bed admission.

We are engaged in a Multi-speciality Community Provider (MCP) transformation programme within Portsmouth, underpinned by a partnership agreement between the Trust, the Portsmouth Primary Care Alliance, the local authority and Clinical Commissioning Group (CCG). The programme builds on work already started to integrate community health and social care services at locality level, centred around primary care. Similar work is underway in Southampton, where, as a key partner in the Better Care Southampton transformation programme we are working with partner organisations to formulate a more robust out of hospital operating model that seeks to underpin the STP strategy. By delivering better integrated out of hospital services we will be able to deliver even better patient outcomes, while also operating more efficiently, establishing a new way of working together with common objectives and accepting collective responsibility for the health and care of the people in the areas we serve.

We acknowledge that the future organisational form for Solent, as we are currently constructed, is unclear and that there is significant uncertainty in relation to the medium and long-term configuration of health and social care services within Hampshire and the Isle of Wight STP. We do know that services will need to be radically transformed in order to ensure services are fit for the future – in terms of ensuring enduring quality and safety, meeting demand as well as achieving efficiencies. Whilst the front line services we offer will predominantly remain the same, it is likely that, in the future, we will increasingly be providing these via integrated models with key partners, supported by effective governance models and new contractual arrangements.

We also know that during times of change we are open to risk. These include risks concerning ensuring we are able to maintain 'business as usual', attract and retain an engaged workforce, remain a credible partner and continue to strive to achieve excellence in all we do. We must not get distracted.

The Board has oversight of our strategic risks, many of which are interdependent, via our Board Assurance Framework and also ensures we have appropriate mitigations in place to manage these, particularly during periods of such significant transformation. Ensuring that Solent provides great care, is a great place to work and provides great value for money remain our priorities.

There have been fewer tender opportunities in 2017/18, but we have continued to respond to those that are aligned to our core business and remain committed to exploring innovative models of integration and contract extension mechanisms to provide continuity for organisations and people who use our services.

Budget pressures and cost efficiency requirements remain a risk and any loss of key services will increase our financial pressure and also potentially destabilise other service contracts where there are significant interdependencies.

Details of our key risks in year are included within the Annual Governance Statement, page [n]

Working with our partners and alliances

As described previously, we continue to be committed to a future of integrated services wherever it makes sense to do so, and will always seek opportunities to work with other organisations to build robust and sustainable out of hospital services, delivering the best possible care to our people at, or close to, their own homes. In the following sections you can read more about our partnership working within our operational care groups.

Southampton and County Services

We remain a key partner in Better Care Southampton, a transformation programme which involves key stakeholders from across the Southampton health and social care community, including the voluntary sector.

The programme aims to:

- put individuals and families at the centre of their care and support, meeting needs in a holistic way
- provide the right care, in the right place, at the right time, enabling individuals and families to be independent and self-resilient wherever possible
- make optimum use of the health and care resources available in the community
- intervene earlier and build resilience in order to secure better outcomes by providing more coordinated, proactive services and
- focus on prevention and early intervention to support people to retain and regain their independence.

During 2017/18, we have continued with our work to design and evolve an operating model to achieve these aims. The model is focussed on wrapping services around the patient. This will allow teams to support more people, with complex needs, to help them to live as independently as possible in their own home, reduce non-elective admissions, as well as lower rates of re-admission post spells of acute care.

We made a number of changes in year which move us towards providing even more joined up services - some examples are illustrated:

Within social care

The Integrated Southampton Urgent Response Service and Community Independence teams bring together teams from the city council and our Solent services under a single management structure. Together they provide reablement and rehabilitation services co-located in bases across the city.

We have made good progress integrating our service provision for children and their families, focussing on 0-19 early help services. We have established a joint leadership team who are working together to deliver a more collaborative service. We have already established partnership arrangements with the council for children with special educational needs, and for services delivering child and adolescent mental health services for looked after children.

Within primary care

Our links with primary care are of key importance as we strive to deliver more community based care. We work very closely with colleagues from Southampton Primary Care Limited, particularly in supporting cluster level work.

Together with colleagues in primary care, we are working on a number of areas to improve the support provided to people in care homes. We are also working in partnership with Southampton Medical Services, supporting them in delivering a Community Wellbeing Service. This service is focussed on prevention and wellbeing in our communities.

Within the secondary sector

We work as a key system partner, supporting colleagues in University Hospital Southampton NHS Foundation Trust (UHS). By establishing strong relationships and transparent partnership working, as well as working in a more integrated way with social care colleagues, we have contributed to the improving position with regards to delayed transfers of care.

Our In- reach Coordinator, based in the hospital actively seeks out service users for discharge and our Community Emergency Department Team works closely with the emergency department and frailty partners to prevent admission through advice and information.

Within our community hospital wards based at the Royal South Hants Hospital, we have implemented a weekly Care Act compliance meeting, which includes colleagues from social care. Together, by sharing information, we evaluate delays to facilitate discharge.

We have also helped to develop the Southampton Integrated Discharge Bureau to become a hub for discharges across the community and acute sector.

Within the voluntary sector

We are working in partnership with Social Care in Action (SCA) Group and Southampton Voluntary Services to provide Southampton Healthy Living, a behaviour change service. The team focus on targeted interventions in smoking cessation, weight management, increasing physical activity and alcohol interventions, as well as provision of mini NHS Health checks and public health campaigns.

We continue to work with our partners to deliver our Homeless Healthcare team, a multi-disciplinary primary care team providing care to homeless people in Southampton.

Portsmouth and South East Hampshire

The priority in 2017/18 has been to further develop partnership arrangements within the city with primary and social care, and to support the creation of the Local Delivery System (LDS).

Multi- specialty Community Provider (MCP)

The Portsmouth MCP Programme is a partnership between the Portsmouth Primary Care Alliance (PPCA), Solent NHS Trust, NHS Portsmouth CCG and Portsmouth City Council (PCC). We have committed to working together to meet the challenges facing the health and care services in the city, through the development of new models of care that dissolve the traditional boundaries between the delivery of primary care, community health, social care and hospital services.

Key transformation programmes include:

Key transformation programme	Description
Community/neighbourhood model	An integrated service based on geography, rather than organisation
Integrated 24/7 primary care	Delivery of round the clock service with consistent capacity and capability provision
Care home team	Provision of regular planned support and improved urgent response
Musculoskeletal triage, emotional wellbeing, paediatric triage	Supporting primary care to help service users access the right services
Unified point of access / clinical assessment service	to simplify access points to services
Pharmacy support	Medicines management support to care homes
Long-term conditions hub	Developing a model of proactive community based
Information and IT	Further expanding the opportunities of the shared care record system support
Organisational development/ Workforce development	Developing shared opportunities for learning and development and designing a new workforce
Communications and engagement	Ensuring our stakeholders and communities are involved in what we do

Within social care

During 2017/18, we worked with Portsmouth City Council to bring together our early help and prevention services. A single leadership structure is now in place, and we are working to integrate our health visiting and family nurse teams, focused on families with children under the age of 5. We are also integrating our school nurses with teams in the local authority who provide services to young people, aged 5-19, and their families.

Services are provided in the community and through Family Hubs, previously known as Children's Centres. These have been rebranded so that they meet the needs of young people up to the age of 19, as well as their families.

As part of the remodelling and integration of the 0-19 services, our Health Visiting Service has been refreshed to offer a targeted response to families who are most in need. We continue to also provide the universal service delivery to everyone; this is core to the health visiting offer.

Our adults teams, who are already collocated, have been working together to provide a single approach to the delivery of adult services. The new neighbourhood model pilots this approach. The model brings together all care delivery, including social care and primary care, to focus on the needs of the population in the neighbourhood. Our integrated approach is not new; we already have this operating in our step down service which has recently partnered with a key domiciliary care provider to make a step change in early supportive discharge from the acute hospital.

Within our mental health services, we continue to operate a successful partnership agreement with social care to ensure we provide joined up care. The team continue to have a positive impact on our clients, and in particular

ensure that they receive services close to home.

Our teams work with teams in Portsmouth City Council to jointly deliver learning disability services in Portsmouth. Through integration, the service has been able to realise its ambitions of providing 'named workers' to all service users, involving people in service design and jointly managing safeguarding adult concerns. The joint team have also developed a housing and support strategy. The changes, brought about by the integration of services, have been really well received by service users and their carers. The achievements of the teams have been noted locally, regionally and nationally.

Within the voluntary and community sector

To ensure people benefit from the wide variety of services available and best suited to their needs, we continue to work in contractual arrangements with a number of community and voluntary organisations, including Society of St James, Solent Mind and No Limits. As an example, we work in close partnership with Solent Mind delivering support and recovery services, helping people to access our mental health services to achieve improved mental health and wellbeing. We also work together with organisations who support children and their families, including Barnardo's and Homestart.

Our role in the Portsmouth and South East Hampshire Local Delivery System

Solent plays an active role in the Integrated Care System which is focussed on four transformation programmes including:

Transformation Programme	Description
Urgent care	Working with our partners, we are providing services to help prevent emergency admissions into hospital and to support people to return home as soon as possible.
Elective care	We are creating local services for the management of long term conditions, and changing pathways to ensure people are triaged before they are referred for surgery.
Community health and care programme (New models of care)	Transforming services to provide an accelerated approach to providing new models of integrated primary and community care.
Mental health	Working with the acute hospital to provide a mental health assessment unit within the emergency department, and working with partners in the provision of mental health services to manage the number of beds available.

Working in the community

Engagement with local people

We always try to ensure that people who use our services and the public are at the heart of everything we do, in line with the NHS Constitution. We believe that by listening to the people who use our services we can understand what matters to people most, and can create, develop and transform services in response. We work with service users and the public to improve services, enhance patient experience and improve quality and safety.

Patient and public involvement (often referred to as engagement or participation) can take place in a variety of ways, for example through social media, formal consultations and meetings. Below you'll find a flavour of some of our involvement activities during the past year;

- The environment in which we provide our services is of the utmost importance to the patient experience. We always seek to ensure that the buildings we provide our services from are fit for purpose. Within the year we asked service users and their families to comment on some of our estates plans, including the proposed move of The Kite Unit (our specialist neuropsychiatric rehabilitation service) to the Western Community hospital and proposed relocation of Podiatry Services from Woolston Clinic to Thornhill Centre for Healthy Living and Bitterne Health Centre. Feedback we received helped shape and inform our plans.
  We have also asked people who use our services to work with us to develop aesthetically pleasing and pyshcologically beneficial surroundings. Recent decoration at both the St Mary's Community Health Campus and The Limes reflects patient feedback we received.
- To help establish a Trust standard for dementia friendly care environments, we asked service users at The Limes, our older person's mental health unit, to help us develop wayfinding that meets their needs. The new signage has been well received and now forms part of our Estates signage portfolio.
- As part of their Quality Improvement project, to reduce the number of HIV patients who do not attend their clinic appointments, our Sexual Health team worked with service users to understand what helps or hinders people from attending appointments and what they could do to make it easier for people to attend. The service will use this information to explore potential changes they can make to better support people to attend.
- Our Homeless Health team have been working with service users to understand why people do not attend their secondary care appointments at hepatology for hepatitis C. Speaking with service users, the team identfied the need to offer additional assistance to help them book appointments. Thanks to feedback, the team are also exploring establishing a mentorship group to offer people peer support.
- Side-by-Side is the name given to a partnership between the Solent Academy of Research and Improvement team and a dedicated group of individuals that give a patient and public perspective to our work. The group meet regularly to help make sure everything that the team do has a patient perspective embedded at the heart of it. This collaboration has been extremely successful and continues to grow. In 2017 Side-by-Side was instrumental in helping us to become one of the first NHS Trusts to gain the internationally recognised 'Patients Included' accreditation for our annual conference. This accreditation is awarded to events which go the extra mile to include service users and ensure that their voice is heard and valued.
- The Board also seeks views directly from service users. Last year we heard service users share their stories from services across the Trust including children's services, Musculo-Skeletal (MSK) physiotherapy, podiatry, sexual health and the falls service – after each story the Board reflects on any learning that could be taken.

You can find more about how we have engaged with people who use our services and our 'Side by Side' Group in our research and quality improvement agenda within our Quality Account, which includes our Research and Improvement Annual Report 2017/18 as an appendix.

Engagement with our Membership

Although we stepped off the Foundation Trust (FT) application pipeline in 2015, and have not held any active recruitment campaigns in the last year, we have remained engaged with our registered membership.Our membership constituencies, as defined when we were on the FT journey, are as follows;

- **Public constituency** – people aged over 14 based in Southampton, Portsmouth and wider Hampshire and includes service users and carers. We have a total of 7,041 public members.
  The public constituency consists of three geographies including Portsmouth City (1,803), Southampton City (2,031) and wider Hampshire(3,207).
- **Staff constituency** –all permanent members of staff, as well as bank staff over 12 months and temporary staff on a contract of over 12 months, unless they opt out. We have a total of 4,080 staff members. You can find more about our Employee Engagement initiatives on page [n].

Over the last year we continued to explore opportunities to engage with our members.
During the year we:

- continued with our programme of Health and Mind events with topics focussing on falls prevention and dementia awareness
- published four, quarterly editions of Shine, our newsletter for both staff and public members
- invited members to attend our Annual General Meeting 2017 and health fair
- shared information on key topics, including our Care Quality Commission inspection and Sustainability and Transformation Plans
- offered members the opportunity to volunteer with us, or to join us as an apprentice
- shared information about various health campaigns including Stoptober and Cover up Mate.

Our volunteers

We recognise the significant contribution volunteers can make to our services; they help to enhance the patient experience and enable communities to participate in the community health agenda. Our volunteers enhance and enrich the work of our employees.

Providing volunteer opportunities and supporting volunteering helps promote active citizenship and social inclusion. In addition, developing volunteer opportunities enables us to foster our relationships and profile with local people.

We continue to actively recruit volunteers into clinical and non-clinical roles. They help to enhance our services by:

- meeting, greeting and directing service users
- gathering patient feedback
- providing clerical assistance
- befriending

- providing peer support
- gardening and tending to flowers

As well as offering traditional volunteer opportunities we also ask people to become volunteers by experience (also known as experts by experience or peer volunteers). Volunteers by experience are recruited to share their own life experience of a health condition or of using a service.

Engagement with Health Overview and Scrutiny Forums

We have continued to regularly attend scrutiny panel/committee meetings in Portsmouth, Southampton and Hampshire.

During the year we provided updates and answered questions on the following subjects:

Southampton (Health Overview and Scrutiny Panel)

- Update on Kite Unit relocation, following some planning delays
- Telephony - moving from BT/Virgin voice phones to free 0300 numbers
- Woolston clinic closure
- Reprovision of services at Thornhill Community Health Centre
- Quality Account
- Substance misuse service (Solent stopping provision of service in the city)

Portsmouth (Health Overview and Scrutiny Panel)

- Update on Kite Unit relocation, following some planning delays
- Telephony - moving from BT/Virgin voice phones to free 0300 number
- St Mary's Community Health Campus redevelopment plans
- CQC inspection update
- CQC National Review of Mental Health Services for Children and Adolescents
- The Trust's Financial Position and Forecast
- Quality Account

Hampshire (Health and Adult Social Care Select Committee)

- Update on Kite Unit relocation, following some planning delays
- Telephony - moving from BT/Virgin voice phones to free 0300 numbers
- Quality Account

The future - our Community Engagement Framework

We know there's a lot more we can do to actively, and meaningfully, engage with our community and to ensure a more consistent approach across our services and interactions with people. During 2018/19 we will be developing a framework for Community Engagement which will focus on four main dimensions for engagement. This will incorporate how we will use our previously registered membership (a requirement of our former Foundation Trust application process) , changes to our Members Council and how we use volunteers.

Investing in our future

We have continued to invest in our infrastructure and in our people. Making the most from our resources will help us deliver great value for money.

Our investment in our estate has been significant during the year, with the single biggest project completed being the move of the Kite Ward from the St James' Hospital site in Portsmouth to the Western Community Hospital in Southampton. This project involved a multi-disciplinary team of people. We have also invested heavily in backlog maintenance to improve the physical condition of our buildings and in anti-ligature adjustments to our mental health facilities; significant spend is earmarked for future years to continue on both these areas.

Having spent significant sums over the last few years on IT equipment, we continue to look at how we can work differently, considering the cultural aspects of change as well as the use of physical assets.

We value our people and recognise that an engaged workforce will deliver great care; we therefore invested significantly in our Organisational Development Programme in year, particularly focusing on our leadership capability and our 'Leading with HEART Programme' for our senior leaders. We recognise the importance of leadership development as being key to creating a great place to work, providing great care and ensuring great value for money. During the year ahead we will be extending our programme to the next tier of leadership.

Charitable funds

Beacon, Solent NHS Charity, raises money for areas not covered or fully supported by NHS funds and aims to make a difference to the experience people have when they come to us. This can be anything from improving a waiting area, buying a more comfortable chair to creating a multi-use outdoor sports area for those staying with us on a longer term basis. Sometimes it is the smallest things that can make the biggest difference.
Whilst we are a relatively small and unknown charity, we are immensely grateful to everyone who has donated money. The donations we received during 2017/18 amounted to £7,081. During the year ahead we will be considering how the charity can make linkages with 'in kind' support opportunities to maximise the social impact and outcomes.

Whole system response and emergency preparedness

The Emergency Preparedness, Resilience and Response (EPRR) for Solent NHS Trust is an ongoing identified work stream which has developed over the past three years.

In 2017/18 we continued to review all of our emergency plans. These are validated as part of the testing schedule within the Trust, often in partnership with the wider health community.

We continue to work with other organisations to prepare for a critical or major incident. Our Chief Operating Officer for Southampton continued to represent us at the Health Resilience Partnership (LHRP), whilst our Emergency Planning Practitioner (EPP) continues to regularly attend local health resilience meetings, sharing information with our Emergency Planning Group.

During 2017/18 we have:

- participated in an incident outbreak planning exercise
- held business continuity exercises to test service business continuity plans
- participated in an exercise in Portsmouth, involving the acute trust and partners
- providing regular training for on call staff
- participated in system wide task and finish groups for flu planning and mass casualty response.

We also implemented a new training plan. The plan, which has been built around the training needs of our employees, using lessons identified from incidents and previous training and included at least one training session for each on-call member of staff during the year.

In preparation for a difficult winter, we reviewed and updated our winter plan ensuring that contingency plans for increased capacity were developed and documented for use during high capacity system challenges.

Each year NHS England (NHSE) assesses us for assurance against the EPRR core standards. In 2017/18, NHSE concluded that we were 'fully compliant' with the EPRR assurance assessment. NHSE acknowledged the work we had undertaken during the year, commending our work to achieve an 'excellent level of compliance'.

Solent news

In the following sections you can read a few examples of our promotional stories.

Southampton and County care group

Helping the homeless for 25 years

Our Homeless Healthcare Team hosted a tea party to mark their 25th birthday in July. The event was attended by service users, stakeholders, staff, the Mayor of Southampton as well as former Southampton Football Club Manager and FA Cup winner, Lawrie McMenemy. The event took place at the self-referral Two Saints Day Centre in Southampton, from where our service is run.

Artwork created by Primary school pupils

Pupils from Thornhill Primary School created a healthy living montage, which takes pride of place in our new children's hub at Thornhill Healthy Living Centre's reception area and upstairs waiting area.
The school's 360 children, with support from local artist Joe Ross and a project officer from Southampton Solent University's School of Art and Design, sketched, modelled and painted their idea of healthy living.

New location for the Kite Unit

In January 2018 our specialist neuropsychiatric rehabilitation service, known as the Kite Unit, moved from St James' Hospital in Portsmouth to a new, purpose-designed area within Western Community Hospital in Southampton. The move followed a £1m investment, which included a complete refurbishment and the creation of bespoke features designed for service users by Solent's Estates team. Specialist features include:

- a 'quiet room', enabling service users to sit in a relaxing space looking out over the unit's gardens
- a fully equipped gym to help service users maintain their fitness and reduce symptoms of depression
- a therapy room and kitchen, enabling service users to re-learn essential life skills, such as cooking, and develop new ones to improve their wellbeing including painting and gardening.

HIV webchat launched

In July our Sexual Health Services launched an online live chat service for people living with, or affected by HIV. HIV Live Chat, funded by Public Health England, is accessible at www.letstalkaboutit.nhs.uk/livechat and is believed to be the first of its kind in England, allowing users to talk directly online with an HIV clinical specialist. The user, whether they are someone diagnosed as HIV positive or someone affected by another with the virus, is given appropriate and confidential clinical guidance, counselling and signposting over the course of the chat.

Elf fundraising

The Special Care Dental Service in the north of the service ran a fundraising event as part of the Alzheimer's Society ELF day in December. The day was arranged to raise vital funds and awareness of the condition.

Portsmouth

Diabetes event

Our Diabetes Specialist Nursing Teams, together with Southern Health NHS Foundation Trust, held an event in May 2017. Attended by over 100 people, information was shared about how to keep healthy while living with diabetes. The teams talked with people about the importance of foot and dental care, and the importance of maintaining a balanced diet.

Praise from parents

Our staff in Children's Services were awarded the 'Parent Appreciation Award' from Portsmouth Parent's Voice (PPV), a forum to support parents and carers find services and support for 0-25 year olds with additional or special needs and/or disability. Sian MacLoed, Specialist Health Visitor, Dr Soha Mina, Dan Bevan, Austism Liaison and Support Worker, and Deborah Burness, from CAMHS, were praised for the difference they have made.

Pulmonary Rehabiliation Week

To mark Pulmonary Rehabilitation Week in June, our Pulmonary Rehabilitation Service teamed up with Breathe Easy, a local British Lung Foundation support group ,and demonstrated exercises in the main reception at the Queen Alexandra Hospital in Portsmouth. The team work with people on the best exercise techniques and education to help them manage their condition on their own.

Trust wide

Baby Buddy App

In November, our health visitors launched a mobile app to help parents and health professionals through pregnancy, birth and the first six months of a baby's life.

The free app,'Baby Buddy', was created with mums, midwives and doctors and is supported by midwives at Portsmouth Hospitals NHS Trust and University Hospitals Southampton NHS Foundation Trust. It acts as a tool to provide people with information that is reliable, accurate and available 24 hours a day.

Solent Mindfulness workshops

Talking Change, a team of psychotherapists and researchers who specialise in the understanding and treament of common mental health conditions, developed mindfulness opportunities for Solent employees. During the year, the team have offered a number of one off sessions, as well as an 8-week mindfullness based stress reduction course.

Premises and Facilities Management (PFM) Awards 2017

Together with Kier Workplace Services, we were shortlisted as finalists for the Premises and Facilities Management Awards at the event held in November.

Research league tables

In August we were named as the top recruiting research Care Trust in England by the National Institute for Health Research. The research was conducted between April 2015 and March 2016 and over 1,800 participated. This was an increase of 48% on the previous year.

Solent regional collaboration housing summit

Sue Harriman, our CEO, hosted a regional housing, health and care summit in September 2017. Senior public sector leaders from housing, health, voluntary sector and care organisations across Hampshire and the Isle of Wight met to agree how they could better work together to consider alternative delivery models and opportunities to:

- use collective assests (including buildings, properties and land to improve the mental health and wellbeing of communities
- utilise and lever greater value from joint workforces to keep people safe and well at home
- building grass-roots community resilience to change and build mental health friendly communities.

Making a difference to employee mental wellbeing

As part of our employee health and wellbeing programme, we worked with people who have experience of mental health problems to develop the OWLES (Optimising the Wellbeing and Lived Experience of Staff) group. The role of the group is to help create a culture where our employees feel comfortable and inspired to talk about mental health, and to encourage everyone to support one another. The group worked together to design and develop a week of activities to help people think about mental wellbeing. As well as ‘Power Hour’ bite size learning sessions and an online activity pack, the group organised a number of mindfulness workshops, stress buster sessions and roadshows.

Going concern

Our statement on Going Concern can be found in Section 4.

Performance Analysis

Performance Measurement

We record and report a range of data on a monthly basis for all of our services, including team level data in some instances. The information is used to help us provide internal intelligence and assurance that our services are delivering safe, effective and efficient care.

In addition to these internal measures, during 2017/18 we also reported against 550 Key Performance Indicators (KPIs) as well as an additional 952 individual reporting indicators – together these help commissioners monitor our performance against the standards of care expected and services commissioned.

On a monthly basis we hold monthly Performance Review Meetings with our service lines and corporate directorates. At these meetings progress against specific agreed indicators is scrutinised and challenged. Any areas of significant risk that are not appropriately mitigated or where assurances are lacking are escalated to our Performance Subcommittees for additional oversight and scrutiny, before being escalated to our Trust Management Team, if appropriate.

Whilst we seek to address areas of exception, where performance is less than expected, we do of course promote and share performance successes and achievements so that we can spread learning.

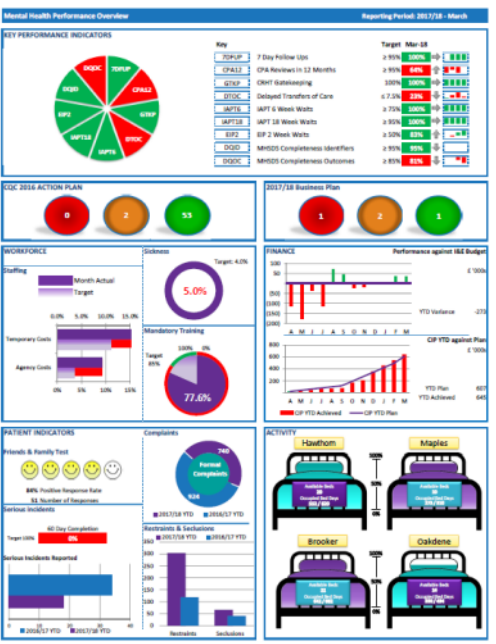
The key core areas reviewed at our monthly performance meetings across all of our clinical services are illustrated below – we also scrutinise other service specific information and reports.

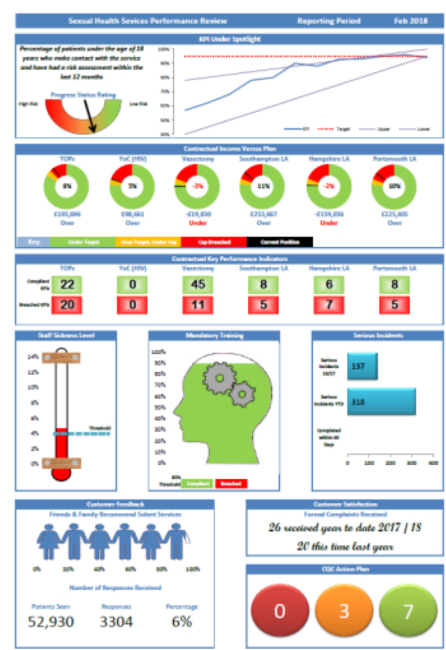
Performance Dashboards

During 2017/18 we introduced a new form of performance dashboard which triangulates information enabling us to enhance our intelligence. The new dashboards incorporate infographics to simplify data presentation and increase accessibility of the information presented with the aim of enabling managers to better engage in performance reporting.

Our dashboards have been co-created with each of our individual service lines to ensure that the information presented is the most relevant to them. During the year ahead we will further embed our dashboards in our formal performance reports.

Examples of our innovations are below:





NHS Improvement Single Oversight Framework

The NHS Improvement Single Oversight Framework (SOF) provides the framework for overseeing organisations and identifying potential performance concerns. We continued to assess ourselves against the standards set out and have maintained our ‘Level 2’ organisational grading, where Level 1 is the best and Level 4 indicates an organisation that is most challenged. We believe this is a positive position for us and our inability to achieve a Level 1 rating has predominately been caused by our forecasted in-year financial deficit.

The framework covers five themes:

1. Quality of care
2. Operational performance
3. Finance and use of resources
4. Strategic change
5. Leadership and improvement capability (well-led)

Currently NHSI has defined metrics associated with the first three themes listed above; as such our performance is summarised as follows. Thresholds highlighted in grey are internal, aspirational thresholds, whereas all others are national targets. NHSI is working to develop the performance metrics associated with the additional themes, aligning approaches to the CQC Domains where possible.

Quality of Care

Under this domain we monitor ourselves against metrics relating to:

- Organisational Health
- Caring
- Effective and
- Safe

Organisation health

We set ourselves some internal ambitious targets and our performance against these is summarised below. Staff sickness showed a gradual increase through 2017 into the winter period but then fell sharply after the flu season had passed. Staff turnover has gradually decreased over the year which is positive and we hope to continue this trend during the year ahead. The utilisation of temporary staffing has been a challenge at times throughout the year, due to a number of reasons including, difficulties in recruiting due to national staff shortages (particularly within our mental health services and band 5 nurses[1] within our community services) as well as supporting system pressures during the challenging winter period. We are however continuing to actively recruit and aspire to be an employer of choice.

Organisational Health — Internal aspirational thresholds are highlighted in grey

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Staff sickness (in month)	4%	4.0%	4.1%	4.1%	4.3%	4.8%	4.6%	4.9%	5.2%	5.1%	5.2%	4.3%	4.2%
Staff turnover (rolling 12 months)	12%	15.2%	15.3%	15.1%	14.8%	14.8%	14.5%	14.2%	14.3%	14.4%	14.1%	14.4%	14.2%
NHS Staff FFT	40%	-	-	64.4%	-	-	64.1%	-	-	-	-	-	-
Proportion of Temporary Staff (in month)	6%	6.9%	5.9%	6.1%	6.1%	6.4%	5.8%	5.7%	6.0%	6.1%	6.0%	5.9%	6.0%

[1] Band 5 nurses are also known as 'staff nurses'

Caring

Our performance against the caring metrics was strong throughout the year with only the Mental Health Patient Friends and Family Test under-achieving[2]. Despite this being a very challenging target, due to the nature of the service provided, we have consistently achieved 80% or more which benchmarks positively nationally.

Caring													
Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Written Complaints		7	21	22	14	16	17	11	19	16	18	22	20
Staff Friends and Family Test Percentage Recommended - Care	80%	-	-	83.0%	-	-	82.3%	-	-	-	-	-	-
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Scores from Friends and Family Test - % positive	95%	96.8%	95.7%	95.1%	97.8%	95.2%	95.0%	96.0%	97.0%	96.6%	96.2%	96.2%	95.9%
Mental Health Scores from Friends and Family Test - % positive	95%	97.2%	88.1%	87.1%	100.0%	90.5%	83.3%	85.4%	91.3%	83.3%	95.6%	84.3%	80.5%

Effective

We performed strongly against the effective domain and metrics throughout the year with the relevant indicators all achieved by our Mental Health Services. Only one month's performance slipped just under the target all year.

Effective													
Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	100%	100%	100%	100%	92%	100%	98%	100%	100%	100%
% clients in settled accommodation		69%	69%	68%	69%	70%	72%	72%	71%	71%	71%	70%	71%
% clients in employment	5.0%	5.6%	6.6%	6.0%	6.0%	5.0%	5.0%	6.0%	6.0%	5.0%	5.0%	5.0%	5.2%

Safe

We also performed positively against the safe domain. During the second half of the year NHSI introduced 2 new indicators for monitoring – including; the number of incidences of Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias and Escherichia coli (E.coli) bacteraemia bloodstream infection. We met the target of zero for both of these indicators.

Safe													
Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-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	1	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95%	91%	100.0%	97.0%	99.0%	98.0%	97.0%	100.0%	97.0%	97.0%	96.0%	95.0%	92.0%
Clostridium Difficile - variance from plan	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile - infection rate	0	0	0	0	0	0	0	1	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA)	0	-	-	-	-	-	-	0	0	0	0	0	0
Escherichia coli (E.coli) bacteraemia bloodstream infection	0	-	-	-	-	-	-	0	0	0	0	0	0
MRSA bacteraemias	0	0	0	0	0	0	0	0	1	0	0	0	0
Admissions to adult facilities of patients who are under 16 yrs	0	0	0	0	0	0	0	0	1	0	0	0	0

[2] The 2016-17 NHS Benchmarking Network: Friends and Family Test results: 85% mean and 88% median

Operational Performance

We performed excellently throughout the year against indicators focussing on our access times, mental health service placements and data quality.

Operational Performance Indicators

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	99.3%	100.0%	100.0%	99.9%	99.8%	99.5%	99.7%	99.6%	99.7%	99.4%	99.4%	99.7%
Maximum 6-week wait for diagnostic procedures	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Inappropriate out-of-area placements for adult mental health	0							0	0	0	0	0	0
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	30.0%	71.0%	50.0%	86.0%	67.0%	83.0%	80.0%	88.0%	50.0%	40.0%	83.0%	100.0%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%							97.7%			98%		
Improving Access to Psychological Therapies (IAPT) / Talking Therapies													
- Proportion of people completing treatment who move to recovery	50%	61.8%	60.2%	57.4%	57.3%	56.5%	61.1%	60.4%	57.8%	53.4%	57.8%	57.6%	58.2%
- Waiting time to begin treatment - within 6 weeks	75%	100.0%	99.8%	99.0%	100.0%	100.0%	100.0%	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%

Finance

The SOF also measures our financial performance via a set of indicators which calculate a 'finance score'.

Finance Score

Indicator Description		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Capital service capacity	Financial Sustainability	0.0	1.1	1.5	1.4	1.6	1.7	1.7	1.6	1.8	1.7	1.8	2.5
Score		4	4	3	3	3	3	3	3	2	3	2	2
Liquidity (days)	Financial Sustainability	-13.0	-12.9	-12.5	-13.0	-12.9	-13.3	-12.7	-14.4	-15.4	-14.7	-10.7	-6.7
Score		3	3	3	3	3	3	3	4	4	4	3	2
I&E Margin	Financial Efficiency	-0.02%	-1.9%	1.3%	1.4%	1.1%	0.9%	1.0%	-1.0%	-1.0%	-0.9%	-0.7%	0.4%
Score		3	4	2	2	2	2	2	4	3	3	3	2
Distance from financial plan	Financial Efficiency	-0.02%	-0.5%	0.0%	0.1%	0.2%	0.3%	0.1%	0.0%	0.1%	0.1%	0.2%	1.3%
Score		2	2	1	1	1	1	1	1	1	1	1	1
Agency spend	Financial Controls	0.3%	25%	24%	25%	47%	40%	38%	38%	42%	42%	43%	38%
Score		2	3	2	2	3	3	3	3	3	3	3	3
	Finance Score	3	3	2	2	2	2	2	3	3	3	2	2
	RAG	R	R	G	G	G	G	G	R	R	R	G	G

Our score fluctuated through the year between 2 and 3, where 1 is the best rating and 4 the worst. The two main areas of variance in the year were caused by our liquidity and our income and expenditure margin. However, as we achieved better than our agreed deficit control target set at the beginning of the year, we have showed a strengthened financial position on recent years.

There have been no important events since the end of the financial year that have affected our overall performance.

Strategic Objectives Achievement

We began the year with 163 strategic objectives planned for delivery against our 2 year Operating Plan (2017-19). These objectives were further split into 669 respective milestones managed locally by service lines and corporate teams - progress is monitored against agreed objectives.

Solent NHS Trust Priorities and the Solent Story

As part of our business planning process for our Operating Plan, service lines and corporate directorates aligned their own strategic objectives to our 9 organisational priorities to ensure there is a direct relationship between the service we provide and our strategic direction - these are mapped in the following tables.

To provide great care		
Improve Quality in line with CQC Requirements	Provide Safe Staffing	Use Technology to work differently
24	16	16

A great place to work		
Plan for long term sustainable staffing	Enhance our leadership throughout the Organisation	Provide training that enables us to deliver great care
22	19	23

To deliver great value for money		
Further Pathway Integration with other providers	Benchmark our services to improve productivity	Change front line and corporate services to live within our income
24	22	19

Our key successes

The following section illustrates some examples where we can demonstrate we have made a difference.

Service line: Adults Southampton
Objective: To develop inpatient services in line with changing health demands of our community

As a result of reviewing patient pathways into our inpatient services based at our community hospitals we have identified opportunities for service users within Acute Medical Units to be safely transferred to the Royal South Hants Hospital – protocols have subsequently been drafted. We have also promoted access to our sister services including the Community Emergency Department Team (CEDT), Urgent Response Service (URS) and primary care. We are now exploring further opportunities to develop IV antibiotic administration in the community, led by the URS with our acute partners.

Service line: Sexual Health
Objective: Grow our local/regional/national reputation as an innovative provider of integrated sexual health services by expanding our digital offer and research capability

The Sexual Health service has improved the digital services available to our service users in order to help raise the profile and awareness of the services that we offers. This was successfully achieved through an increase in posters, oral presentations and journal articles which helped improve our engagement with our service users. The service also successfully developed a web-chat facility for our service users with HIV, improving access for service users who required advice. Due to the success of the web-chat facility, the Sexual Health service are now looking to roll this out in 2018/19 to the wider service so that this facility is available for all Sexual Health service users.

Service line: Child & Family
Objective: To develop options on how services can deliver differently using interactive platforms, new technologies and intelligent use of patient record systems

By engaging with almost 200 service users, the service ran a digital innovation project to re-develop how our staff engaged with service users, what communication methods we offered and what our current patient facing website offered. Consequently, a new website was launched in November 2017 with reliable up to date information, contact details and interactive media. The service is also planning to commence live question and answer events from May 2018. We will also be launching a new messaging service allowing direct contact with a qualified nurse enabling service users to choose phone, email or text as their method of preferred communication. We have also promoted reliable Apps which we believe will benefit service users.

NHSI Well Led Framework and licencing requirements

You can find more about our compliance with the Well Led and Licencing requirements within our Annual Governance Statement. Any risk to licencing non-compliance would be appropriately reflected within our Board Assurance Framework and appropriate mitigations would be implemented.

There were no confirmed Human Rights violations by us during 2017/18 and the Trust has an agreed Anti-fraud, Corruption & Bribery Policy and procedures. Our policies are available on our public website www.solent.nhs.uk .

Environmental Reporting

We have developed a Sustainable Development Management Plan that aligns with the NHS Standard Contract, specifically the Service Contract item SC18 – Sustainable Development.

On an annual basis we complete the Sustainable Development Unit report, supported by ERIC returns (Estates Return Information Collection) and from data provided through our energy bureau. This is in line with our Carbon Reduction Action Plan, to meet our mandatory sustainability reporting requirements.

In addition, on a monthly basis, we monitor our waste disposals and utilities consumption. Our utilities consumption is compared with previous year's usage to ensure economic efficiencies and to track consumption in line with our carbon reduction targets. Our waste disposal locations are monitored to ensure minimal waste to landfill, and to track increasing recycling rates. We work with our waste contractor to increase segregation to improve recycling rates, and with their subcontractors to increase clinical waste residues to R1[3] recovery facilities, instead of previous landfill sites. With the agreement of the Environment Agency, the waste contractors permit has been enhanced allowing offensive waste to also be disposed of and recovered, via R1 facilities. In accordance with the HM Treasury Sustainability Reporting Guidance, our Carbon Reduction Action Plan addresses the minimum requirements concerning Green House Gases (GHG) both Scope 1, (direct GHG emissions), Scope 2 (energy indirect GHG emissions), and Scope 3 (Other Indirect GHG emissions) as well as Finite Resource Consumption including estates water consumption, via our ERIC return (measured in cubic meters).

We are committed to sustainable procurement practices and all new contracts are issued in accordance with NHS Terms and Conditions. By ordering our goods via a supply chain we minimise fleet mileage, deliveries, congestion and associated pollutants. During the year we improved the analysis of our environmental information and data across our estate footprint more thoroughly through the use of data available from our energy bureau that will support the ERIC process and requirements under the Sustainable Development Unit, as well as more broadly ensuring sustainability is embedded within business practices across the organisation.

Further information about our environmental responsibilities can be found within the Annual Governance Statement.

The Performance Report is signed by

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

[3] R1 recovery facilities use waste to generate energy

Section 2: Accountability and Corporate Governance

Directors' report

Governing our services

Our Board of Directors

Accountable to the Secretary of State, the Board is responsible for the effective direction of the affairs of the organisation, setting the strategic direction and appetite for risk. The Board establishes arrangements for effective governance and management as well as holding management to account for delivery, with particular emphasis on the safety and quality of the trust's services and achievement of the required financial performance as outlined in its Terms of Reference.

The Board leads the Trust by undertaking the following key roles:

- ensuring the management of staff welfare and patient safety
- formulating strategy, defining the organisation's purpose and identifying priorities
- ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
- seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- shaping a positive culture for the Board and the organisation.

The business to be conducted by the Board and its committees is set out in the respective Terms of Reference and underpinned by the Scheme of Delegation and Reservation of Powers.

The Board meets formally every other month In-Public. Additional meetings with Board members and invited attendees are held following In-Public meetings to discuss confidential matters. The Board also holds confidential seminar (briefing) meetings every other month and development days every other month. All non-executive directors take an active role at the Board and board committees.

Balance, completeness and appropriateness of the membership of the Board of Directors

The Board of Directors comprises six non-executive directors (NEDs) including the Chairman and five voting executive directors. The executives with voting rights include the Chief Executive Officer, the Deputy CEO and Director of Finance and Performance, the Chief Medical Officer, Chief Nurse and Chief People Officer. Together with the Chief Operating Officer for Portsmouth and Commercial Director and the Chief Operating Officer for Southampton and County Services they bring a wide range of skills and experience to the Trust enabling us to achieve balance at the highest level. The structure is statutorily compliant and considered to be appropriate. The composition, balance of skills and experience of the Board is reviewed annually by the Governance and Nominations Committee.

Appointments

Executive director appointments

In year there were a number of changes to the Executive team as follows;

- Helen Ives was appointed as Chief People Officer in April 2017
- Lesley Munro was appointed as Interim Chief Operating Officer for Southampton and County services between February 2017 and May 2017. From June to November 2017 Lesley was the Interim Chief Nurse.
- From December 2017 Jackie Ardley was appointed as Interim Chief Nurse. A substaintive recruitment process commenced in Quarter 4 2017/18 and following an assessment centre in mid April 2018 we substantively appointed Jackie into the Chief Nurse role permanenty.
- David Noyes was appointed as Chief Operating Officer Southampton and County Services in July 2017.

Executive recruitment consultants, Odgers Berndston, provided executive search assistance with our executive director appointments.

Non-executive director appointment

During 2017/18 Stephanie Elsy was appointed as a Non-executive director supported by Odgers Berndtson. Interview panels were convened of representatives of NHS Improvement, an independent Trust Chair, the Trust's Lead Governor and the Trust's Chairman.

The people

Non-executive directors

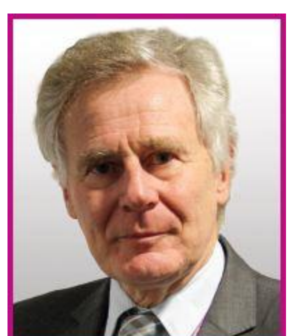
Dr Alistair Stokes, Chair

Alistair was appointed to the Trust in April 2011. He has had a wide ranging career in marketing, business development and administration in the chemical and pharmaceutical industries including working as Commercial Director with Monsanto Company and as Managing Director for UK operations and subsequently Regional Director for the Far East and South East Asia for Glaxo PLC. From 2007, Alistair served as Chairman of the Ipsen Group's UK companies, retiring from that role in 2010. Alistair also served as Regional General Manager for the NHS in Yorkshire and for several years as a member and Vice Chairman of a District Health Authority and from 1992 until 1998 as Chairman of an NHS Trust. He is a Fellow of the Institute of Directors and a Chartered Director. Alistair is the lead NED for Health & Safety (including Local Security Management).

Mick Tutt, Deputy Chair and Non-executive Director

Mick was appointed to the Trust in April 2011. He has more than 40 years NHS experience, including 20 years in Senior Management and more than a decade at Executive Director (and equivalent) level. As a qualified nurse Mick has managed mental health and learning disabilities services in a number of different Trusts and has experience of working with the CQC and its predecessors, including chairing comprehensive inspections and taking part in the new Well Led regime during the last year. Mick has also acted as the Nurse/Manager representative on several independent inquiries and has undertaken many investigations into disciplinary and grievance matters and serious incidents. Mick was a former lay member of the Portsmouth Community and Mental Health Service Board before being appointed as Non-Executive Director for Solent NHS Trust. He now acts as a manager for appeals against Mental Health Act detentions and also chairs the Mental Health Scrutiny Committee and Assurance Committee. Mick is also the lead NED for Patient Safety (including mortality).

Jon Pittam, Senior Independent Director and Non-executive Director



Jon was appointed to the Trust in June 2012. Since 1997 until his retirement in 2010, Jon was the County Treasurer for Hampshire County Council as well as being Treasurer for the Hampshire Police and Fire Authorities. In these roles, Jon provided financial and strategic advice in support of the authorities' corporate strategies and was the chief financial officer for budgets approaching £2 billion. Jon was an elected council member of his chartered accountancy body and the national spending convenor for local government finance during several public expenditure rounds. Jon is an Associate Hospital Manager, the chair of the Audit & Risk Committee and the lead NED for procurement.

Mike Watts, Non-executive Director

Mike grew up and went to school in Southampton. He is a Hampshire resident and has an extensive and wide ranging track record in organisational design and development that has driven business performance. Mike is currently the lead consultant with Capability and Performance Improvement Ltd of which he is a co-owner. He has previously held senior HR roles at Southampton City Council, and the Chartered Institute of Professional Development; Cabinet Office; Lloyds TSB and Scottish Widows. During his time in the Cabinet Office, Mike was recognised by HR Magazine as one of top 30 influencers of HR practice. He has also held a previous Non Executive Director role with the Scottish Executive. Mike was appointed in October 2016 and Chairs the People and OD Committee as well as the Remuneration Committee. He is also the lead NED for Medical and Professional Fitness to Practice issues.

Professor Francis Davis, Non-executive Director

Francis was appointed to the Trust in October 2016. Francis is currently Professor of Communities and Public Policy at the University of Birmingham where he publishes on inclusion, disability, cohesion and teaches post graduate policy and politics. He has, for 20 years, been active in founding, chairing and supporting community groups, voluntary organisations and social enterprises in health and social care. He helped to launch the 'Hampshire Festival of the Mind' and also the first UK 'Mental Wealth Festival'. Formerly a private sector CEO Francis has chaired industry bodies for the South and South East, worked as a senior civil servant at Cabinet level and is an advisor to CIPFA Consulting. He chaired both the Mayor of London's and the Mayor of the West Midlands cohesion summits and has been a member of the Department of Health's cross government Independent Advisory Group on Carers. Francis chairs the Finance Committee and the Charitable Funds Committee and is also an Associate Hospital Manager.

Stephanie Elsy, Non-executive Director

Stephanie has worked in the delivery of public services for over 30 years . She was a CEO in the charity sector for 15 years managing community and residential services for people recovering from substance misuse, people with disabilities and people living with HIV and AIDS. She then entered local politics as a Councillor in the London Borough of Southwark in 1995, becoming Chair of Education in 1998 and then Leader of the Council in 1999. After retiring from local government in 2002 Stephanie served on the Board of Southwark Primary Care Trust which had pooled its resources with the Social Services Department and had a joint Director. She also started a consultancy business providing services in health, local and regional government. Serco Group PLC became one of her clients, and in 2004 she was invited to join the company as a senior Director to support its Board and Senior Executives in raising the company’s profile in government and business. She was a member of the company’s Global Management Team and helped shape the company’s business strategy and supported new market entry in the UK and internationally. Stephanie left Serco in 2012 to establish a new consultancy business, Stephanie Elsy Associates, an advisory consultancy specialising in public sector services and the government contracting markets. She lives in Emsworth where she is Chair of the local Neighbourhood Forum which is developing a Neighbourhood Plan for the town. She also sits on the Board of the Responsible Finance Association, who represent Fair Finance providers that provide finance to customers not supported by mainstream lenders. Stephanie joined the Trust in September 2017 and is the lead NED for Patient Experience and Emergency Planning, Resilience and Response.

Non-executive directors who left in year

Jane Sansome

Jane was appointed to the Trust in June 2015. Jane had an extensive and highly successful 21 year career in the NHS before joining the Ministry of Defence in 2000 to lead the operational planning and delivery of the strategy to transform Defence Medical Services. In 2004 with the first stage of the strategic plan delivered, Jane moved to the private sector to become the Chief Executive Officer of the project company delivering the £1.2billion redevelopment programme for Barts and the London Hospitals. In 2012 Jane joined Skanska UK as a Non-Executive Director where she supported the Managing Director of Skanska Facilities Services to develop the strategy, resource and contract delivery plans for the company. Jane left Skanska at the end of February 2015 to become a freelance management consultant. Whilst at Solent NHS Trust Jane chaired the Finance Committee and Remuneration Committee and was the lead NED for patient experience and oversight of medical fitness to practice issues. Jane left the Trust in May 2017.

Executive Directors

Sue Harriman, Chief Executive

Sue trained as a nurse in the Royal Navy. During her 16 year military career, she worked in both primary and secondary care, including spending five months on board a hospital ship during the 1990 Gulf War conflict.

Sue was a trained critical care nurse for a number of years, and after completing a BSc in Infection Prevention at the University of Hertfordshire, joined the NHS in 2002 to become a Nurse Consultant in Infection Prevention. Sue has developed a management and leadership portfolio that includes attending Britannia Royal Naval College, Dartmouth, and gaining Masters level Management and Leadership qualifications at the University of Southampton.

Sue has been an Executive Board Director for 10 years. Her executive roles have included Director of Nursing and Allied Health Professions, Chief Operating Officer and Managing Director. Sue was appointed to lead Solent NHS Trust as Chief Executive in September 2014.

Sue has lived and worked, locally, in Hampshire since her military career brought her here nearly 30 years ago. She is committed to bringing health and care services together so they work in partnership with the community, and those who use and work with them.

As the Chief Executive, Sue believes her role is to empower the Trust to provide the best care possible, for its team of staff to feel supported and happy at work, whilst ensuring the Trust always offers best value for money.

Sue says, "I feel very privileged to be leading Solent NHS Trust at this time, I will never forget my roots as a nurse, caring for people and their families and friends at such important times in their lives. I became a nurse because I cared deeply about helping others, now as a Chief Executive I will do everything I can to make sure our team at Solent can always continue to care with compassion, and be the best they can whilst providing the care their service users want and need."

Andrew Strevens, Director of Finance and Performance and Deputy Chief Executive

Andrew is the Director of Finance and Performance and joined the Trust in August 2015. He has worked within the health service since 2009 and brings a whole system view, having worked in senior positions for providers (Hampshire Community Health Care and Southern Health) and as a commissioner (NHS England South Region). He also has a commercial background, having worked for KPMG and B&Q Plc.

Chief Medical Officer, Dr Daniel Meron

Dan joined the Trust in January 2016. Dan studied Medicine at the University of Southampton, and completed psychiatry training in Wessex. He went on to become a consultant in general adult psychiatry in Avon & Wiltshire, where he held consultant posts in community teams, Crisis Resolution and Home Treatment, Acute Inpatient, Assertive Outreach, and Primary Care Liaison. Over the years he developed a management and leadership portfolio and continued to combine senior management roles with active front-line clinical work. He is actively engaged in research at the School of Medicine, University of Southampton, where he completed a Doctor of Medicine higher research degree. He has special interest in mood and anxiety disorders, trauma, addiction, recovery, and mindfulness. Dan undertook an Executive-MBA degree at Hult International Business School and graduated with distinction in 2014. Dan believes that integration between mental and physical, primary and secondary, and between health and social care in a community-based system, is the way to improve the lives of the people we are here to serve.

Sarah Austin, Chief Operating Officer Portsmouth and Commercial Director

Sarah originally trained as a nurse in London and specialised in renal care in Portsmouth, undertaking both a teaching qualification and a BSc. Her career to date includes 17 years in Portsmouth Hospitals Trust latterly working as Director of Strategic Alliances leading the merger with Royal Hospital Haslar, five years as Director of Central South Coast Cancer Network and three years in South Central Strategic Health Authority focusing on strategy, system reform and market development. Sarah joined Solent NHS Trust in autumn 2010 as Transforming Community Services Programme Director before being appointed as Director of Strategy in November 2011. Sarah is now COO for Portsmouth and South East Hampshire (PSEH) and Commercial Director for Solent, and has additional responsibilities for the Integrated Care System as Director of System Delivery.

Jackie Ardley, Interim Chief Nurse[4]

Jackie has over 40 years experience in the NHS as a nurse. She commenced her career in Critical Care, working across the health system in General Nursing, Primary Care and Mental Health and Community Services. In 2001 Jackie spent seven years working on national service redesign programmes, leading a number of successful initiatives within a number of roles including Director of Service Improvement and a Regional Director post in Improvement Partnerships. Jackie has worked as Chief Nurse in Leicestershire Partnership NHS Trust. She is passionate about improving service users and their families experience across health and social care. Jackie joined us in December 2017.

David Noyes, Chief Operating Officer Southampton and County Wide Services

Prior to his life in the NHS, David spent 28 years in the Royal Navy, as a Logistics Officer, serving at sea and ashore in a wide variety of roles, including during hostilities in both the Gulf and in support of operations in the former Yugoslavia. His professional responsibilities spanned a broad range of operational disciplines including all support related operational matters, such as logistics, catering, HR, cash/budgets, medical, equipment support, infrastructure and corporate support functions. During his career, he also served in major Headquarters undertaking strategic planning roles, and also twice worked in the Ministry of Defence in London, directly supporting members of the Admiralty Board, including the First Sea Lord. Towards the end of his military career, David was seconded to the Army, and served with 101 Logistics Brigade, during which time he served as Deputy Commander in the Joint Force Support Headquarters deployed for six months in Helmand province, Afghanistan. Having left the Royal Navy in 2013, David joined the NHS, and initially worked as Director of Planning, Performance and Corporate Services for Wiltshire Clinical Commissioning Group, before joining Solent NHS Trust as Chief Operating Officer for Southampton and County wide services in July 2017.

Helen Ives, Chief People Officer

Helen Ives joined us in May 2016 to lead our organisational development programme and was appointed to the role of Chief People Officer in April 2017. Helen is an organisational psychologist and an HR professional. She is a fellow of the Chartered Institute of Professional Development and member of the British Psychological Society. Prior to joining the NHS, Helen worked in a variety of business sectors, including: technology, logistics and professional services. Helen also runs her own business as an independent consultant, working with organisations to develop their culture and people. As Chief People Officer, Helen is accountable for the development, and successful implementation, of the People and Organisational Development Strategy. She works with our people and teams to develop our culture – our vision, mission and how we create a working environment in which people can thrive, make a difference to the communities we serve and deliver great care. She is also the executive lead for workforce planning, ensuring we have a sustainable workforce plan that enables us to deliver our services.

[4] Jackie was appointed in December 2017 – April 2018 as our Interim Chief Nurse. In April 2018 following an external recruitment process and assessment centre , Jackie was appointed as our substantive Chief Nurse.

Executive directors who left in year

Mandy Rayani, Chief Nurse

Mandy trained in Swansea as a Registered Mental Health Nurse (RMN) and subsequently worked in mental health services for approximately 20 years. In 2005, Mandy became Regional Nurse for Mid and West Wales Regional Office working with the Welsh government, before taking up the role of Deputy Nurse Director at Cardiff and Vale NHS Trust, one of the largest teaching hospitals in the UK in 2007. Following the NHS Wales reorganisation in 2009, she was appointed Deputy to the Executive Nurse Director of Cardiff and Vale University Health Board, a fully integrated healthcare organisation providing primary, community, secondary mental health and tertiary services. Mandy joined Solent NHS Trust in September 2014 as Chief Nurse and left in June 2017 to join Hywel Dda University Health Board in Wales as the Director of Nursing Quality and Patient Experience.

Board development and performance evaluation

The Board of Directors keeps its performance and effectiveness under on-going review.
The Board holds workshops every two months to focus on developmental and strategic topics.

During 2017 the Board commissioned a specialist firm of business psychologists and consultants to support the delivery of the on-going Board Development Programme. This work focused on values and behaviours and the critical role of the Board in ensuring that Solent is a well-led organisation and is able to respond to the varied and complex demands of system working. A comprehensive internal Board appraisal was also conducted in year, the results of which support the on-going development work of the Board.

The Trust also conducted a self- assessment against the NHS Improvement (NHSI) Well Led Framework and in support of the forthcoming CQC Well Led inspection - consequently a robust action plan has been developed to address any areas requiring attention. The Board acknowledges the requirements of the Well Led Framework to conduct an independent assessment and will do so with the prescribed timeframe.

In addition, an annual governance review is conducted by the Governance and Nominations Committee and each Board committee completes a mid-year review against its agreed annual objectives and, at year end, presents an annual report to the Board on the business conducted.

The Board also reflected on the recommendations following external governance reviews, including a review of Risk Management. The Trust is implementing the recommendations identified.

Individual Board members are appraised annually and mid-year reviews are conducted.

Declaration of interests and Non-Executive Director Independence

The Board of Directors is satisfied that the Non-Executive Directors, who serve on the Board for the period under review, are independent, with each Non-Executive Director self-declaring against a 'test of independence'.

The Board of Directors are also satisfied that there are no relationships of circumstances likely to affect independence and all Board members are required to update their declarations in relation to their interests held in accordance with public interest, openness and transparency.

Name	Interest registered
Dr Alistair Stokes Chairman	No interests to declare
Jon Pittam Non-executive director	No interests to declare
Mick Tutt Non-executive director	• Specialist Advisor /Bank Inspector – Care Quality Commission • Pelican Consulting - sole trader offering management advice and support to health and social care organisations
Francis Davis Non-executive director	• Employed by University of Birmingham and St Mary's University , Twickenham • Working with Minister of State at Department for Work and Pensions for Disabilities to enhance and develop the disability and enterprise policy. No financial interest or political affiliations (ending 31st March 2018) • Advisor to CIPFA Directorships • Vivo Care Choices (ended September 2017) • Holocaust memorial Day Trust • Near Neighbours • Power 2 Inspire • St Ethelburga's Centre (ended September 2017) • Aequus International • Chair of Metro Mayor of West Midlands Community Cohesion Process and Conference (1st September to 30th November) • Trustee Cathedral Innovation Centre
Stephanie Elsy	Directorships • Stephanie Elsy Associates Ltd • Emsworth Forum Ltd • Community Development Finance Associate Ltd Ownership of business • Stephanie Elsy Associates Ltd
Mike Watts Non-executive director	• Director: Capability & Performance Improvement Ltd • Project work for various external clients
Sue Harriman Chief Executive Officer	Gifts and hospitality – Women in Leadership lunch at the House of Lords 15th March 2018
Helen Ives Chief People Officer	No interests to declare
Andrew Strevens Director of Finance and Performance	No interests to declare

Name	Interest registered
Dan Meron Chief Medical Officer	• University Hospitals Southampton NHS Foundation Trust (UHSFT) – Honorary Deputy Medical Director • Southern Health NHS Foundation Trust (SHFT) – Honorary Consultant Psychiatrist • University of Southampton – Honorary Senior Clinical Lecturer at School of Medicine • Care Quality Commission (CQC) – Secondment for occasional CQC inspections • Pinstriped Sandals Consulting Ltd – sole Director. Offering training, research and consultancy services • Member Royal College of Psychiatrists • All non NHS activities conducted outside of NHS contracted time • No shares or direct financial interest in any pharmaceutical company
Jackie Ardley Chief Nurse	• 0.2 WTE Dartford, Gravesham, Swanley and Swale CCG
Sarah Austin Chief Operating Officer - Portsmouth &Commercial Director	• Close family friend works for Capsticks • Close friend works for CGI • Close friend is owner of ExForcesNet and I am co-author of Forces4Change Charter
David Noyes Chief Operating Officer – Southampton	• Vice Chair of Southampton Connect • Trustee of Southampton Healthy Living
Members that have left in year	
Jane Sansome Non-executive director	• Director of Sansome & Co Ltd • Interim Managing Director of MYFM Limited.

Information Governance

Incidents concerning personal data are formally reported to the Information Commissioners Office, in accordance with Information Governance requirements. Further information can be found within the Annual Governance Statement, pg [n].

Statement of Accountable Officers Responsibilities

The Statement of Accountable Officers Responsibilities is located on pg [n].

The Board's committees

The Board has established the following committees:

Statutory committees

- Audit and Risk Committee
- Governance and Nominations Committee
- Remuneration Committee
- Charitable Funds Committee

Designated committees

- Assurance Committee
- Finance Committee
- Mental Health Act (MHA) Scrutiny Committee
- People and OD Committee

Composition of Board committees at 31 March 2018

Director	Position	Board	Finance Committee	Remuneration Committee	Assurance Committee	MHA Scrutiny Committee	Governance & Nominations Committee	Audit and Risk Committee	Charitable Funds Committee	People and OD Committee
Alistair Stokes	Chairman	Chair	-	Member	invited	Member	Chair	-	-	-
Mick Tutt	Deputy Chair/ Non-Executive Director	Member	-	Member	Chair	Chair	Member	-	Member	-
Jon Pittam	Senior Ind. Director / Non-Executive Director	Member	(to attend when available)	Member	Member	Member	Member	Chair	-	-
Francis Davis	Non-Executive Director	Member	Chair	Member	Member	Member	-	-	Chair	-
Mike Watts	Non-Executive Director	Member	Member	Chair	Member	Invited	-	Member	-	Chair
Stephanie Elsy *Started Sept 2017*	Non-Executive Director	Member	Member	Member	(invited initial 6 months)	invited	-	Member	-	Member
Sue Harriman	Chief Executive	Member	Member	Member			Member	Invited	-	-
Andrew Strevens	Deputy CEO & Director of Finance and	Member	Member			-	-	Member	-	-
Dan Meron	Chief Medical Officer	Member	-	-	Member	Member	-	Invited	-	-
Jackie Ardley *Started Dec 2017*	Interim Chief Nurse	Member	-	-	Member	Member	-	Invited	-	-
Helen Ives *Started April 2017*	Chief People Officer	Member	-	-		-	-	-	-	Member
David Noyes *Started July 2017*	COO Southampton & County Wide	Non – voting member	-	-	Member	Member	-	-	Member	-
Sarah Austin	COO Portsmouth & Commercial Director	Non – voting member	-	-	Member	Member	-	-	-	-
Members that left this year										
Jane Sansome *Left May 2017*	Non-Executive Director	Member	Previous chair	Previous chair	-	-	-	Member	-	-
Mandy Rayani *Left June 2017*	Chief Nurse	Member		-	Member	Member	-		-	-
Lesley Munro *From June 2017 – November 2017*	Interim Chief Nurse	Member		-	Member	Member	-	-	-	-

Membership of Board committees at 31 March 2018

Director	Position	Board (6 meetings)	Finance Committee (12 meetings)	Remuneration Committee (4 meetings)	Assurance Committee (10 meetings)	MHA Scrutiny Committee (4 meetings)	Governance & Nominations Committee (2 meetings)	Audit and Risk Committee (4 meetings)	Charitable Funds Committee (4 meetings)	People and OD Committee (3 meetings)
Alistair Stokes	Chairman	5/6	3/12	3/4	5/10	2/4	1/2	-	-	-
Mick Tutt	Deputy Chair/ Non-Executive Director	6/6	4/12	4/4	10/10	4/4	2/2	-	4/4	-
Jon Pittam	Senior Ind. Director / Non-Executive Director	6/6	2/12	2/4	8/10	3/4	2/2	4/4	-	-
Francis Davis	Non-Executive Director	5/6	11/12	4/4	8/10	1/4	-	-	4/4	1
Mike Watts	Non-Executive Director	6/6	11/12	4/4	8/10	-	-	4/4	-	3/3
Stephanie Elsy *Started Sept 2017*	Non-Executive Director	3/4	3/7	1/1	2/6	-	-	2/2	0/2	0/3
Sue Harriman	Chief Executive	6/6	8/12	2/4	7/10	1/4	2/2	4/4	-	-
Andrew Strevens	Deputy CEO & Director of Finance and	6/6	12/12	2	1	-	-	4/4	-	-
Dan Meron	Chief Medical Officer	6/6	1	-	7/10	3/4	-	-	-	-
Jackie Ardley *Started Dec 2017*	Interim Chief Nurse	2/2	-	-	2/3	0/1	-	1/1	-	1
Helen Ives *Started April 2017*	Chief People Officer	6/6	-	3	2/9	-	-	-	-	3/3
David Noyes *Started July 2017*	COO Southampton & County Wide	3/5	7/9	-	7/7	2/3	-	-	3/3	-
Sarah Austin	COO Portsmouth & Commercial Director	4/6	4/12	-	7/10	0/4	-	-	-	-
Members that left this year										
Jane Sansome *Left May 2017*	Non-Executive Director	1/1	2/2	2/2	-	-	-	1/1	-	-
Mandy Rayani *Left June 2017*	Chief Nurse	1/1	-	-	2/2	0/1	-	1/1	-	-
Lesley Munro *From June 2017 – November 2017*	Interim Chief Nurse	3/4	-	-	6/7	2/3	-	-	1/1	-

Key – blue figures indicate where Board member attended as an invitee, rather than being a member of the Committee.

Audit and Risk Committee

Frequency of meeting: At least quarterly (plus private meeting with External Auditor). During 2017/18 the committee met four times and separately in private.

The purpose of the Audit & Risk Committee is to provide one of the key means by which the Board of Directors ensures that effective internal control arrangements are in place. The Committee operates in accordance with Terms of Reference set by the Board, which are consistent with the NHS Audit Committee Handbook. All issues and minutes of these meetings are reported to the Board. In order to carry out its duties, Committee meetings are attended by the Chief Executive, the Director of Finance and Performance and representatives from Internal Audit, External Audit and Counter Fraud on invitation. The Committee directs and receives reports from these representatives, and seeks assurances from trust officers. The Committee's duties can be categorised as follows:

- Governance, Risk Management and Internal Control
- Internal Audit
- External Audit
- Other Assurance Functions – including Counter Fraud
- Financial Reporting

In year the Committee has received progress reports against recommendations identified by Internal and External Auditors, committee specific health sector updates, and received updates on financial governance processes, including single tenders, losses and special payments, whistleblowing, as well as receiving briefings on clinical audit and counter fraud investigations.

[*any*] significant issues in relation to the financial statements of 2017/18, operations or compliance were raised by the Audit and Risk Committee during the year. AUDIT COMMITTEE TO CONFIRM AT MAY 2018 MEETING

Audit and Risk Committee composition and attendance 2017/18 is previously summarised.

Details of other committees of the Board are described in the Annual Governance Statement, page [n].

Internal audit

Our Internal Auditors during 2017/18 were PricewaterhouseCoopers LLP, PwC.

Internal Audit provides an independent assurance with regards to the Trust's systems of internal control to the Board. The Audit and Risk Committee considers and approves the internal audit plan and receives regular reports on progress against the plan, as well as the Head of Internal Audit Opinion which provides an opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The Committee also receives and considers internal audit reports on specific areas, the opinions of which are summarised in the Annual Governance Statement, page[n].

The cost of the internal audit provision for 2017/18 was £57,300 (excluding VAT).

As a result of a tendering exercise PwC were reappointed as our internal auditors from 1st April 2018.

External audit

Our External Auditors are Ernst & Young LLP (appointed from August 2012 following the transfer of audit function from the Audit Commission to private organisations). The main responsibility of External Audit is to plan and carry out an audit that meets the requirements of The Code of Audit Practice and the NHS Manual for Accounts. External Audit is required to review and report on:

- Our financial statements (our accounts)
- Whether the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

The Audit and Risk Committee reviews the external audit annual audit plan at the start of the financial year and receives regular updates on progress. The Committee also receives an Annual Audit Letter.
The cost of the external audit for 2017/18 was £63k (including VAT).

Our external auditors did not conduct any non-audit services in year.

As a result of a tendering exercise Ernst & Young LLP were reappointed as our external auditors from 1st April 2018.

Disclosure of information to auditors

Please refer to the statement of directors responsibilities in respect of the accounts pg [n]

Countering fraud and corruption

A Local Counter Fraud Specialist (LCFS) is provided by Hampshire and Isle of Wight Fraud and Security Management Service. The role of the LCFS is to assist in creating an anti-fraud, corruption and bribery culture within the Trust; to deter, prevent and detect fraud, to investigate suspicions that arise, to seek to apply appropriate sanctions; and to seek redress in respect of monies obtained through fraud. The Audit and Risk Committee receives regular progress reports from the LCFS during the course of the year and also receives an annual report. Our Counter Fraud provision has received an overall rating of Green (the highest possible rating) from NHS Counter Fraud Authority.
We have implemented agreed policies and procedures, such as the Fraud, Corruption and Anti-bribery Policy as well as a Freedom to Speak Up Policy and issues of concern are referred to the LCFS for investigation. We also ensure that there are various routes through which staff can raise any concerns or suspicions.

Remuneration

Full details of remuneration are given in the remuneration report on page [n].

Members Council

Elections to our inaugural Council of Governors were announced in August 2013. However, further to the announcement to step off the Foundation Trust pipeline back in December 2015, the Governors and Board previously took the opportunity to review their Terms of Reference. Under the revised Terms of Reference agreed in 2016 the name of the Council was amended to reflect the strengthening engagement with the membership to 'Members Council'.

The responsibilities of the Members Council and Governors as previously agreed were to:

- act as a critical friend and advisor, representing the interests of the organisation, staff, members and wider public
- support the Board in the development of the organisation's strategic plans (including the Annual Plan) seeking assurance and continued transparency on its delivery and implementation
- play a role in promoting integrated and partnership working and in assessing its effects
- provide third party expertise and advice, on invitation from Officers of the Trust
- be an advocate for the Trust providing support and bringing to the attention of the Trust any matters of broad concern (not individual cases) raised by constituent members in relation to standards of care, safety, performance, value for money or any matter contrary to the Trust's values and in the spirit of the 'See something, say something' campaign.
- work with the Board to establish a process for handling issues such as; the removal of Council members, dealing with disputes, tenure and other 'constitutional' matters

In addition, Governors have previously been invited to participate in the Board level appointments process and observe a number of Board Committees.

The original Council comprised 14 publicly elected governors and five staff elected governors representing the constituencies of Portsmouth, Southampton and Hampshire, as well as six appointed governors from partner organisations.

The future

During the last year, in light of the council vacancies, the changing external context including the Sustainability and Transformation Partnerships and developing Integrated Care Systems we embarked on a journey, in collaboration with our governors, to further reconsider their role, the Members Council, as well as that of our wider membership. These considerations have been incorporated into the development of our emerging wider Community Engagement Framework, which will be finalised during Quarter 2 of 2018/19.

Composition of Members Council

Constituency		Name	Council Attendance 10th March 2017	Council Attendance 19th October 2017	Declarations of Interest
Staff	Southampton	Debra O'Brien	✓	X	• Nil
		Sarah Oborne	X	X	• Member of St John Ambulance
	Portsmouth	Jenny Ford	X	X	• Branch Secretary of Unison Portsmouth Health Branch
		Vacancy			
	Hampshire	Vacancy			
Public	Southampton	Clive Clifford	✓	X	• Nil
		Jon Clark	✓	X	• Wife works for Faculty of Medicine at the University of Southampton
		Vacancy			
		Vacancy			
		Vacancy			
	Portsmouth	Narcisse Kamga	✓	X	• The Sickle Cell Society • MENCAP
		Michael North	✓	✓	• Chair of a Patients Participation Group – Drayton, Portsmouth • Chair of a Patients Participation Group – Wootton Street Surgery, Cosham
		Sharon Ward	X	X	• Nil
		David Stephen Butler	✓	✓	• Portsmouth Royal Dockyard Historical Trust
		Vacancy			
	Hampshire	Sharon Collins	✓	X	• Director – Collins Corporate Solution Ltd • Director – Shared Ventures Ltd and facilitator of Solent Region Collaboration Hub – enabling conversations and collaboration opportunities across health, housing and social care across Hampshire, Portsmouth, Southampton and Isle of Wight • Volunteer on the Committee of Hampshire Hornets Wheelchair Basketball (a fully constituted, not-for-profit accessible basketball club with charitable aims)
		Harry Hellier	✓	X	• Nil
		Robert Blackman	✓	✓	• Nil
		Vacancy			
Nominated Governors	Portsmouth City Council	David Williams	X	X	• Board member of Portsmouth CCG • Director of University Technical College Portsmouth (UTC Portsmouth)
	Southampton City Council	Cllr. Warwick Payne	✓	✓	• Labour Party membership
	Hampshire County Council	Cllr. Peter Latham	X	X	• Member of Conservative Party
	NHS Southampton City CCG	Beccy Willis	X	X	• Partner works for Southampton City Clinical Commissioning Group and is involved in the Solent contract
	University of Southampton *	Vacancy			
	NHS Portsmouth City CCG	Vacancy			

**(rotational seat with University of Portsmouth)*

You can read how we engaged with our membership during the last year on page [n].

Governance Statement

Annual Governance Statement 2017/18

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *Accountable Officer Memorandum.*

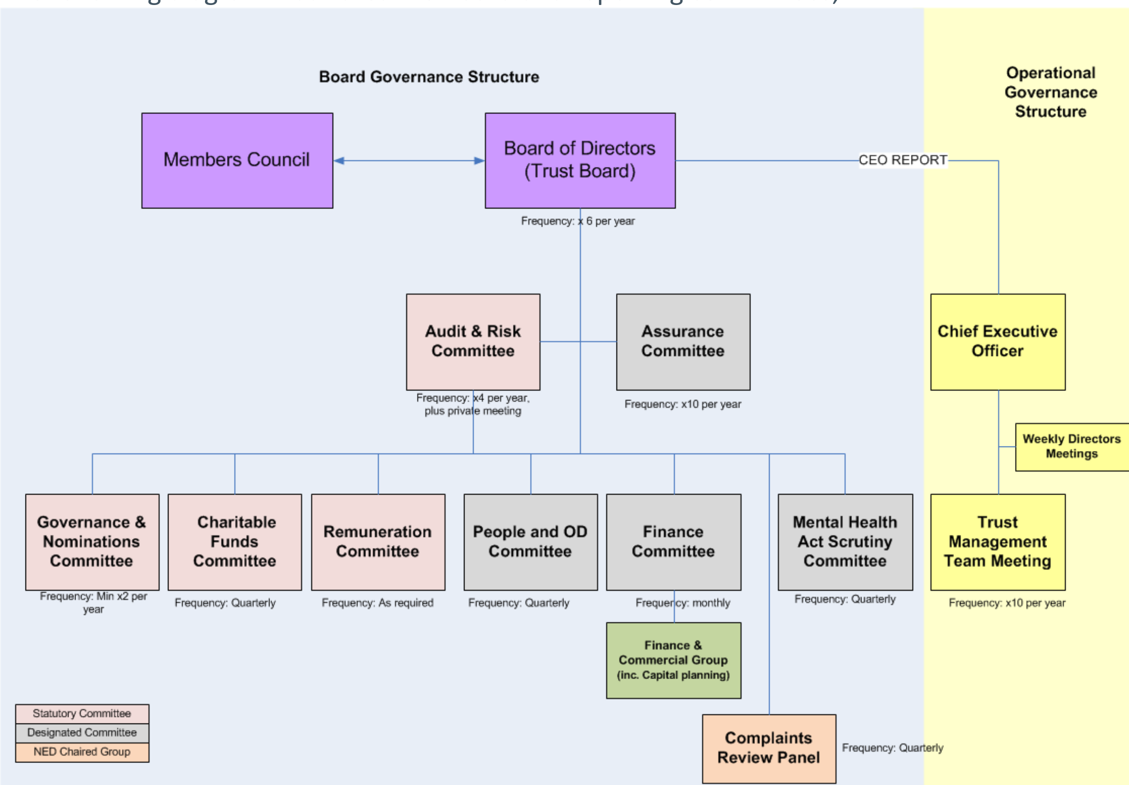
The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Solent NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Solent NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

The Governance Framework of the Organisation

The role of the Board and its duties are explained on page [n] of the Annual Report.
The individuals who serve on the Board and changes to appointments can be found on pg [n] of the Annual Report.

The following diagram illustrates the Board and reporting committees;



A summary of the role of the Audit & Risk Committee is found on page [n] of the Annual Report and internal audit opinions for the audits carried out in year are as follows:

Audit title	Opinion
Key financial systems	Low risk – Fixed Assets
	Low risk – Capital Expenditure
	Low risk – Cash
	Low risk – Budget Control
General Data Protection Regulations	Medium Risk
Information Governance Toolkit	Medium risk
Clinical Data Quality	Low risk
Clinical Supervision	High Risk[5]
Review of the Assurance Committee	Medium Risk

Significant progress has been made in respect of responding to recommendations made by our internal auditors, as reflected within their Head of Internal Audit Opinion. In particular in response to the Clinical Supervision audit we have reviewed our policy, which will be implemented in Q1 2018/19, and have enhanced our processes.

Governance and Nominations Committee

Frequency of meeting: At least twice a year and as required. During 2017-18 the Committee met 2 times.

The Committee's main purpose is to lead in the identification and recommendation of candidates to executive vacancies to the Trust Board. The Committee also considers and keeps under review governance arrangements for the Trust including Fit and Proper Person processes, Committee Structure and Committee Terms of Reference and to make proposals to Trust Board as appropriate. The Committee also approves recommendations regarding Associate Hospital Manager appointments and renewals of tenure.

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

The Committee is responsible for assessing the size, structure and skill requirements of the Board, and for considering any changes necessary or new appointments. If a need is identified, the Committee will consider if external recruitment consultants are required to assist in the process and instruct the selected agency, shortlist and interview candidates. If the vacancy is for a non-executive director the recruitment process is handled by NHS Improvement. The Chairman, Non-Executive Directors and the Chief Executive (except in the case of the appointment of a new chief executive) are responsible for deciding the appointment of executive directors. The Chairman and the Non-Executive Directors are responsible for the appointment and removal of the Chief Executive. All new appointees received an appropriate induction.

Remuneration Committee

Frequency of meeting: At least annually and as required. During 2017-18 the Committee met 4 times.
The Remuneration Committee is comprised of the Non-Executive Directors (and others by invitation). The Committee reports to Confidential Board meetings regarding recommendations and the basis for its decisions. The Committee makes decisions on behalf of the Board about appropriate remuneration (including consideration of performance related pay and to ratify decisions of the Clinical Excellence Awards Panel), allowances and terms of service for the Chief Executive and other Executive Directors.

Charitable Funds Committee

Frequency of meeting: Quarterly (or as required). During 2017-18 the Committee met 4 times.
The Corporate Trustee (Solent NHS Trust), through its Board, has delegated day to day management of the charity (Solent NHS Charity) to the Committee. The Committee ensures that funds are spent in accordance with the original intention of the donor (where specified), oversees and reviews the strategic and operational management of the Charitable Trust Fund as well as ensuring legislative requirements in accordance with the Charity Commission are met. The Committee is also responsible for developing and managing policies and procedures in relation to the management of Charitable Funds, monitoring the investment portfolio and the development of the fundraising strategy.

Assurance Committee

Frequency of meeting: Ten times a year. During 2017-18 the Committee met 10 times.
The Committee is responsible for providing the Trust Board with assurance on all aspects of quality of care. This includes quality governance systems, ensuring regulatory standards of quality and safety are met and that risk across the organisation is mitigated. In particular the Committee provides assurance to the Board regarding:

- Regulatory compliance (including CQC requirements and Safeguarding) and the provision of services in accordance with statute, best practice and guidance
- High standards of healthcare governance and high quality service provision.
- Risk – ensuring that risks are identified, prioritised and appropriately managed.
- A culture of continuous improvement across the Trust exists and learning is shared and embedded

The Committee also seeks assurance that the development of all clinical governance activities within the service lines improve the quality of care throughout the Trust. A programme of annual assurance reporting and deep dives are scheduled annually. Deep dives conducted in year included oversight of CQC actions, Medicine Management (which reports by exception to the QIR Group and Assurance Committee), Health and Safety, Research and Development and Safeguarding.

Finance Committee

Frequency of meeting: Monthly. During 2017-18 the Committee met 12 times.
The Finance Committee is responsible for ensuring appropriate financial frameworks are in place to drive the financial strategy, and provide assurance to the Board on financial matters as directed. The Committee focuses on the following areas; strategic financial planning, business planning processes, annual budget setting and monitoring, treasury management and financial control, business management as well as conducting in depth reviews of aspects of financial performance as directed by the Board. The Finance Committee has been integral to the Board in providing scrutiny and oversight concerning the delivery of the financial plan.

Mental Health Act Scrutiny Committee (MHAS Committee)

Frequency of meeting: Quarterly. During 2017-18 the Committee met 4 times.
The central purpose of the Committee is to oversee the implementation of the Mental Health Act (MHA) 1983 functions within the Trust principally within Adult and Older Persons Mental Health, and Learning Disabilities services. The Committee has primary responsibility for seeing that the requirements of the Act are followed. In particular, to seek assurance that service users are detained only as the Mental Health Act 1983 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, on an annual basis the Trust's external legal advisors provide update training in relation to the Mental Health Act. The Committee also seeks assurance on the appropriate application for Deprivation of Liberties Safeguards (DoLS) as well as seeking assurance regarding adequacy of training and development opportunities provided for front-line practitioners and of the monitoring of competence regarding the application of the MHA and DoLS.

People and Organisational Development Committee

Frequency of meeting: Quarterly unless the Chair of the Committee decides it necessary to alter the frequency of the meeting based on the volume or complexity of business that the Committee is asked to consider. During 2017-18 the Committee met 3 times.
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.

Attendance records at the Board and its committees are included within the Annual Report pg [n].

Highlights of Board Committee Reports

The Board has an agreed annual cycle of business and receives exception reports via the relevant Chair in relation to recent meetings of its committees. The Board, as a standing item at each meeting, also considers whether additional assurance is sought from its committees on any items of concern. The Chief Executive Report to Board includes commentary on significant changes recorded in the Board Assurance Framework and Corporate Risk Register. Progress on corporate and strategic objectives is reported quarterly within the performance report. In addition, a number of internal audits were completed, as described on page [n] and annually each Board Committee presents an annual report to the Board detailing a summary of business transacted and achievements against the agreed Committee objectives. The Committee annual reports will be available via the Trust website.

Performance Evaluation of Board

Details can be found within the Annual Report of the processes undertaken in year in relation to Board Effectiveness, pg [n].

Capacity to Handle Risk

Risk management and quality governance arrangements, accountability and leadership

As Chief Executive, I am ultimately accountable for governance and risks relating to the operational delivery of all clinical and non-clinical services provided by the Trust including its subcontracts. The Board sets the Trust's risk appetite and is briefed through the CEO report on all significant risks.
The Trust has a range of arrangements in place which provide monitoring and assurance on matters relating to quality, safety and regulatory matters. Each service line has an identified lead for quality safety and assurance who is responsible for supporting the service line Clinical Director in the delivery of the quality, safety and governance agenda. The service line Professional Leads for Quality Safety and Assurance also liaise with the Trust Quality Risk and Professional Standards team to support cross organisational work streams and learning arising from incidents. Each Service Line has a governance structure in place which reports through to the Quality Improvement & Risk Group and the Assurance Committee.

Key roles in relation to risk management and quality governance include;

- Chief Nurse - nominated Executive Lead Director for risk management, quality governance and health and safety compliance
- Chief Medical Officer - Lead director with responsibility for Learning from Deaths (mortality) agenda (Patient Safety Director as defined by national guidance on learning from deaths, National Quality Board 2017)
- Director of Finance and Performance – nominated Executive Lead Director for health and safety compliance
- The Head of Patient Safety working with the Clinical Risk Manager is responsible for ensuring the development and oversight of implementation of the Trust Risk Management Framework, risk procedures and administration of the Corporate Risk Register
- Clinical Directors - accountable for risk and clinical governance within their respective service lines, supported by the Operational Directors and Professional Leads for Quality Safety and Assurance .
- Operational Directors and Heads of Service – responsible for managing operational risks originating within their service areas.
- Executive oversight, via the Chief Operating Officer for Southampton and County Services, ensuring emergency planning and disaster recovery plans are established and regularly tested.

Specific Trust wide arrangements are in place which support robust assurance include:

- Care Group Meetings , chaired by Chief Operating Officers, general performance of quality and other operational issues
- Service Line Clinical Governance Groups, chaired by the Clinical Director - responsible for the oversight of quality and risks, triangulating performance information to monitor and address service quality. The groups provide exception reporting to the Quality Improvement and Risk Group which is chaired by the Chief Nurse and these are then scrutinised at the Assurance Committee. The service line structure provides high levels of autonomy increasing the effectiveness and accountability of the clinical services.
- Trust Management Team - oversees operational responses to risks contained in the Corporate Risk Register. The roles of the Assurance Committee and Audit and Risk Committee are described previously.

- Contract, Quality & Risk Management Meeting (CQRM) monthly meetings with commissioners
- Care Group and corproate team monthly Performance Reviews Meetings (PRM) are held to seek assurance regarding the management of operational risk. In addition, we monitor quality indicators through service line performance sub-committee meetings.
- Each service line has a documented local Annual Governance Statement which outlines the internal control and risk management processes under the leadership of each Clinical Director, and underpins the Trust wide Annual Governance Statement with regard to the internal control and clinical governance processes within our clinical services.
- Serious Incident requiring investigation (SI) process including Root Cause Analysis (RCA) investigation and SIRI panel arrangement
- Learning from Deaths process for unexpected deaths (mortality reviews)
- An audit programme (Trust wide and service level covering standards and topic specific issues)
- Board to Floor visits (includes executives, non-executives and governors) to engage with frontline staff and service users
- Service review visits by commissioners
- Announced and unannounced visits to clinical areas/teams by the Quality Risk & Professional Standards Team
- Patient and service user feedback (Friends and Family Test and other local mechanisms)
- Patient-Led Assessments of the care environments
- Patient and carer stories to Board
- Monthly reporting and publication of safe staffing status (with sign off by matrons and oversight by the Quality Risk and Professional Standards Team)
- The Board is apprised of any key quality and safety matters at the beginning of each Board meeting
- Our Quality Account is produced annually which outlines the progress made and action taken to improve and maintain quality and safety within and across Trust services. The Annual Quality Account is developed in consultation with key stakeholders and serves as an additional validation mechanism for determining the quality of services. More information on the Quality Account is provided on page[n] (of the Annual Report).
- Our Patient Experience Strategy was approved following consultation with a wide range of service users and partner agencies. The Trust Patient Experience forum continues to meet quarterly and oversees the delivery and implementation of the strategy.
- We also have an established processes to formally assess Cost Improvement Plans (CIPs) and other transformation schemes through a Quality Impact Assessment (QIA) process. Within the QIA process, foreseeable or potential risks which could impact on quality are considered and key leading indicators are identified to help highlight the realisation of any actual risks. A gateway approach to the agreement of CIPs and QIAs has been embedded with sign-off by the applicable service line Clinical and Operational Directors in consultation with services prior to review by the Chief Medical Officer and Chief Nurse. The Service Line Clinical Governance Groups are responsible for the management and monitoring of the leading indicators identified within signed off QIAs and for ensuring that in collaboration with the Chief Medical Officer and Chief Nurse, risks associated with QIAs are escalated to the Assurance Committee.

Risk Management Training

We provide a range of risk management training including;

- At Corporate Induction – where an introduction to risk management, Serious Incidents (SI) and Duty of Candour is provided.
- Risk management refresher training will be provided every two years to all staff from 1 April 2018. The training includes; risk management principles, escalation processes, accountability, risk assessment and hazard identification.

- Risk Register training – for all staff who have responsibility in using the Trust's on line risk register
- A two day training package for SI Investigators - provided in collaboration with neighbouring organisations. This training provides in depth training on root cause analysis, identification of hazards and the SI process.
- Formal Incident reporting and reviewers training, as well as;
- Bespoke training provided by the Quality and Risk Team.

Risk Assurance

The Board Assurance Framework (BAF) provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been identified and where gaps exist, that appropriate mitigating actions are in place to reduce the risk to a tolerable level. The Audit and Risk Committee tests the effectiveness of this system annually.

The Risk and Control Framework

I am assured that risk management processes are continuing to be increasingly embedded within the Trust and incident reporting is openly and actively encouraged to ensure a culture of continuous improvement and learning. I am also assured that there are appropriate deterrents in place concerning fraud and corruption. The organisation understands that successful risk management requires participation, commitment and collaboration from all staff. A new Risk Management Framework has been developed in 2018 to replace the former Risk Management Strategy and provides a clear overarching framework for the management of internal and external risk and describes the accountability arrangements, processes and the Trust's risk tolerance. The Framework is underpinned by a new step by step guide to the Risk Management Process for frontline staff, and revised induction and refresher training for all new and existing staff.

The Trust's approach to risk management encompasses the breadth of the organisation by considering financial, organisational, reputational and project risks, both clinical and non-clinical. This is achieved through:

- an appropriate framework; delegating authority, seeking competent advice and assurance
- a risk culture which includes an agreed risk appetie, as outlined within the framework
- the integration of risk management into all strategic and operational activities
- the identification and analysis, active management, monitoring and reporting of risk across the Trust
- the appropriate and timely escalation of risks
- an environment of continuous learning from risks, complaints and incidents in a fair blame/non-punitive culture underpinned by open communication
- consistent compliance with relevant standards, targets and best practice
- business continuity plans and recovery plans that are established and regularly tested; and
- fraud deterrence including the proactive work conducted by the Local Counter Fraud Service, policies on fraud, corruption and anti-bribery , debt recovery and the threat of prosecution. Fraud deterrence is integral to the management of risk across the organisation especially as there could be clinical or health and safety implications which could then impact upon the organisation. Staff are encouraged to report any potential fraud using the online incident reporting process appropriately including anonymous reporting if necessary. We are not aware of any specific areas within the organisation that are at risk of material fraud, however we cannot be complacent. One incident of fraud with an immaterial financial impact was handled during the year. Notifications from the Counter Fraud team improve our knowledge and awareness of the risk of fraud.

Equality impact assessments are carried out to assess the impact of the Trust's decisions and design of services as part of the Trust's legal duty under the Equality Act 2010 – we also use assessments in the development of policies

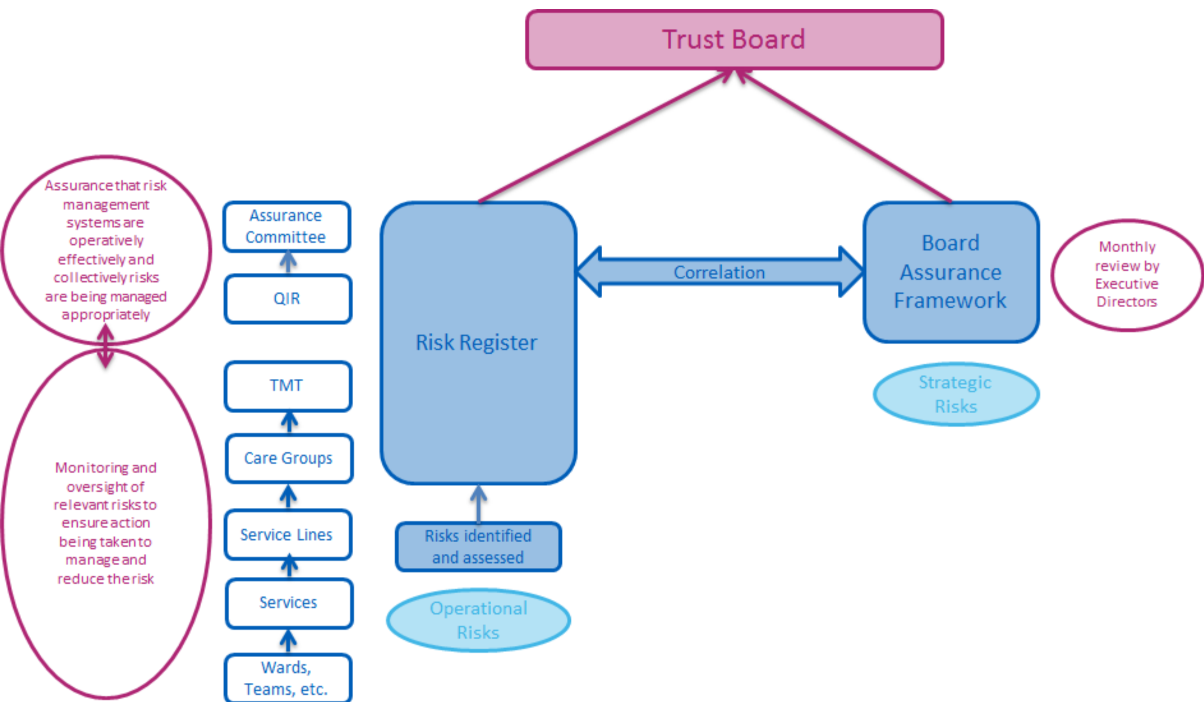
and in consideration of cost improvement plans.

Risk Assessment Process

The organisation has structured risk assessment and management processes in place as set out in the Risk Management Framework. This also includes having trained, service-based risk assessors in place to undertake assessment to support local management. Managers are responsible for managing action planning against identified risks and for escalating those risks with additional resource implications via service risk registers. The Risk Management Team receives and centrally records risk assessments to identify commonalities for organisational risk treatment and escalation.

Risk registers operate at service line level for all identified risks. Risks assessed as scoring 12[6] or above have increased oversight and monitoring by formal committees including the Trust Management Team for all risks scoring 15 or greater. This is in accordance with the risk appetite, agreed by Board and set out in the Risk Management Framework.

The below diagram illustrates the assessment, reporting and oversight process:



Risk identification and measurement

Risk identification establishes the organisation's exposure to risk and uncertainty. The processes used by the Trust include, but is not limited to; risk assessments, adverse event reports including trends and data analysis, Serious Incidents requiring investigation (SI), learning from deaths, claims and complaints data, business decision making and project planning, strategy and policy development analysis, external/internal audit findings /recommendations and whistle blowing in accordance with the Trusts Freedom to Speak Up policy.

The online Risk Register is now fully embedded and has provided the ability for real time reporting and escalation; it also aligns existing systems used for incident, complaints and claims reporting. In turn this has enabled the Quality &

[6] Risks are scored against the NHS National Patient Safety Agency risk matrix, which scores risks on a scale of consequence 1-5 (with a score of 5 being catastrophic) and a scale of likelihood 1-5 (with a score of 5 being almost certain)

Risk Team (and service managers) to provide swift response and support to services. The use of the online system supports the triangulation of data from incidents, claims and complaints for further analysis and assurance.

The Trust uses the National Patient Safety Agency likelihood and severity matrix to assign a risk score and we recognise that in all cases it is vital to set the risk into context for evaluation. Risks which fall outside of the remit of routine clinical assessment or are potentially significant for the organisation are approached and managed in line with the Risk Management Framework. The Trust is aware and encourages a proactive safety culture, good communication and teamwork, all of which are inherent in the improvement of risk and the implementation of good clinical risk assessments. To ensure clinical risk assessments are appropriate they are always reviewed as part of all serious or high risk investigations so that lessons can be learnt and assessments improved if necessary.
The positive risk management culture and risk management processes have enabled the Trust to proactively identify, assess, treat and monitor significant risks in year.

Strategic Risks

The organisations strategic risks (scoring 12 or over), at the end of the current financial year and as detailed within the Board Assurance Framework relate to:

- Workforce Capacity – as described within the operational context. In addition work continues to develop alternative career and learning pathways to support news models of care.

- Quality Governance and quality improvement – the Trust continues to implement action plans to address issues raised as a consequence of the comprehensive CQC inspection and subsequent inspections , and further embed the Solent Quality Improvement Programme.

- Future organisational function – clarification on structure, leadership and multi-agency accountability will be required as the organisation responds to the Sustainability & Transformation Partnership (STP) plans, local delivery systems and associated work streams as a consequence of the rapidly changing external environment.

As these are strategic risks they have longevity and will pose as risks to the Trust into the future – we are actively mitigating these to an agreed tolerable level and, as with operational risks, ensure that any learning is disseminated to reduce the chance of reoccurance .

There is clear alignment between the Board Assurance Framework and operational risks.

Operational Risks

The highest operational risks in year are identified below, however, each are being managed by the Executive Lead to reduce the risk to an acceptable level:

- Workforce Sustainability - there is a risk that we are unable to recruit and / or retain sufficient numbers of clinical staff with the skills and experience required. Particular pressures in our Adult Mental Health, Adults Services Southampton and Children's services have existed throughout the year which pose a risk to service delivery and the quality of patient care. We remain committed to ensuring that staffing levels are appropriate to meet the identified needs of patient/service users. Nursing and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for our service users. Where we have staff shortages we are developing solutions including providing additional training to new and existing cohorts of staff, for example including the introduction of Associate Nurse Practioner roles within our Mental Health Services. In accordance with national requirements we monitor the appropriateness of nursing staffing levels and skill mix to ensure we provide safe and effective care that reflects the acuity and dependency needs of individual patient groups. However, we recognise that safe staffing must also acknowledge the contribution of other disciplines and professions within the overall staffing establishment to ensure that clinical teams deliver safe, effective and high quality care in an increasingly complex environment.
- Telephony – we currently operate out of a number of locations where we do not manage the IT for the site but where staff report telephony issues which could impact on clinical care. This is being actively addressed by IT services with the premise owner so that faults can be effectively reported howeverservice business continuity arrangements are in place should the risk materialise.
- Estates – we are aware that some of our services are operating out of sub optimal sites impacting on service provision. Services have implemented mitigation plans and our estates team continue to actively seek alternative sites.

We will continue to monitor and mitigate all significant risks associated with Cost Improvement Plans identified via the Quality Impact Assessment process.

Well Led

In year we have completed self –assessments against the NHSI Well Led Framework and CQC Key Lines of Enquiry and have implemented action plans to address areas where we know we can improve.
We also assess ourselves monthly against the requirements of the NHS Provider Licence to ensure compliance, in accordance with the NHSI Single Oversight Framework requirements – the details of which are incorporated into our Board Performance Report.

Information Governance Toolkit and Data Security

Data Security is a significant part of the national Information Governance (IG) Toolkit requirements as well as ensuring that at least

95% of staff have completed IG training annually, which is nationally recognised as an extremely challenging standard. We achieved Level 3 compliance with these requirements.

IG serious incidents are reported and monitored via the Toolkit and to the Information Commissioner's Officer as described below.

In March 2018 we achieved Level 3 (the highest level in compliance) in 42 out of the 45 requirements outlined in the IG Toolkit. We achieved the mandated minimum Level 2 in the remaining three requirements, and our overall compliance level is 97%. We continue to monitor all incidents and risks associated with IG matters and ensure we learn as a consequence.

Serious Incidents Requiring Investigation

A total of 78 Serious Incidents requiring investigation (SI) were raised 36 of which related to incidents concerning pressure ulcer management/care. Other SIs concerned unexpected deaths (20), slips/trips and falls (4), as well as treatment delays, surgical errors, safeguarding adults and children. As part of the SI process we actively identify learning opportunities.

We also investigated and responded to six Information Governance (IG) SIs, all of which are categorised as:

- Staff Breach – investigated through disciplinary processes
- Personally Identifiable Data sent to wrong person / address
- Security of information – changes in processes made

None of the above SIs resulted in data loss.

Our Caldicott Guardian and Senior Information Risk Officer are consulted with whenever there is an IG Serious Incident and our commissioners provide scrutiny to our SI process and confirm closure on investigations once appropriate assurance has been sought.

The Information Commissioner's Officer are also advised of every incident and have confirmed that they are happy with the immediate actions taken and have closed their investigations into all six incidents.

Care Quality Commission (CQC) Compliance

The Trust has reported full compliance with the registration requirements of the Care Quality Commission through the year and routinely receives visits and inspections from the CQC. There are no outstanding issues recorded against the Trust. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

After the comprehensive inspection of the Trust by the CQC in June 2016, the CQC re-visited a number of services that had been identified as 'Inadequate' and re-rated them. Whilst this did not affect the overall rating, all of our services are now either rated as 'Good' or 'Requires Improvement' with the Learning Disability service rated as 'Outstanding'.

There remains a small number of actions associated with the Inspection that are managed though normal governance arrangements. This feeds into the Quality Improvement & Risk Group through to the Assurance Committee. This is supplemented by Board oversight through activities such as Board to Floor visits, Quality Review

Visits, review of performance management information and Friends and Family Test feedback.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employers contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Environmental responsibilities

We reviewed the impacts of climate change for delivering our services back in 2015/16 and in response to the Sustainable Development Unit Guidance, implemented a Sustainability and Carbon Management Strategy. The strategy incorporates a Sustainable Development Management Action Plan and a Carbon Reduction Action Plan, which are reviewed at least annually to ensure they remain relevant and reflect the changing estate.

We have developed a Sustainable Development Management Plan that aligns with the NHS Standard Contract, specifically Service Contract item SC18 – Sustainable Development, this is due for submission to our Board for approval in May 2018.

This plan recognises the challenge in meeting our carbon reduction targets and sets out the measures to be taken and establishes our commitment in meeting carbon reduction obligations. A number of initiatives are already in place delivering improvements as part of our management plan, and regular monitoring against our baseline is in place to record the achieved reductions against target.

We are committed to being a leading sustainable healthcare organisation, and to carrying out our business with the minimum impact on the environment. Our Sustainable Development Management Plan (SDMP) priorities are:

- To reduce our carbon footprint by a minimum of 2% year on year, through a combination of technical measures and staff behaviour change.
- To embed sustainability considerations into our core business strategy.
- To work collaboratively with our key contractors and stakeholders to deliver a shared vision of sustainability.
- To comply with all statutory sustainability requirements and implement national strategy.

During 2017/18, across the Trust we:

- Invested over £150K in energy efficiency measures.
- Involved staff in a Green Impact campaign to raise awareness and generate environmental improvement actions.

- Reduced total waste volumes compared with 2016/17, our target for 2018/19 is to achieve zero waste to landfill.
- Improved our mixed waste recycling, our target for 2018/19 is to separate out our waste streams where possible to enable independent recycling of waste paper and cardboard.
- Introduced initiatives to make our procurement more sustainable.

Through the implementation of a new Access & Transport Policy our target for 2018/19 is to effectively monitor travel and identify actions that can be supported to encourage staff to consider alternative means of transport. This will enable us to reduce single occupancy car travel and increase cycling in conjunction with our Sustainable Travel Plan.
We are undertaking risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that our organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The following key processes are in place to ensure that resources are used economically, efficiently and effectively:
- Scheme of Delegation and Reservation of Powers, Standing Orders and Standing Financial Instructions approved by the Board. These key governance documents include explicit arrangements for:
  - Setting and monitoring financial budgets;
  - Delegation of authority;
  - Performance management; and
  - Achieving value for money in procurement.
- A financial plan approved and monitored by the Board.
- The Trust operates a hierarchy of control, commencing at the Board and cascading downwards to budget managers in relation to budgetary control, balance sheet reconciliations, and periodic review of service level income with commissioners. In addition, the Finance Committee provides scrutiny and oversight which has been supplemented this year by independent commissioned reviews.
- Robust competitive processes used for procuring non-staff expenditure items. Above £5,000 procurement involves competitive tendering. The Trust has agreed procedures to override internal controls in relation to competitive tendering in exceptional circumstances and with prior approval obtained.
- CIPs, which are assessed for their impact on quality with local clinical ownership and accountability
- Strict controls on vacancy management and recruitment
- Devolved financial management with the continuation of service line reporting and service line management
- The Trust participated in the National Benchmarking Network's Children's & Adolescent Mental Health Services (CAMHS) project, with separate submissions for our Southampton and Portsmouth services, Corporate Services, Learning Disabilities, Intermediate Care (NAIC), Mental Health, Delayed Transfers of Care, Community Services and Pharmacy and Medicines Optimisation and Diagnostic projects. In addition, Solent NHS Trust has been part of the monthly community indicator workstream and are part of the Model Hospital application.
- The Trust Board gains assurance from the Finance Committee in respect of ensuring appropriate financial frameworks are in place to drive the financial strategy and provide assurance to the Board on financial matters as directed, including to review the impact of CIPs on forward financial planning.
- The Audit and Risk Committee also receives reports regarding losses and compensations, SFI breaches, financial adjustments and single tender waivers. The Board gains assurance from the Assurance Committee regarding the quality of services and compliance with regulatory control. The Audit & Risk Committee test the effectiveness of

these systems.

Performance Reporting

During 2017/18 the performance governance structure has continued to mature to optimise escalations of significant performance to the senior leadership team and Trust Board. The meeting structures in operation are described as follows;

- Concerning our clinical service lines: Chief Operating Officers meet with their service line senior managers on a monthly basis and review performance against quality, workforce, finance, business plans, operations, data quality and any other issues pertinent at that time. The exceptions form the agenda at a later monthly meeting chaired by the Director of Finance and Performance where these are discussed in-depth, necessary mitigations implemented, and assurance sought where appropriate.
- Concerning our non-clinical functions: Monthly Corporate Performance Subcommittees meetings review and scrutinise the performance under executive respective areas of responsibility
- A summary of all operational and corporate exceptions are then submitted through to the monthly Trust Management Team Meeting ensuring oversight.

In addition to standard performance monitoring, other significant areas of risk can be requested for review at the performance meetings, for example, progress against the CQC Action Plan, agency spend and contract performance notice remedial action plans. Similarly, the Chief Operating Officers and Director of Finance and Performance have discretion to include agenda items, where appropriate, to ensure all necessary and required items for performance assurance are considered. Specialised forums are also held periodically to provide additional scrutiny and support to managers where escalation is required on finance, quality and workforce.

We have implemented an internal data quality tool that is validating incorrectly reported waiters due to front end data entry issues. In 2017/18, the Trust reduced the number of incorrectly reported 52 week breaches by 1000s across the Trust. During 2018/19, a similar process will be implemented and monitored to validate incorrectly reported waiters between 18-52 weeks.

Our Data Quality Team works collaboratively with our services to validate data including waiting time performance indicators and continue to systemically review all service users on waiting lists to ensure they are accurate and appropriately recorded. Regular reporting and oversight is shared with services and senior management to ensure validations and outcomes are being recorded correctly.

As stated within the Annual Results Report for the year ended 31 March 2018, our external Auditors anticipate issuing an *[unqualified Value for Money opinion and an unqualified opinion concerning the Trust's financial statements].* *[To be updated when auditor opinion known]*

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to Trusts on the form and content of annual Quality Reports – we have produced our annual Quality Account in compliance with these requirements, and in doing so has consulted with key stakeholders.

The Account includes a summary of the arrangements in place to assure the Board that the reporting of quality

presents a balanced view and that appropriate controls are in place to ensure the accuracy of data.

The Trust has in place a number of systems and processes to ensure that we are focusing upon the right quality indicators and that quality reports are integral to the overall performance monitoring of the Trust. This is led by executive leadership to ensure that quality and other performance information is triangulated and presented in a balanced view.

Quality indicators are based upon a range of sources, including regulatory, national, best practice and locally agreed improvement targets. Many indicators are established internally in collaboration with clinical services to help achieve the highest possible standards of quality and care.

All quality metrics have systems to appropriately capture the information, analyse and onward reporting to the applicable stakeholders, including internally (the Board, Care Group Performance Subcommittees) or externally (for example NHS Improvement and local commissioners). Our Quality Account is available in section [n] of the Annual Report.

The Quality Improvement Strategy is currently being reviewed to reflect the refreshed value statements being developed within the organisation and work is planned for 2018/19 in supporting an enhanced focus on quality improvement linked to embedding cultural change.

Significant Issues during 2017/18

As part of its role in ensuring effective direction of the Trust, the Board continuously seeks assurances on the detection and management of significant issues. As Accountable Officer, I ensure that Board members are apprised of real or potential significant issues on a no-surprises basis, both within formal Board meetings and as required between meetings. Electronic briefings are circulated to non-executive directors to inform them of any emerging issues in between Board meetings. The Board Assurance Framework is updated to reflect significant issues and the mitigation thereof.

In year the following significant issues occurred:

- Like many NHS organisations, a number of our services experienced **staffing pressures** due to sickness, vacancies and difficulties recruiting due to national staff shortages, such as community adults and children staff and mental health nurses. This has resulted in the over reliance on agency staff and the breaching of the mandatory spending cap despite significant development in recruitment and retention approaches and a Solent managed bank. Workforce controls continue to be implemented including ensuring the vast majority of temporary staff are sourced through our in house bank, and where necessary block booking agency which has provided additional assurance in terms of the quality of temporary staff supply.

- We continued to constructively support **system working** as part of our involvement with the Sustainability and Transformation Partnerships (STP) and developing Integrated Care Systems (ICS), particularly in the support of hospital admission avoidance and discharging medically fit patients from the acute sector. However, the system is not yet in financial balance resulting in pressures in some community services - this was particularly evident during the period of the national and well publicised winter pressures.
  We also recognise that despite our increased joint working arrangements with partners we have more to do in relation to developing **robust integrated governance arrangements** across sectors and organisations. We continue to participate in the development of associated governance frameworks to ensure appropriate risk management and internal control arrangements are established relating to the Hampshire and Isle of Wight STP

and Local Delivery Systems (LDS).

- **Serious incident reporting** arrangements have been enhanced during the last year to reduce a backlog of closures - the number of serious incident investigation reports that breach the closure deadline has been actively managed with few/minimal breaches of late.

- We were unsuccessful in securing the **necessary funding** from the Department of Health for the redevelopment of the **St James Hospital and St Mary's Health** Campus in the first and second waves of funding application which delayed strategic plans associated with our estates and capital programmes. We have however been successful in the wave 3 application. The delay in securing the necessary funding has resulted in circa £1.7m annual savings not being achieved by the Portsmouth health system and the release of land for housing development being later than expected; operationally it has meant our services being delivered from sub-optimal premises.

- We continued to operate in **challenging financial times** with a deficit target of £1.5m. In year we encountered a number of financial related risks as summarised below:
    - in relation to **VAT partial exemption calculations** concerning changes due to commissioning moving from NHS organisations to local authorities; consequently we are actively working with experts and advisors and the Finance Committee and Board have been fully apprised.
    - In relation to the Hampshire & IOW STP and **related system financial pressures** including expectations to work together to reduced costs which could significantly destabilise Solent services and impact on neighbouring system partners as well as adversely affecting the quality of our service offer
    - there have been a number of contract challenges which have been inspired by the significant financial challenges faced by certain Clinical Commissioning Groups, which we have dealt with robustly.

- **Areas rated by CQC as Requires Improvement** – we continued to actively address areas rated by the CQC in their comprehensive inspection as requiring improvement. Whilst significant progress has been made, it is acknowledged that a small number of actions require complex resolution and/or assistance from partner agencies. The areas that remain being actively addressed include;
    - Statutory and mandatory compliance
    - Wheelchair provision – we are actively working with our CCG partners (as the commissioner of the service) and with the independent provider to ensure systems and processes are in place to ensure a responsive and timely service
    - The environment within our Pschiatric Intensive Care Unit
    - Spiritual support for our service users

  We continue to strive to improve services using a Quality Improvement (QI) approach which supports our continuing learning from investigations. You can read more about our QI programme within the Quality Account.

- Having invested significantly in new IT systems and hardware for our staff, and a complete transfer from a complex fragile network to a new and resilient infrastructure, national benchmarking data identified us as an outlier in relation to **IT related expenditure**. Consequently we proactively reviewed our IT programme and agreed to further explore opportunities for cost, efficiency and service improvement whilst continuing to work cooperatively with our outsourced IT provider. We were hit by the **national IT cyber-attack**, Wannacry, however our security systems proved robust resulting in minimal business and service interruption.
- **Operational Performance** was also impacted in year as summarised as follows:

- **Looked after Children out of area placements** - statutory health assessments and reviews for Looked after Children continued to breach timescales in year. Although the responsibility for the breaches is multi-organisational, it is still a concern and our Children and Families service line continue to review possible actions to help mitigate this issue.

- **Wheelchair provision delays** - we continue to see delays in the provision of wheelchairs for our patients, particularly our 0-19 service users, from the externally commissioned provider. We are actively engaged with commissioners and the wheelchair provder in seeking resolutions, moving forwards.

- **Dental General Anaesthetic Waiting Lists** - waits are still longer than desirable due to a shortage of available theatre space to undertake our procedures and we continue to work with partners to seek theatre capacity.

Demand on our services at times does create longer than acceptable waiting times in areas such as Child & Adolescent Mental Health services (CAMHs), Speech & Language Theraphy and Psychological Therapies. In all cases, we implement clinical prioritisation processes, continue to monitor this via our monthly performance review meetings and performance reports to the Board, as well as ensuring an issues of a quality nature are escalated via our Quality Improvement & Risk Group through to the Assurance Committee. We are also in constant dialogue with our commissioners via contract review meetings.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit & Risk Committee, Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The following key processes have been applied in maintaining and reviewing the effectiveness of the system of internal control:

- a review of committee governance by the Governance and Nominations Committee. The Board consider recommendations made by the committee and is ultimately responsible for approving and monitoring systems to ensure proper governance and the management of risk
- reviews of key governance documentation such as Standing Orders, SFIs, Scheme of Delegation and the Board Assurance Framework
- the oversight by the Audit & Risk Committee of the effectiveness of the Trust's systems for internal control, including the Board Assurance Framework (BAF). In discharging their duties the committee takes independent advice from the Trust's internal auditors (PwC) and external auditors (Ernst & Young). The BAF is also reviewed and challenged by the Board and updates are presented monthly via the Chief Executive's report to the Board
- the internal audit plan, which has been adapted in year to address areas of potential weakness in order that the Trust can benefit from insight and the implementation of best practice recommendations - and the findings of relevant internal audits.
- the scrutiny given to the Clinical Audit Programme by the Audit and Risk Committee

- the Trusts assessment against NHSI's Well Led Framework and associated action plan
- the scrutiny given by the Mental Health Act Scrutiny Committee in relation to the implementation of the Mental Health Act and
- the review of serious untoward incidents and learning by SI and , Learning from Death Panels and Service Line Clinical Governance Groups.

The Head of Internal Audit Opinion (HOIA) concluded an opinion of 'Generally satisfactory with some improvements required'. Update once confirmed HOIA known.It was noted however, that there are some areas of weakness and as such the Trust is actively addressing these; particularly concerning those raised within the Clinical Supervision Audit Report (which was rated as 'High Risk'). The HOIA also highlights areas of good practice identified as a consequence of our auditors reviews.

I therefore believe that the necessary arrangements are in place for the discharge of statutory functions, that the Trust is legally compliant and there are no irregularities.

Conclusion

In conclusion, and in acknowledgment of the referenced significant issues, I believe Solent NHS Trust has a generally sound system of internal controls that supports the achievement of its objectives.

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

Statement of Chief Executive's responsibilities as the Accountable Officer of Solent NHS Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum.

These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors and I consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the trust's performance, business model and strategy. A statement regarding the going concern position in relation to the accounts can be found on page [n]

Disclosure of information to auditors

The directors and I confirm that, so far as we are aware, there is no relevant audit information of which the trust's external auditors are unaware. We also confirm that we have taken all steps that we ought to have taken as directors in order to make ourselves aware of any relevant audit information and to establish that the auditors are aware of that information.

By order of the Board

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

[signed]
Andrew Strevens
Deputy CEO and Director of Finance and Performance

Date: xxxxx

Remuneration and Staff Report

Remuneration report

Remuneration of the Chief Executive and Directors accountable to the Chief Executive is determined by the Remuneration Committee. The terms of reference of this Committee comply with the Secretary of State's "Code of Conduct and Accountability for NHS Boards".

The Remuneration Committee met 4 times during 2017/18.

The committee considers the terms and conditions of appointment of all Executive Directors, and the appointment of the Chief Executive and other Executive Directors.

All Non Executive Directors and the Chairman are members of the Committee. Although the Chief Executive, Director of Human Resources, and Director of Finance & Performance attend the meetings by invitation, they are not members of the Committee.

The attendance by members is detailed below:

Member	15th May 2017	30th May 2017	22nd June 2017	14th December 2017
Jane Sansome *Left 31/05/2017*	✓	✓		
Alistair Stokes	✓	✓	x	✓
Jonathan Pittam	x	x	✓	✓
Mick Tutt	✓	✓	✓ *	✓
Mike Watts (Chair)	✓	✓	✓	✓
Francis Davis	✓	✓	✓	✓
Stephanie Elsy *Appointed 01/09/2018*				✓

**Chaired the meeting*

Although the Remuneration Committee has a general oversight of the Trust's pay policies, it determines the reward package of Senior Managers only. All Senior Managers are Executive Directors. Other staff are covered either by the national NHS Agenda for Change pay terms or the national Medical and Dental pay terms.

In year the Committee:

- were kept briefed on appointment processes to executive team vacancies and preferred candidates following assessment centre outcomes
- discussed and agreed remuneration matters concerning executive pay

- considered Mutally Agreed Resignation Schemes (MARS)
- considered the CEO appraisal
- ratified the recommendations made by the Clinical Excellence Awards Panel

Senior Managers Remuneration Policy

Our policy on the remuneration of senior managers for the current and future financial year is based on principles agreed nationally by the Department of Health taking into account market forces and benchmarking. During 2017/18 NHS Information undertook a benchmarking exercise on Executive Director and Non-Executive Director pay, which has been used to review remuneration of the Chief Executive and Executive Directors.

Senior managers pay includes the following elements as set out by the Department of Health: Basic Pay, Additional Payments in respect of Recruitment and Retention, and Additional Responsibilities. All Recruitment and Retention additions are subject to benchmarking, whilst additional responsibilities additions are awarded in line with the requirements of the Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts. All elements of the executive directors' remuneration package are subject to performance conditions and achievement of specific targets. No Directors are currently being paid a performance bonus.

Two Directors’ receive a salary in excess of £150,000. Paying a salary above this threshold has been agreed by the Trust Remuneration Committee and the NHS Improvement Remuneration Committee for one Director. The other Director is paid in accordance with the relevant national Medical and Dental terms as they also perform clinical duties.

Individual annual appraisals assess achievements and performance of Executive Directors. They are assessed by the Chief Executive and the outcome is fed back to the remuneration committee. Individual executive performance appraisals and development plans are well established with in the Trust and follow agreed Trust procedures. This is in line with both Trust and national strategy.

The Chair undertakes the performance review of the Chief Executive and Non-Executive directors.

Our Non-Executive Directors, including the Chairman, are paid the rates set by the Secretary of State and NHS Improvement.

There were no senior managers seconded into the organisation during the year 2017-18.

Service Contract Obligations

All senior manager contracts require them to meet the Fit and Proper Persons requirements specified in Section 7 of the Health and Social Care Act 2008. Failure to do so would be considered a breach of their contractual terms.

Loss of office payment for Senior Managers are determined in accordance with Sections 14-16 and 20 of the NHS Terms and Conditions of Employment. For the year 2017-18 there was no loss of office payments made.

Duration of Contracts

All Executive Directors are employed without term in accordance with the Trust Recruitment and Selection Policy.

All Executive Directors are required to give six months' notice in order to terminate their contract. Termination payments are on the grounds of ill health retirement, early retirement, or redundancy on the same basis as for all other NHS employees as laid down in the National Terms and Conditions of Employment and the NHS Pension scheme procedures.

Within the 2017-18 financial year there have been no early terminations of an Executive Director and no non-contractual payments have been made.

The Chairperson and Non-Executive Directors are appointed on a term set by the Secretary of State. They are office holders and as such are not employees, so are not entitled to any notice periods or termination payments.

Awards made to previous Senior Managers

There have been no awards made to past Senior Managers in the last year and therefore no provisions were necessary.

The Trust's liability in the event of an early termination will be in accordance with the senior managers' terms and conditions.

Off payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Trusts must publish information on their highly paid and or senior off-payroll engagements

In accordance with the Manual of Accounts Annual Reporting Guidance 2017-18, all public bodies are required to publish the following information within their 2017-18 Annual Report.

Off payroll engagements in place as at 31/03/18, for more than £245 per day that last longer than six months	
Total number of off pay scale engagements in place as at 31st March 2018	4
Of which, the number that have existed for:	
less than one year at the time of reporting	3
between one and two years at the time of reporting	1
between two and three years at the time of reporting	0
between three and four years at the time of reporting	0
four or more years at the time of reporting	0

A review of all off-payroll engagements has been undertaken, and assurance has been sought on all contracts to ensure the individual is paying the right amount of tax. As a result the Trust believes it is fully compliant with the requirements.

All new off-payroll engagements or those that reached six months in duration between 01/04/17 31/03/18, at a rate of £245 or more per day and that last longer than six months	
Number new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3
Of which number assessed as:	
within scope of IR35	3
not within the scope of IR35	0
Number engaged directly (via PCS contracted to trust) and on the trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	3
Number of engagements that saw a change to IR35 status following the consistency review	0

Notes: All contracts in place prior to the 01/04/17 were reviewed in the light of the Review of the tax arrangements of public sector appointees introduced in the Finance Bill of 2017 relating to off-payroll working (IR35) within the Public Sector.

For all new appointments an IR35 assessment has been undertaken prior to commencement of a contract.

Off payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 01/04/17 and 31/03/18.	
Number of off-payroll engagements of board members, and or senior officers with significant financial responsibility, during the year	0
Number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility during the financial year. This figure includes both payroll and off-payroll engagements	8

Period and details of the exceptional circumstances that led to this appointment and period of appointment: There were no off payroll engagements of board members and or senior managers.

Expenditure on consultancy

During the 2017-18 financial year £1,251k was sent on consultancy.

Expenses

During the 2016-17, and 2017-18 financial years, subsistence and travel costs were paid as follows:

	Number	Number making a claim	2016-17 £00	2017-18 £00
Executive Directors	8	8	80-90	111-112
Non-Executive Directors	7	7	30-40	66-67
Shadow Governors	16	2	8-9	2-3
		Total	131-132	180-182

The salary, emoluments, allowances, exit packages, and pension entitlements of the Trust's Senior Managers are detailed in the following sections.

Fair pay multiples (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director/Member in Solent NHS Trust in the financial year (£000), 2017-18 was £155-£160 (2016-17, £155-160). This was 5 times (2016 - 17, x5), the median remuneration of the workforce (£28,746), which was £28,101 (2016–17, £28,101).

In the 2017-18 one (2016 - 17, two) employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £14k to £185k (2016–17, £15k-£180k)

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind, but does not include severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

When calculating the median figure, individuals employed via a bank contract who did not work on the 31st March 2018 have been excluded; together with employees who left prior to the April 2017, honorary appointments, Non-executive directors who receive allowances only, individuals who are undertaking training in receipt of a training allowance only and individuals who were not directly employed by the Trust.

Exit packages (audited)

Changes have continued to take place within the organisation in the 2017-18 financial year and whilst we endeavour to do all we can to ensure the continued employment of our staff there have been 4 severance payments totalling £147k made in the year. All of these payments relate to compulsory redundancies. None of these payments relates to senior managers as detailed in the accounts and all payments have been made in accordance with the NHS Pension Scheme procedures and National Terms and Conditions, as a result Treasury Approval has not been required.

Exit Packages agreed in 2017-18

								2017-18
Exit Package cost band (including and special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	1	6,816	0		1	6,816	0	
£10,000 - £25,000	2	37,950	0		2	37,950	0	
£25,001 - £50,000	0		0		0		0	
£50,001 - £100,000	0		0		0		0	
£100,001 - £150,000	1	102,667	0		1	102,667	0	
£150,001 - £200,000	0		0		0		0	
>£200,000	0		0		0		0	
Totals	**4**	**147,433**		**0**	**4**	**147,433**		

This note provides an analysis of Exit Packages agreed during the year. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS redundancy arrangements. Exit costs in this note are accounted for in full in the year of departure. Other departures have been paid in accordance with the Mutually Agreed Resignation Scheme (MARS). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

The table below reports the number and value of exit packages agreed in the year.

Analysis of Other Departures	2017-18	
	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	
Mutually agreed resignations (MARS) contractual costs	0	
Early retirements in the efficiency of the service contractual costs	0	
Exit payments following Employment Tribunals or court orders	0	
Non-contractual payments requiring HMT approval **	0	
Total	**0**	

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total number in table 1 which will be the number of individuals.

*: any non-contractual payments in lieu of notice are disclosed under "non contractual payments requiring HMT approval".

**: includes any non-contractual severance payment made following judicial mediation, and no amount relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary. The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Salaries and allowances (audited)

Name and Title	2017-18						
	(a)	(b)	(c)	(d)	(e)	(f)	Total
	Salary and fees including R&R (bands of £5,000)	Expense Payments (taxable) (total to nearest £100	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other payments (bands of £5,000)	All pension-related benefits (bands of £2,500	(a to f) (bands of £5000
	£000	£00	£000	£000	£000	£000	£000
S Harriman – Chief Executive	155-160	0.2-0.3	0	0	0	22-22.5	175-180
A Strevens – Director of Finance and Performance	120-125	0.1-0.2	0	0	0	17.5-20	135-140
H Ives – Chief People Officer	100-105	0-0.1	0	0	0	12.5-15	115-120
D Meron – Chief Medical Officer*	135-140	0-0.1	0	0	0	17.5-20	155-160
M Rayani – Chief Nurse Resigned 17/06/17	20-25	0-0.1	0	0	0	2.5-5	25-27.5
S Austin – Chief Operating Officer Portsmouth	105-110	0	0	0	0	15-17.5	102-125
D Noyes – Chief Operating Officer Southampton & County Commenced 03/07/17	80-85	0.1-0.2	0	0	0	10-12.5	90-95
J Ardley – Chief Nurse Commenced 18/12/17	30-35	0.1-0.2	0	0	0	0	30-35
A Stokes – Chairman, (Non- Executive Director 01/01/18-31/03/18)	25-30	0	0	0	0	0	25-30
M Tutt – Non Executive Director (Acting Chairman from 01/01/18 to 31/03/18)	10-15	0.4-0.5	0	0	0	0	10-15
F Davis – Non Executive Director	5-10	0	0	0	0	0	5-10
J Pittam – Non Executive Director	5-10	0.2-0.3	0	0	0	0	5-10
M Watts – Non Executive Director	5-10	0-0.1	0	0	0	0	5-10
J Sansome – Non Executive Director Resigned 31/05/17	0-5	0-0.1	0	0	0	0	0-5
S Elsy – Non Executive Director Commenced 01/09/17	0-5	0-0.1	0	0	0	0	0-5

For individuals who joined or left the Trust part way through the year, the full time equivalent salary plus any additional remuneration, excluding severance payments have been used to calculate the rate of payment.

The expenses shown column (b) are different to those shown in the Expenses section as column (b) relates solely to taxable expenses, compared to all expenses shown in the Expenses Section.

* The Chief Medical officer role is combined with clinical duties. These figures include £45k-50k (expressed in bands of £5,000) relating to clinical duties.

Previous year salary and allowances

Name and Title	2016-17						
	(a)	(b)	(c)	(d)	(e)	(f)	Total
	Salary and fees including R&R (bands of £5,000)	Expense Payments (taxable) (total to nearest £100	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other payments (bands of £5,000)	All pension-related benefits (bands of £2,500	(a to f) (bands of £5000
	£000	£00	£000	£000	£000	£000	£000
S Harriman – Chief Executive	155-160	0.2-0.3	0	0	0	20-22. 5	175-180
J Pennycook- Director of Human Resources & Organisational Development Resigned 31/12/16	75-80	0-0.1	0	0	40-45	10-12.5	125-130
A Strevens – Director of Finance and Performance	100-105	0.1-0.2	0	0	0	12.5-15	115-120
D Meron – Chief Medical Officer*	135-140	0.2-0.3	0	0	0	17.5-20	155-160
A Whitfield – Chief Operating Officer Southampton and Hampshire Wide Resigned 12/03/17	100-105	0.1-0.2	0	0	0	12.5-15	115-120
M Rayani – Chief Nurse	105-110	0.2-0.3	0	0	0	15-17.5	120-125
S Austin – Chief Operating Officer Portsmouth	105-110	0	0	0	0	15-17.5	120-125
A Stokes – Chairman	15-20	0	0	0	0	0	15-20
D Batters – Non Executive Director Resigned 31/07/16	0	0	0	0	0	0	0
F Davis – Non Executive Director Commenced 01/10/16	0-5	0	0	0	0	0	0-5
J Pittam – Non Executive Director	5-10	0.2-0.3	0	0	0	0	5-10
J Sansome – Non Executive Director	5-10	0-0.1	0	0	0	0	5-10
M Tutt – Non Executive Director	5-10	0.4-0.5	0	0	0	0	5-10
M Watts – Non Executive Director	0-5	0	0	0	0	0	0-5

* The Chief Medical officer role is combined with clinical duties. These figures include £45k-50k (expressed in bands of £5,000) relating to clinical duties.

Pension benefits 2017-18 (audited)

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash equivalent Transfer Value at 1 April 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension to nearest £100 £000
S Harriman – Chief Executive	0.0 -2.5	(2.5) - 0.0	30 - 35	70 - 75	489	52	540	
A Strevens – Director of Finance and Performance	2.5 -5.0	0	15-20	0	151	53	203	
D Meron – Chief Medical Officer*	0.0-2.5	2.5 -5.0	30 -35	100-105	612	76	688	
D Noyes – Chief Operating Officer Commenced 03/07/17	0.0 -2.5		5-10		78	27	105	
M Rayani – Chief Nurse Resigned 17/06/17	5.0-7.5	22.0-22.5	50-55	160-165	852	217	1,069	
S Austin – Chief Operating Officer Portsmouth	0.0- 2.5	(2.5) – (5.0)	50 -55	95-100	784	67	852	

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 the Occupational Pension Schemes (transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Note:

[signed]
Sue Harriman
Chief Executive Officer
Date: xxxxx

Staff Report

Our Staff

Last year, we employed 4,086 clinical and non-clinical members of staff (including part time and bank staff) which equates to 2,899 whole-time equivalents (WTE), all of whom contribute to providing high quality patient care across our local communities. Our team members work hard to improve efficiency, to meet national and local quality targets and to bring innovations in care to people who use our services. Most people are permanently employed in clinical roles and directly deliver patient care. We also employ a significant number of scientific, technical and administrative staff who provide vital expertise and support. The following table provides a breakdown of our workforce at the end of the year (March 2018).

Staff Group	Female FTE	Female %	Male FTE	Male %	Total FTE
Admin & Estates	559.07	88.26%	74.37	11.74%	633.45
Director	4.00	57.14%	3.00	42.86%	7.00
Healthcare Assistants and Other Support Staff	562.11	80.82%	133.43	19.18%	695.54
Managers and Senior Managers	42.28	60.13%	28.03	39.87%	70.31
Medical & Dental	98.32	71.26%	39.65	28.74%	137.97
Nursing & Midwives	702.55	92.05%	60.68	7.95%	763.23
Scientific, Therapeutic & Technical	528.44	89.26%	63.55	10.74%	591.99
Total	**2496.77**	**86.11%**	**402.72**	**13.89%**	**2899.49**

Our workforce is predominately female (86%) and this is the predominant gender in all of the staff groups, except for the managers and senior managers group/Directors. We published our Gender Pay Gap reporting (available on our website) and remain committed to the Equality and Diversity agenda working to strengthen inclusive people practices across the Trust.

The following tables provide detail on staff numbers and expenditure. The expenditure is for the full year and the staff numbers represent average figures for the year.

Employee Benefits – Gross Expenditure (audited)	**Permanent £000s**	**Other Agency £000s**	**Total £000s**
Salaries and wages	94,757	4,960	99,717
Social security costs	8,784		8,784
Apprenticeship Levy	465		465
Employer Contributions to NHS BSA Pensions division	12,211		12,211
Other pension costs	5		5
Termination benefits	148		148
Total employee benefits	**116,370**	**4,960**	**121,330**
Employee cost capitalised	95		95
Gross Employee Benefits excluding capitalised costs	**116,275**	**4,960**	**121,235**

Average Staff Number	**Permanent Number**	**Other Agency Number (inc. Bank Staff)**	**Total Numbers**
Medical & Dental	141	4	145
Admin & Estates	700	33	733
Healthcare Assistants and Other Support Staff	691	85	776
Nursing, midwifery and Health Visiting Staff	751	56	807
Nursing, midwifery and Health Visiting Learners	13		13
Scientific, Therapeutic & Technical	590	9	599
Other			
Total	**2886**	**187**	**3,073**

Despite on-going challenges with regards to recruitment in certain professional disciplines and particular areas such as specialist nursing and mental health, the overall level of vacancies are around 2.8% of the total workforce. The demand for bank and agency staff remains high and the amount of spend on bank and agency is 8% of the total pay bill. This is reflective of demand for Mental Health and Community services and national staffing shortages in some key roles.

The Trust Agency ceiling is £3.6 million and our spend for the year is above our threshold at £4.9 million. There is an improvement plan in place to continually drive down the use of Agency, however, winter pressures have created significant challenges that have impacted our progress.

Our in house bank continues to fill 68% of requested shifts with internal bank staff and works hard to ensure that we use as little Agency as is possible.

Staff retention programme

As part of the work we are doing around Quality Improvement, we have been working with service lines and engaging with groups of staff across the organisation to understand the biggest issues and root causes of staff turnover. This activity has highlighted the following areas as the prioritised delivery areas for focus and action planning:

- Recruitment - attraction and brand: Employer Value Proposition & Distinctive Brand
- Flexible working arrangements
- Training for our managers in people development
- Reward and recognition
- Career progression: defined progression routes
- Induction – the root into Solent

In addition, we have a strategic initiative underway to implement the 6 step methodology for workforce planning. This is a critical success factor for recruitment and retention, and much more broadly, organisational effectiveness.

Although we will continue to improve in our day to day operational delivery, we have a strategic action plan in place that focuses on the above 6 areas, with the aim of delivering a significant reduction in turnover by the end of 2019.

Equality and Diversity

Every effort is made to ensure that all our staff are treated fairly, inclusively and equitably regardless of their individual characteristics and circumstances. All new employees are given training in relation to our values and the principles of treating others with dignity and respect. Robust arrangements are also in place to deal with any reports of non-compliance and we continue to monitor trends and take action where necessary.

With regards to disabled employees or those who become disabled whilst working for us, we provide support, training and make reasonable adjustments as necessary to ensure our staff can enjoy a fulfilling career with us. We continue to encourage and support applications for employment from all individuals. For applicants who disclose a disability, reasonable adjustments are put in place upon request and all appointments are based on merit.

Progress continues with the implementation of our Equality and Diversity Strategy. We annually review our performance against the Workforce Race Equality Standards and are working through our action plan for the Equality Delivery System. We have participated in the NHS Employers Diversity & Inclusion Partners Programme. We are engaging through our internal and external networks on the Workforce Disability Equality Standard and the Sexual Orientation Monitoring Standard. We ensure that all of our policies are developed with equality and diversity as one of the main considerations.

During the year ahead we are also planning on establishing closer links with our veteran community. Working with Forces4Change, we will be holding an event in April 2018 to launch our initiatives bringing together a passion for supporting veterans and for enabling military to civilian transition and creating a network of colleagues within the organisation who can support veterans and their families.

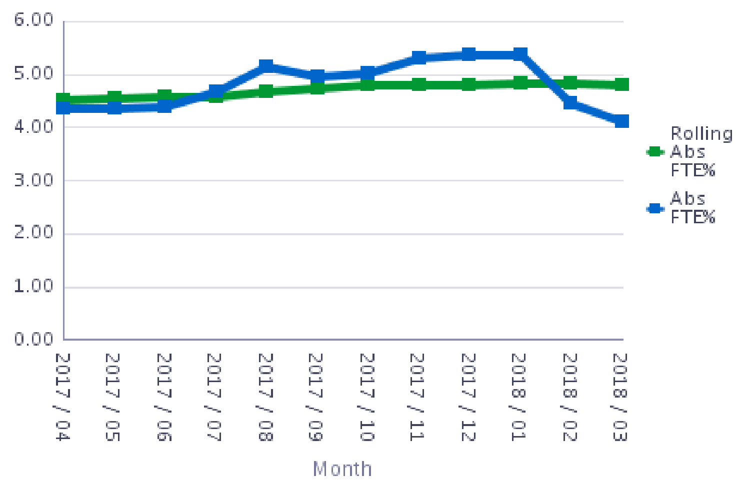
Partnership Working

We pride ourselves on having developed excellent partnership arrangements with our staff side representatives. This is formally supported within the Joint Consultative Committee (JCC) and the newly introduced Joint Consultative and Negotiating Committee (JCNC). The local Doctors and Dentists Negotiating Committee (DDNC) specifically deals with matters for medical staff. We also have a Policy Steering Group to ensure that we continue to develop partnership arrangements when renewing and considering new policies that affect the workforce and wider external environment to ensure fairness and equity.

Sickness Absence

We have seen our annualised sickness absence rise during the year from 4.51% to 4.80%. Mental health-related conditions are the main cause of sickness at 28.4%; this is up 5% on the previous 12 month period. The following graph shows sickness absence rates for April 2017 to March 2018. Sickness rates have fluctuated throughout the period, with a peak of 5.38% in Jan 2018. The average for community and mental health trusts for the same period was 4.53%.

The graph below represents data between April 2017 and March 2018



In response to sickness absence data, various initiatives have been implemented and evaluated to improve staff health and wellbeing. The 2017 staff survey shows that people's satisfaction with action taken around health and wellbeing has improved by 5% since the 2015 survey. More on specific action taken to improve levels of organisational health and wellbeing can be found in the Occupational Health section of this report, on page [n].

Employee Engagement

There is a clear relationship between employee satisfaction and patient satisfaction and we recognise that the highest quality of care for people who use our services is delivered through a high quality and engaged workforce where staff feel empowered to really make a difference. We operate a number of employee engagement and patient care measures throughout the year as demonstrated in figure [n], all with the primary purpose of measuring and enhancing employee engagement.

We have a variety of employee engagement initiatives in place within our Great Place to Work programme, which was launched in 2016, the elements of which are illustrated below.

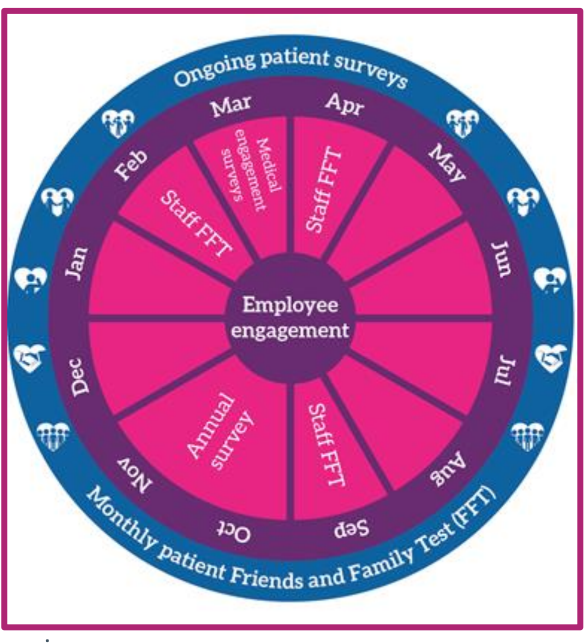


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Figure [n] – Employee Engagement

Figure [n] – Great place to work

A summary of each element is outlined as follows:

Leading with Heart

- Leading with Heart Senior Leadership and Board development programme
- Management development programmes and workshops
- Back to the Floor – members of the Board spend time working with teams
- Director drop-in sessions – Executive Directors join teams informally to listen and learn

At the Heart

- Engagement Forums – organised by Occupational Group to explore key workforce issues
- Focus Groups – in response to specific concerns raised by employees
- At the Heart team sessions – team engagement programme to strengthen the Heart values
- Communications Champions – employee communication and engagement network
- Power Hours – hour-long webinars to share knowledge and expertise

The Way Forward

- Strategy communications - connecting employees with our vision, priorities and progress
- Monthly "Ask Sue" forums – staff are invited to contact the CEO in an online Q&A

The Difference

- Communication and Engagement programme – using the power of storytelling to involve people and recognise the difference our care makes
- Weekly Employee newsletter and regular Manager newsletter

People First

- We are working to continually improve our employee experience from the moment people express an interest in joining Solent throughout their entire career with us, see Figure [n].

Figuren [n] Employee experience model

Being Agile

- Continual quality improvement and innovation are supported through Dragon's Den (where staff can apply for funds to fast track new initiatives) and the Quality Improvement (QI) Programme (development to support teams on their own quality improvement projects).
- Involvement and consultation with employees facing or affected by change is integral to the way we lead the organisation. With adherence to our Organisational Change Policy we seek to ensure our consultations are meaningful, fair, transparent and consistent. Our consultations are carried out in partnership with our staff side colleagues and we adhere to our policies throughout.

Staff Survey

The 2017 Annual Staff Survey was carried out by Quality Health with a total of 1876 people taking part. This is a response rate of 56% which is above average for combined mental health / learning disability and community trusts in England (45%), and compares with a response rate of 55% in 2016.

Trust engagement shows a marginal increase of .3% when compared with last year, as detailed below. However, this is still .7% higher than the national average for community trusts.

Figure x: Overall Staff Engagement

(The higher the score, the better)

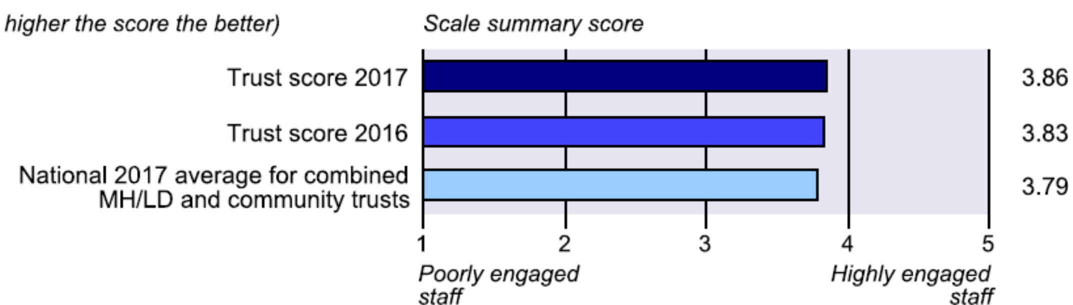


Table X. Top 5 ranking scores compared with combined Mental Health, Learning Disabilities and Community Trusts in England

Key findings	Solent 2017	Average MH /LD / Community Trusts
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	9%	14%
Staff confidence and security in reporting unsafe clinical practice	3.9	3.72
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.92	3.76
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	16%	20%
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	92%

In addition to the above improvements, there are a number of areas where we have maintained a positive level of engagement over the year;

- Effective team working
- The quality of our non-mandatory training
- The provision of Equal opportunities for progression regardless of background
- Positive action taken around health and wellbeing

Table x: Bottom 5 ranking scores compared with combined Mental Health, Learning Disabilities and Community Trusts in England

Key findings	Solent 2017	Average MH /LD / Community Trusts
Staff satisfaction with resourcing and support	3.33	3.33
Staff satisfaction with the quality of work and care they are able to deliver	3.82	3.85
Percentage of staff working extra hours	71%	71%
Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	58%	57%
Percentage of staff / colleagues reporting most recent experience of violence	89%	88%

There is still more work to do around satisfaction with levels of resource and support; action around sustainable staffing levels, safe staffing and productivity improvement remains an on-going priority for the coming year. Each service line business plan has clear deliverables against these priority areas which will be monitored through the Board Performance Reporting process

We will also continue the work we have been doing around our Great Place to Work programme, specifically the further development of our leaders, teams and culture through the HEART values.

2017 NHS Staff Survey headlines

55.8% of people took part

3.86* Engagement score (increase from 3.83* in 2016 and above the average of other comparable trusts: 3.79*)

Out of 22 NHS key findings we had:

15 better than average

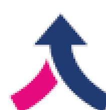
0 worse than average

The majority of the questions show an improvement on last year

Here are some areas where the improvement is significant

The care of patients/service users is my organisation's top priority
79% Increase of 4%

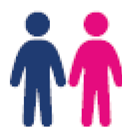
I would recommend my organisation as a place to work
59% Increase of 3%



The team I work in have a shared set of objectives
77% Increase of 3%

My organisation takes action around errors, near misses or incidents
79% Increase of 3%

I am satisfied with the support I get from my immediate manager
76% Increase of 4%



My immediate manager can be counted on to help me with difficult tasks
78% Increase of 3%

I have had training, learning or development in the last 12 months
77% Increase of 5%

My immediate manager asks for my opinion before making decisions that affect my work
63% Increase of 3%

My immediate manager is supportive in a personal crisis
80% Increase of 3%

Areas which people scored the same:

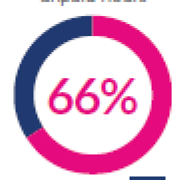
- The way we work together in our teams
- The quality of our non-mandatory training
- The opportunities we give for career progression, regardless of background
- The difference you feel you make to patients
- The action we take to help you manage your health and wellbeing

Areas which people scored lower:

I am satisfied with my level of pay

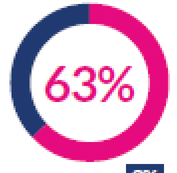
Decrease of 6%

I am working additional unpaid hours



Decrease of 3%

I had the opportunity to talk about the Trust values and my development needs during my appraisal



Decrease of 2%

Next steps

Look out for your team reports. Your manager will talk with you about next steps and the actions you can take as a team.

Over the coming weeks we will be communicating the Trust results with you in more detail. You can find all the survey reports on SolNet within Staff Zone.

Exit Packages

Details of exit packages can be found on page [n]

Off payroll engagements

Details of off payroll engagement can be found on page [n]

External consultancy

At times it is necessary for us to make use of the skills of external consultants and at these times, we ensure that the arrangements comply with our standing financial instructions and offer good value for money. External consultancy is used within the Trust when we require objective advice and assistance relating to strategy, structure, management of our organisation, for example. This year we have sought advice and assistance from external consultants relating to Organisational Development and property related issues. The cost associated with consultancy can be found within the Remuneration Report on page [n].

Occupational Health and Wellbeing Service

Our Health and Wellbeing Steering Group is held bi-monthly and is attended by key stakeholders involved in supporting staff and who take an active role in supporting the delivery of our health and wellbeing plan. In support of employee experience, we have a robust Occupational Health and Wellbeing service in place that proactively supports the health of our employees through initiatives. These initatives include; the Global Challenge - a 100 day step challenge, health and wellbeing events as well as our Optimising Wellbeing & Lived Experience of Staff (OWLES) group, aimed at spreading the word on mental health. This year we held a launch event to promote the active participation in this group and spread the word on support available to our people.

Our physiotherapy service has worked proactively with services to support staff with musculoskeletal (MSK) problems and to work with managers to review and consider the challenges associated with our people working in some of our community environments that pose higher levels of risk in terms of MSK injury.

In response to sickness absence data, various initiatives have been implemented to improve staff health and wellbeing. These include easy access to occupational health and fast track physiotherapy services. Targeted support has been made available for services with high sickness rates and health and wellbeing support programmes to include; emotional resilience workshops and self-care support and resource material designed to motivate and empower staff to promote self-care approaches that will help them to improve their lifestyle. Managers are supported by HR, Occupational Health and our Employee Assistance Programme (EAP) to manage sickness absence in line with our policy and to support staff in attending work regularly or to sustain their return to work following a period of absence.

NHS Constitution

The NHS Constitution was established in 2009 and revised in summer 2015. The constitution sets out the principles and values of the NHS. It also sets out the rights to which patients, service users, the public and staff are entitled, a range of pledges to achieve and the responsibilities which patients, service users, the public and staff owe to one another to ensure that the NHS operates fairly and effectively. We operate in accordance with the principles and pledges as set out in the NHS Constitution and undertake an annual review of our compliance, which is reported to our In-public Board meeting.

Health and Safety

We are committed to the health, safety and welfare of our colleagues, and third parties that work within our operational footprint and have remained compliant with Health and Safety legislation in year. We have not had any investigative proceedings being undertaken in regards to breaches of health and safety legislative requirements, Regulatory Reform (Fire Safety) Order or the Environmental Protection Act and have not received any external visits from any external regulatory agency, as a result of a specific incident or complaint. The executive lead for the Health and Safety portfolio is the Deputy CEO and Director of Finance & Performance. The Associate Director of Estates and Facilities chairs the Health and Safety Group, which meets quarterly.

NHS Foundation Trust Code of Governance

Although as an NHS Trust, the NHS Foundation Trust Code of Governance does not directly apply to us, the principles are seen as good governance practice. We have, therefore, applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis, where applicable. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Enhanced quality governance reporting

Care Quality Commission (CQC)

You can find more about our compliance with CQC registration requirements and our response to CQC findings in the Annual Governance Statement and Quality Account.

Quality governance reporting

Our quality governance structure is well-established within the organisation. Each clinical service line has a dedicated forum within which clinical governance matters are discussed. The forum, chaired by a Clinical Director, monitors the progress and impact of local quality improvement schemes, including lead quality indicators, and takes appropriate action to mitigate any areas of clinical risk at the earliest opportunity. This is supplemented by a monthly performance review in each Care Group which undertakes an overall 'healthcheck', looking at financial, workforce and activity data alongside quality metrics, and taking remedial action as required. All clinical governance groups

report monthly to the Quality Improvement and Risk Group.

The Trust's Quality Improvement and Risk (QIR) Group is chaired by the Chief Nurse who has lead executive responsibility for quality improvement. This group has oversight of the full quality, safety and risk agenda across the Trust and provides appropriate direction and guidance to care groups and corporate functions, including the dissemination of shared learning within the Trust and with partner organisations. Our Corporate Performance Management Office (CPMO) continues to support the quality team to monitor performance against the action plans developed in response to the CQC inspection findings, enabling escalation to executives and the Assurance Committee and through to Board as necessary.

The QIR group seeks updates and assurance from a range of sub-groups that collectively shape and influence the Trust's quality agenda. This includes, but is not limited to:

- Service-Line Clinical Governance Groups
- Serious Incidents Requiring Investigation (SIRI) Panel
- Learning From Deaths Panel
- Health and Safety Group
- Medicines Management Group
- Clinical Audit and Effectiveness Group
- Safeguarding Steering Group
- Emergency Planning and Resilience Group
- Research and Development Group
- Quality Impact Assessments and review process
- Infection Prevention & Control Group

The QIR group is responsible for ensuring compliance with all statutory and regulatory requirements, including publication of the Quality Account and monitoring of progress against the associated priorities. It reports directly to the Trust's Assurance Committee and will make recommendations on quality improvement requirements in addition to highlighting key areas of risk that need visibility and response at Board level. The Assurance Committee reports to the Trust Board in turn.

The Quality Account provides more detail of the governance arrangements in place and reflects the achievements against the quality priorities set for 2017/2018 as well as outlining our priorities for the year ahead, 2018/19.

The Quality Account can be found on page [n].

You can also read more about our internal control processes associated with clinical governance and risk management within our Annual Governance Statement on page [n]

Quality Improvement

During 2017/2018 we have seen a high level of activity focused on improving patient and service user experience and outcomes. Implementation of the Friends and Family Test (FFT) has continued to be supported across all of our service lines. Overall feedback received through FFT and other local feedback mechanisms has been positive. In

addition, feedback received through the formal complaints process has been used to inform further improvement initiatives such as a review of our Customer Care Training programme.

We run a formal Quality Improvement programme to provide staff with the skills and confidence to identify and deliver improvements in their own services. A core element to this programme is partnership working with patients, service users and colleagues. Teams work in partnership to identify areas for improvement, identify and test changes and share findings. In some instances, service users or carers lead the improvement work.

We were invited to join NHS England's Always Events® as part of cohort five. Always Events® focus on the experiences that our service users, carers and service users identify that they should always have when accessing our services. The emphasis of, Always Events® is focused on relationships rather that clinical processes. The work with NHS England marks an exciting opportunity to focus our learning from patient experience through co-production and we will be progressing this further during the year ahead to working side-by-side and in partnership with our patients, carers and service users.

Our public and patient representative group (Side by Side) support the day to day running of our improvement work. We have jointly developed a charter for joint working and the group support the planning and running of events as well as award schemes to share learning.

A number of our teams and individual staff members have once again received recognition for their work in supporting patient care and progress has also continued to be made against clinical audit, research and development plans at service and corporate levels; the details of which are outlined in the Quality Account. It is particularly pleasing to note that we have continued to be an exemplar organisation in the level and quality of research and development activity being undertaken with contribution recognised through national publications.

Accessible information

The Accessible Information Standard (AIS) applies to service providers across the NHS and adult social care system. The aim of the Standard is to establish a framework and set a clear direction such that patients and service users (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss receive;

- Accessible information - information which is able to be read or received and understood by the individual or group for which it is intended'; and
- Communication support - support which is needed to enable effective, accurate dialogue between a professional and a service user to take place

We conducted an audit during Quarters 3-4 2017/18; and whilst our compliance with the AIS continues to improve, we will be working during the year ahead to further promote the AI Awareness film we have developed, roll out specilaist workshops and guidance across the Trust.

Commissioning for Quality and Innovation (CQUIN)

A proportion of our income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between ourselves and our commissioners through the Commissioning for Quality and Innovation payment framework (CQUIN). You can find more about CQUINs within the Quality Account.

Complaints and compliments

Receiving feedback about the services we provide is really important to us – it's how we learn and make improvements. We have embedded processes in place to allow the people we treat,their families and carers, to provide feedback to us. You can find more about our compliants and compliments procedures via our website at www.solent.nhs.uk and how we learn from complaints within the Quality Account.

Innovation

You can read about our Dragons Den iniative and the innovation projects we have supported within the Research and Improvement Annual Report appended to our Quality Account.

Trade Union (Facility Time Publication Requirements) Regulations 2017

Since the introduction of the Trade Union (Facility Time Publication Requirements) Regulations 2017 the Trust is required to publish the following data.

Table [x] – The total number of employees who were relevant union officials between period 1st April 2017 to 31st March 2018

Number of employees who were relevant union officials between 1st April 2017 to 31st March 2018	Full time equivalent employee number
24	19.80

Table [x] - Percentage of time spent on facility time

Number of employees who were relevant union officials employed between 01/04/17 and 31/03/18 spent a) 0%, B) 1%-50%, c) 51-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	17
1-50%	6
51-99%	0
100%	1

Table [x] - Percentage of pay bill spent on facility time

Cost	£000
The total cost of facility time	£31
The total pay bill	£121,235
Percentage of total pay bill spent on facility time*	0%

*Percentage calculated as (total cost of facility time divided by total cost of pay bill) times 100

Table [x] – Paid trade union activities

As a percentage of total paid facility time hours, the number of hours spent by employees who were relevant union officials between 01/04/17 and 31/03/18 on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours *	100%

* Calculated as (total hours spent on trade union activities by relevant union officials between 1st April 2017 and 31st March 2018 divided by total paid facility time hours) times 100

Note:

Facility time = Total time paid by the employer to undertake Union activities as specified in the Trade Union and Labour Relations (Consolidation) Act 1992 excluding time not paid by employer.

Paid trade union activities = Time take off under section 170(1)(b) of the Trade Union and Labour Relations (Consolidation) Act 1992.

The Accountability and Corporate Governance Report is signed by;

[signed]

Sue Harriman
Chief Executive Officer
Date: xxxxx

Section 3:
The Auditors Report

Independent auditors report to the Accountable Officer of Solent NHS Trust

EY to provide

Section 4: Our Summary Accounts

Our summary accounts

Foreword and Statement on Financial Performance

We have ended 2017-18 by achieving three of our four financial statutory duties:

- External Financing Limit (EFL) which is an overall cash management control. The Trust was set an EFL of £6.5m cash outflow for 2017-18, actual EFL was £2.1m cash inflow and therefore the Trust achieved the EFL target with a positive variance of £8.6m.

- Capital Cost absorption rate is based on actual (rather than forecast) average net relevant assets and therefore the actual capital cost absorption rate is automatically 3.5%.

- Capital Resource Limit (CRL) which represents investments in fixed assets throughout the year. The Trusts fixed asset investment for 2017-18 was £3.6m a £0.3m underspend against the target of £3.9m.

- Whilst the Trust achieved an in year adjusted surplus of £0.7m, the Trust did not achieve is cumulative breakeven duty, a measure of financial stability, with a cumulative adjusted retained deficit of £8.2m reported in 2017-18.

The 2017-18 financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS. Where the Group Accounting Manual permits choice of accounting policy, the accounting policy which is judged to be the most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

[signed]
Sue Harriman
Chief Executive Officer
Date: xxxxx

Finance Review & Statutory Duties in relation to the Accounts

The statement of directors responsibilities in respect of the accounts can be found on page [n].

Break-even position (a measure of financial stability)

The Trust has a statutory duty to achieve break-even in the year. The Trust has achieved the breakeven duty in year, reporting a £0.7m adjusted surplus in 2017-18. As the Trust has previously reported deficit results, the cumulative breakeven position has not been achieved, with a cumulative adjusted deficit of £8.2m. Our regulators were aware of this position and continue to support us in our delivery of key community and mental health local services.

Capital Costs Absorption Rate (a measure of Statement of Financial Position Management)

The Trust is required to absorb the cost of capital at a rate of 3.5% of actual average relevant net assets. The average net relevant assets exclude balances held in the Government Banking Service bank accounts. The dividend payable on public dividend capital is based on actual (rather than forecast) average relevant net assets and therefore the actual cost absorption rate is automatically 3.5%.

External Financing Limit (an overall cash management control)

The Trust was set an External Finance Limit of £6.5m cash outflow for 2017-18 which it is permitted to undershoot. Actual external financing requirements for 2017-18 were £2.1m cash inflow and therefore the Trust achieved the target with a positive variance of £8.6m.

Capital Resource Limit (Investment in fixed assets during the year)

The Capital Resource Limit is the amount that the Trust can invest in fixed assets during the year; a target with the Trust is not permitted to overspend. The Trust was set a capital resource limit of £3.9m for 2017-18. Our actual fixed asset investment was £3.6m, an £0.3m underspend against target.

Want to find out more?

Included on the previous pages are the 'summary accounts' of the Trust and an overall picture of our fiscal performance. A copy of our full accounts are available in Appendix [X]

Financial Statements

Statement of Comprehensive Income for year ended 31 March 2018

	2017-18 £000	2016-17 £000
Employee benefits	(121,235)	(117,630)
Other costs	(58,276)	(64,454)
Revenue from patient care activities	166,882	162,247
Other Operating revenue	20,122	18,428
Operating surplus/(deficit)	7,493	(1,409)
Investment revenue	24	23
Other gains and (losses)	(4)	(11)
Finance costs	(151)	(159)
Surplus/(deficit) for the financial year	7,362	(1,556)
Public dividend capital dividends payable	(2,305)	(2,314)
Retained surplus/(deficit) for the year	5,057	(3,870)
Impairments and reversals taken to the revaluation reserve	(546)	(4,032)
Revaluations	351	0
Total comprehensive income for the year	4,862	(7,902)

Financial performance for the year

	2017-18 £000	2016-17 £000
Retained surplus/(deficit) for the year	5,057	(3,870)
Impairments (excluding IFRIC 12 impairments)	(4,310)	1,740
Adjustments in respect of donated asset respect elimination	(10)	46
Adjusted retained surplus/(deficit)	737	(2,084)

Statement of Financial Position as at 31 March 2018

	31 March 2018 £000	31 March 2017 £000
Non-current assets	86,435	82,958
Current assets	24,625	19,909
Current liabilities	(26,447)	(24,213)
NET CURRENT ASSETS / (LIABILITIES)	(1,822)	(4,304)
TOTAL ASSETS LESS CURRENT LIABILITIES	84,613	78,654
Non-current liabilities	(5,223)	(4,126)
TOTAL ASSETS EMPLOYED	79,390	74,528
FINANCED BY TAXPAYERS' EQUITY	79,390	74,528

Statement of Changes in Taxpayers' Equity for year ended 31 March 2018

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2017	**6,435**	**59,930**	**8,163**	**74,528**
Changes in taxpayers' equity for 2017-18				
Retained surplus/(deficit) for the year		5,057		**5,057**
Impairments and reversals			(195)	**(195)**
Transfers between reserves		259	(259)	**0**
Net recognised revenue/(expense) for the year	**0**	**5,316**	**(454)**	**4,862**
Balance at 31 March 2018	**6,435**	**65,246**	**7,709**	**79,390**
Balance at 1 April 2016	**6,435**	**63,438**	**12,557**	**82,430**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year		(3,870)		**(3,870)**
Net gain / (loss) on revaluation of property, plant, equipment				**0**
Impairments and reversals			(4,032)	**(4,032)**
Transfers between reserves		362	(362)	**0**
Net recognised revenue/(expense) for the year	**0**	**(3,508)**	**(4,394)**	**(7,902)**
Balance at 31 March 2017	**6,435**	**59,930**	**8,163**	**74,528**

Statement of cash flows for the year ended 31 March 2018

	2017-18	2016-17
	£000	£000
Net cash inflow/(outflow) from operating activities	7,830	4,308
Net cash inflow/(outflow) from investing activities	(3,730)	(4,002)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**4,100**	**306**
Net cash inflow/(outflow) from financing activities	(790)	410
INCREASE / (DECREASE) IN CASH	**3,310**	**716**
Cash at the beginning of the period	6,291	5,575
Cash at year end	**9,601**	**6,291**

Better Payment Practice Code : Measure of Compliance 31 March 2018

	2017-18		2016-17	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	24,989	50,562	28,529	56,003
Total non-NHS trade invoices paid within target	23,479	47,509	26,648	48,637
% non-NHS trade invoices paid within target	94%	94%	93%	87%
Total NHS trade invoices paid in the year	1,230	17,446	1,912	16,365
Total NHS trade invoices paid within target	1,067	16,514	1,589	15,630
Percentage of NHS trade invoices paid within target	87%	95%	83%	96%

*The **Better Payment Practice Code** requires the Trust to aim to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later.*

Challenges ahead

The challenges we face as we head in to the new financial year include ensuring we deliver safe and effective services whilst balancing financial efficiencies and within a financial envelope which is subject to year on year cost reductions. We ended 2017/18 achieving a £0.7m surplus with Board recognition that there are more challenging years ahead.

Our efficiency target for 2017/18 (Cost Improvement plan) was £6.1m and we delivered cost savings of £4.2m (the balance was achieved by other measures) but we recognise that there is more to do – both internally within the organisation and with partners to radically transform health and care pathways in accordance with the ambition and plans of the Hampshire and Isle of Wight STP. Working differently and with our partners as part of a 'system' may, at times, mean we need to make difficult decisions for the greater good of our service users and the wider NHS – we will always endeavour to put our citizens and communities before services, and services before organisations, in accordance with our guiding principles.

We are vulnerable to risk during times of change – we must ensure we are vigilant to ensure that we are able to maintain 'business as usual' and that the quality of care we provide, our performance and ultimately our organisational values are not compromised as a consequence.

The key challenges we face in 2018-19 are as follows:

- Delivery of the deficit target of £1.0m
- Delivery of the efficiency savings programme – including significantly reducing our agency spend in order to be compliant with the agency ceiling cap. However, the quality and safety of our services must always remain our highest priority.
- Delivery of key programmes including estates rationalisation – including significantly the St James Hospital and St Mary's Hospital campus
- Working within the Sustainability and Transformation Programme, developing Local Delivery Systems and Integrated Care Systems

The internal control processes for managing risks are outlined in the Annual Governance Statement found on page [n].

Going Concern

The financial statements have been prepared on a going concern basis, as management have no significant reasons to believe otherwise. This is supported by the recent contract negations with NHS and Local Authority organisations to provide continuing services throughout 2018/19 within an agreed Control Total.

In conclusion, having considered the challenges we face, particularly with reference to our operating plan for the next twelve months, and having reviewed with our external auditors, the Board has a reasonable expectation that the Trust has access to adequate resources to continue in operational existence in the foreseeable future. For this reason the Trust continues to adopt the going concern basis in preparing the annual accounts. However, as the Trust has not achieved a cumulative breakeven position over the last four years, it is acknowledged that our Auditors have referred a matter to the Secretary of State in accordance with Section 30 of the Local Audit and Accountability Act 2014.

The statement of financial position is signed by:

[signed]
Sue Harriman
Chief Executive Officer

Date: xxxxx

Section 5:
Quality report incorporating the Quality Account 2017/18

To be inserted once approved (presented separately)

Appendix 1 – Full Accounts

To be inserted once approved

Quality Account 2017/18 (incorporating our priorities for quality improvement in 2018/19)

Part One

Statement of Quality from Sue Harriman, Chief Executive

Thank you for taking the time to read our Quality Account.

Each year all providers of NHS healthcare services are required to produce an annual Quality Account for publication. We welcome the opportunity to share how we performed during 2017/18, as well as the opportunity to reflect on the areas for further improvement. I hope that you find this report a useful guide to our performance and achievements in quality, safety and patient experience over the past year, and our plans and priorities for the year ahead.

Why we exist - 'The Solent Story'

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

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

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

We know our vision is ambitious, but we have excellent foundations. Our priorities are what we do all of the time, they are how we:

Deliver great care

- Involving service users in shaping care and always learning from their experiences
- Working closely with partners to join up care
- Treating people with respect, giving equal emphasis to physical and mental health
- Ensuring we provide quality services, which are safe and effective

Make Solent a great place to work

- Supporting people to look after their health and wellbeing
- Improving the workplace by listening to ideas and acting on feedback
- Developing leaders to support and empower people in making a difference

Deliver the best value for money

- Spending money wisely and by working with partners
- Involving people in decisions about spending money
- Enabling services to have more time to provide care

To us, **Great Care** means care that is safe, joined up, simple and easy to access, and based on the best available evidence.

We talk about **Great Care** in the context of:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

Providing **Great Care** is at the heart of everything we do.

It's the most important thing to us and to our patients, and as part of the NHS family, the quality of the care we provide reflects on the whole of the NHS, so it's vital we get it right.

Because we have many aspects of quality to share with you, we have provided signposts/hyperlinks to more detailed information.

Great Care in Action

Sally Griffin - Children's Asthma Nurse, Southampton

"I make a difference by supporting children and their families in all aspects of asthma management through offering advice, support and education.

Empowering children and young people to manage their condition safely, aims to reduce hospital admissions, promote better quality of life, and produce better health outcomes.

In addition to carrying out home visits and telephone support, I use social media to communicate relevant public health advice and health tips to service users, which keeps children and young people engaged, and informed, about the safe management of their condition".

I am proud to be the Chief Executive of a Trust that puts quality at the centre of everything we do. We have a team of dedicated and committed staff, who each make a difference and strive to deliver consistently great care.

Sue Harriman

Chief Executive Officer

Statement from our Chief Medical Officer and Chief Nurse

Developing, delivering, and maintaining strong and effective, high quality services is the core priority for Solent NHS Trust. We are continually reviewing and improving our systems and processes to ensure that the quality of our services is at the heart of what we do every day, and how we do it.

We are committed to providing care that is safe, effective and efficient. It is important that service users, patients and their families have a positive experience of our services, and can clearly see the ways in which we strive, year on year, to improve what we offer. As such, we continue to gather feedback using the Friends and Family Test (FFT) which asks patients and users of our services, as well as our people, to tell us to what extent they would recommend our services to their friends and families.

Our Quality Improvement (QI) programme continues to grow in strength and impact, aiming to support all who work with us (patients and colleagues) to develop the skills and confidence to identify, deliver and sustain improvements across our services. Our QI programme has been extended this year to include a 'Foundation Level' one day training to provide an introduction to Quality Improvement methodology, as well as bespoke QI sessions within Trust leadership and development programmes.

A core part of the programme is the involvement of patients, service users and families in identifying what could be improved, and in delivery and testing of changes. This is part of the Foundation training and of the core programme.

Looking ahead, we will maintain our focus on the quality of care, safety and the wellbeing of people who use our services and our staff. This remains our highest priority. The purpose of this Quality Account is to confirm this pledge and to hold our organisation to account to deliver these standards across all those services we directly provide and in those services where we work in partnership with others.

Dan Meron

Chief Medical Officer

Jackie Ardley

Chief Nurse

Part Two: Priorites for Improvement and statement of assurance from the Board

2.1 Quality Themes and Priorities

Quality Themes

Our quality themes next year are linked with our strategic corporate aims, and focused on the integration of these into a continuously- monitored improvement loop. Each statement is both stand-alone and concomitant. They can inter-weave to create a sustainable dynamic framework of co-operative working, with outcomes of a truly shared vision and measureable parameters of improvement.

Theme 1: Involving People

In order to continue to deliver great care, we will further-develop a community engagement framework, which is inclusive of patients, people who live within our communities and our local organisations and stakeholders.

In 2018/19 we will:

- Embed a sustainable community engagement framework, which is inclusive of patients, people who live in our communities, local partner organisations and external stakeholders.
- This will incorporate the use of assistive technology to successfully access “hard to reach” groups such as the frail, elderly and housebound.
- We will seek out and work with patient groups such as MH patients and their families, used as subject-experts to ensure we meet their highly specific needs to make our environments as safe as possible for them. This will be in part evidenced by the accurate and contemporaneous ligature risk assessment in our inpatient wards. We will also be able to demonstrate learning from their experiences, and from the very precise knowledge they can be enabled to share with us.
- We will increase our engagement with our local Healthwatch groups, to ensure they are aware of our most up to date quality work. A measurable outcome will be held within records of these meetings and their opportunity to feedback real-time quality comments to further improve our relationship and functional work dynamic with our partners.

Theme 2: Ensuring Safe Care

To ensure we provide quality services which are safe and effective, we will further embed quality improvement. Our key safety message will be that, “It is everyone’s business,” and this will be embedded from Induction, and evidenced through supervision, one to one conversations and annual appraisals.

In 2018/19 we will:

- Launch the Research and Improvement Academy. By using different learning approaches, our staff will be able to access high quality, research-led learning over the 24 hour period, at home or at work. The safety of care will improve as a direct result of staff working within an active safety culture, where the everyday norm is looking for improvement.

- Roll out the QI Leaders programme. This is aimed at all staff, both clinical and non clinical .
- Ensure safety is a parameter integrated and evidenced through documented one to one supervision conversations and pre-set personal outcomes for learning.

Theme 3: Learning and Improving

We continue to strengthen our reputation as a learning organisation, delivering real and measureable change that makes a difference to people we care for and treat. These changes are made as a result of collating and actively utilising lessons from positive and negative events and from feedback.

In 2018/19 we will:

- Utilise the Learning from Deaths and serious incidents panels to learn, implement and disseminate positive change
- Launch a change and improvement data base
- Develop a toolkit for learning from excellence
- Evidence the improvements as a result of learning and change

Theme 4: Sharing excellence

Our organisation has several areas of outstanding practice, excellent multidisciplinary teamwork and quality improvement facilitators.

In 2018/19 we will:

- Continue to present at local or national conferences on subjects of interest and expertise
- Work with system partners to ensure they are fully briefed on our most up to date improvement work
- Work towards identifying all people with cognitive disability accessing any of our services and provide appropriate adjustments to their care plans
- Replicating outstanding success factors from the cognitive disability service across other service lines

Theme 5: Supporting vulnerable people

We will continue to help vulnerable people in our communities live safer lives.

In 2018/19 we will:

- Further embed Mental Capacity Act (MCA) and Safeguarding training across our services
- Develop our capabilities in the application of the MCA and safeguarding principles
- Ensure senior managers and the Executive attend MHA -specific training to use as a senior information resource for staff

Theme 6: Looking after each other

In order to ensure Solent remains a great place to work, we will continue to develop and support our people.

In 2018/19 we will continue to promote wellbeing in the workplace:

- By promoting equality and diversity initiatives
- Supporting openness about mental health challenges

- Developing our apprentices and reviewing their planned progression
- Increase mindfulness course availability
- Running bespoke information and training session to specific work groups
- Creating internal and external opportunities for professional and personal development; this will sometimes involve working with system partners to identify unique opportunities for individuals to explore latent talents. We also use talent management identification for accelerated career progress
- Rewarding excellence in our people, by the use of nominations for national award schemes, monthly internal awards for colleague/team/manager of the month, and an “Outstanding contribution” award. We also hold larger Annual Award celebrations.

2.2 Statements of assurance from the Board

Contracts

We have a total of 99 contracts that are related to healthcare and of these, 52 related to where we purchase health services.

We have reviewed all the data available to us on the quality of care in these contracts. The income generated by these contracts represents 100% of the total income generated from the provision of these relevant health services by the Organisation for 2017/18.

Participation in local and national clinical audits and national confidential enquiries

National Clinical Audits

During 2017/18, we participated in 11 out of 12 national clinical audits and national confidential enquiries, covering health services that we provide. The audits and enquiries that we were eligible to participate in during 2017 /18 are included in Appendix A, together with the number of cases submitted to each audit or enquiry.

National audit reports are distributed on publication to the relevant service line and local audit leads along with a summary of recommendations and an action tracker to measure compliance. National audit reports are also highlighted at the Trust learning and improvement group to promote cross-service learning for improvement.

Local Clinical Audits and Service Evaluations

109 local audit and service evaluation project reports have been completed and reviewed during the 2017/18 financial year. These projects are determined by each service, based on their priorities, and are as a result of patient and staff feedback, business plans, complaints investigations, serious and high risk incident investigations, as a means of measuring compliance with NICE guidance and as a baseline measure for Quality Improvement projects.

Audit plans and actions are reviewed at service line audit groups with key learning and improvements shared at the Trust learning and improvement group. Audit and evaluation action planning for improvement is also increasingly

integrated into the Trust Quality Improvement programme. Specific training on audit and evaluation is also provided.

Examples of some of the improvement outcomes achieved and actions planned as a result of local audits and service evaluations are detailed in the tables below:

Audit title	Improvement as a result of audit
Re audit of Nutrition and Hydration for in patients (Royal South Hants).	An improvement was demonstrated to achieve 100% compliance with standards in comparison to 76% in the previous quarter.
Re-audit of pelvic inflammatory disease care in sexual health services.	Improvements were shown in comparison to the 2015 audit in exclusion of pregnancy (from 45% to 72%), correct antibiotics given (from 57% to 98%) and attendance for treatment of partners (from 1% to 16%).
Re-audit of Patient Group Directive (PGD) compliance in sexual health.	Documentation of expiry date and batch numbers of medication improved from 21% errors in 2016 to 6.7% errors in 2017 re-audit.
Re-audit of recording parental consent in specialist dental.	Compliance with the standard increased from 44% in the previous audit to 65%.
Re-audit in Mental Health services of short-term risk assessment of a self-harm episode on or during admission (NICE NG16).	Compliance with the NICE criteria was 100% from previously less than 8% in the original audit conducted in 2014.
Re-audit in Child and Family of CAMHS "was not brought" (WNB) children.	This re-audit demonstrated an improvement in attendance rates for appointments at Southampton CAMHS since September 2016, from 13% WNB to 7.9%. The most marked change was in initial assessments, from 47% WNB in 2016 to 5.6% in 2017.
Re-audit in Primary Care services of retinal screening of diabetic patients registered at Solent GP.	The percentage of patients who had documentation of retinal screening had improved since the initial audit from 71% to 76%.
Re-audit of pressure ulcers comparison with NICE guidance.	June 2017 compliance with standards was 94-100% except use of at risk care plan (88%). Re-audit in August 2017 shows similar high scores and increase use of care plans to 100%.
Re-audit of triage and prioritisation of referrals into adult speech and language therapy (east).	A previous audit highlighted that receipt of referrals was slow and the use of triage and prioritization was limited as was use of the single point of access (SPA). The re-audit shows significant improvement in all areas measured with the majority now achieving 100% compliance. The average time from sending to triage of referrals had reduced from 8 to 3 days.
Re-audit of Podiatry use of PGD (Patient Group Directions) for provision of antibiotic therapy.	Comparing 2016/17 to 2015/16 audit results there have been significant improvements. Appropriate provision increased from 63% to 100%. Adherence to treatment increased by between 16% for antibiotics and 28% for Doxycycline to reach 100%. In all cases where antibiotics have been provided, signs of clinical infection have been well documented
Re-audit of antibiotic prescribing in Solent Special Care Dental Service.	Antibiotic training in staff meetings has resulted in an improvement in record keeping and compliance. 100% compliance with standards indicated that appropriate antibiotics are being selected and dose regimes are correct. Very few antibiotics were prescribed in the audit period by the dental service which suggests that appropriate surgical management of dental infections is being carried out.
Re-audit of completion of discharge summaries for adult inpatient services (West).	Both inpatient wards demonstrated an overall improvement in compliance percentage. Fanshawe scored 94% in quarter 1 and 100% in quarter 3. Lower Brambles scored 94% in quarter 1 and 99.7% in quarter 3.

Audit/Evaluation title	Example actions planned as a result of audits and evaluations
Evaluation of parental satisfaction with autism assessment pathway (LD services).	Parents were concerned about waiting time and uncertainty of process for feedback. A feedback clinic has been set up to address this.
Evaluation of 'ADAPT' Pain Management Programmes (PMP).	Maintain on-going review of the PMP working with the local IAPT service and pain clinic; review how the initial screening service dovetails with subsequent assessments of suitability for PMP or 1:1 self-management; look into the longevity of giving patients pre-group preparation sessions. Reduce the number of sessions for PMP to 10 from the current 12; change from 1 month and 9 month follow-ups, to just one follow-up at 6 months.
Evaluation of clinical discussions regarding Domestic Violence (DV) (Health Visiting).	Provide further training to explore the nature of DV conversations (for disclosure and public health information) and how to enable effective early intervention to improve outcomes and safe discussions around DV; change of electronic records to incorporate healthy relationships, discussion questions and DV on every template; review individual staff record keeping and provide feedback regarding conversations about DV, interventions offered and the outcome evident; review current practice guidance to update insert that is attached to each Parent Held Record.
Evaluation of paediatric saturation probes in GP Surgeries within Portsmouth COAST catchment (NICE Clinical Knowledge Summary).	The majority (76%) of GP surgeries had at least one paediatric oxygen saturation probe; 82 % did not have paediatric saturation probes available in all consultation rooms; 72% felt that this was a problem. Some surgeries have indicated that they will change practice. Audit findings were sent to GPs to encourage them to invest in sufficient paediatric probes.
Impact of the introduction of CAMHS East Crisis Role.	Introduce another clinician to increase the amount of children and young people offered duty appointments and risk reviews; develop an urgent distress tolerance group to ensure they receive fast, effective treatment to manage their emotions and mental state.
Re-audit of Infection Prevention and Control (multi-service).	Staff training provided to highlight issues around use of hand moisturiser; hand hygiene; waste knowledge.
Routine sexual history consultation of patients presenting with a new diagnosis of sexually transmitted infection at the Royal South Hants Hospital.	Create a patient information collection tool to use with the current sexual history tool, to simplify partner notification and risk assessment and for use with the geospatial mapping software to highlight locations where there is a cluster of STIs to target health promotion; create posters for staff rooms to remind clinicians to follow the BASHH guidelines; present audit findings at monthly staff meeting.
Risk assessment for self-harm (longer term management) (NICE CG 133) in adult mental health.	Raise awareness of the importance of maintaining compliance with standards by presenting the audit at Solent's 2017 Research & Improvement Conference; set up psycho-education in coping strategies for self-harm patients on Orchards ward.
Re-audit of "Was Not Brought" children to CAMHS.	Develop a reminder service (text message) as clinicians who carried out telephone reminders had low WNB rates. Educate staff on completing appointments on electronic records; introduce pro-forma text on records to assist with the process of recording outcome / reason for WNB.
Prescriptions of Tramadol or Pregabalin with antidepressant drugs in a pain service outpatient clinic (NICE-CSK Analgesia).	Develop a process to ensure concomitant use of SSRI, SNRI and TCA and Tramadol are always included in GP correspondence; create a patient information leaflet & process; recommend to GPs that they repeat the GAD score to consider appropriate treatment; create a service standard to document if patient reports euphoria/internet buying, add record alerts to warn of concomitant use of these medications as risk factors for addiction.
Audit of Pressure Ulcers (2017-18 Quarter 3) (NICE CG 179 / QS 89) Southampton.	Introduce measures to reduce pressure ulcers by: (i) Roll out of Intentional rounding to all localities once new community nursing structure is embedded, (ii) Consideration of extension of Purpose-T pilot to community teams (Purpose-T = Pressure Ulcer Risk Primary Or Secondary Evaluation Tool); Launch updated "TIMES" wound assessment tool on records.

Audit/Evaluation title	Example actions planned as a result of audits and evaluations
Audit of Family Nurse's use of Ages and Stages Questionnaires (ASQ) and Family Nurse Partnership (FNP) tools with evaluation of training needs.	Meet with nurses to provide them with the FNP guidelines and a quick start guide provided to use whilst administering ASQs; order the most up to date ASQ 3rd edition resources; arrange for NHS Digital to amend FNP Information System cut-off scores, to reflect those shown on paper assessments; establish an ASQ Pathway to ensure consistent use.
Re-audit of triage and prioritisation of referrals into adult speech and language therapy (east).	Form a centralised triage team and process to ensure that referrals are triaged equitably across the three general caseload areas. Develop a tool for demand and capacity.
Completion of diabetic foot assessment tools by GP's and nurses (Podiatry).	Attend meeting between podiatry and the nursing team to discuss findings and get feedback about DFA forms from nurses; a new DFA is now available online which may increase accuracy and completeness of forms.
Re-audit of retinal screening of diabetic patients registered at Solent GP.	Set up a batch report to ensure texts are sent to all patients who have not had retinal screening, on a six monthly basis (and check the rate of screening six monthly to ensure uptake does not drop below 75%).
Re-audit of Nutrition and Hydration for in patients (Royal South Hants).	Feedback audit results to staff with discussion around critical completion times; a mitigating circumstances box was entered onto electronic records for staff to record the reason why a MUST assessment wasn't completed, inform senior staff that they need to monitor compliance; remind staff that a care plan is needed for a MUST score of 1 or more.
Response time to safeguarding team advice line, since introduction of Lync system.	Undertake customer satisfaction evaluation; share information with the Adult Safeguarding Lead Nurse that data collecting tool should include the service that had contacted the team to make the data collection more streamlined.
Re-audit of Dental Recall Interval (NICE CG 19) (2017-18).	Share results with all staff via "Newsbites", discuss in locality meetings, discuss in general anaesthetic clinic meeting; seek clarification as to whether NICE tab used for audit data collection and the new compulsory field could be combined.

Research

In 2017/18, 2310 patients, receiving relevant Solent health services, were recruited and participated in research ethics committee approved research programmes.

The Trust continues to be the highest recruiter of participants in research for Care Trusts in England and further information on research activity can be found within our Research and Improvement Annual Report annexed to the Quality Account and at http://www.academy.solent.nhs.uk/.

Commissioning for Quality and Innovation

A proportion of our income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between ourselves and our Commissioners through the Commissioning for Quality and Innovation payment framework.

		Achievement			
Service Line	**Scheme**	**Q1**	**Q2**	**Q3**	**Q4**
Portsmouth Care Group	#1 – Improving Staff Health and Wellbeing				G
Southampton Care Group	#1 – Improving Staff Health and Wellbeing				G
Adult Mental Health	#3 – Improving Physical Health for people with Severe Mental Illness	G	G	G	G
Adult Mental Health	#4 - Improving services for people with Mental Health needs who present to A&E	G	G	G	G
Childrens East	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	G	G		A*
Childrens West	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	G	G		G
Adults Portsmouth	#8b – Supporting proactive and safe discharges - Community		G		G
Adults Southampton	#8b – Supporting proactive and safe discharges - Community		G		A*
Portsmouth Care Group	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	G			
Primary Care	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	G			
Adults Portsmouth	#10 – Improving of Wounds Assessment		G		G
Adults Southampton	#10 – Improving of Wounds Assessment		G		G
Adults Portsmouth	#11 – Personalised Care and Support Planning		G	G	G
Adults Southampton	#11 – Personalised Care and Support Planning		G	G	G
Sexual Health Services	#1.1 – Activation System for Patients with Long Term Conditions (LTCs)				R**

*final CQUIN figures will not be available until beginning of June
**It should be noted that the evidence to support the achievement of the Activation System for Patients with Long Term Conditions (LTCs) by Sexual Health Services was outside the contractual timeframe

Flu Vaccinations

This year we were set a target of vaccinating 70% of front line staff against the Flu. This was a significant challenge to us as the previous year we achieved 54%. Our Occupational Health Team initiated a number of new approaches including the introduction of peer vaccinators within service lines, incentive schemes/competitions to encourage uptake and a proactive communication strategy. This has had a significant effect and by the end of the year we vaccinated 71% of our front line staff and over 2300 staff in total.

Care Quality Commission (CQC)

We are required to register with the Care Quality Commission (CQC). Our current registration status is "registered without conditions"; we are therefore licenced to provide services. The Care Quality Commissioner has not taken any enforcement action against us during 2017/18.

The CQC registers and licences us as a provider of care services as long as we meet the fundamental standards of quality and safety. The CQC revisited a number of services in 2017/18. As we reported in last year's Quality Account, there were a number of services rated 'Inadequate', and it was these services that were re-inspected:

Children and Young Peoples Service were revisited by CQC in October

The Inspectors noted substantial improvements in the service delivered through the specialist schools we inspected on this occasion, and evidenced through the pre-inspection presentation.

They re-rated the service 'Requires Improvement' from 'Inadequate' as the Service had:

- Medicines management processes, although showing improvements, were not yet fully embedded for safe practice
- Records were, in the main, stored correctly but not consistently and some contained out of date information

They also commented on the highly personalised care, record keeping and process assurance at one of the schools, and that the services had completed the actions we required it to take following the inspection in June 2016.

Child and Adolescence Mental Health Services were revisited in May

The Inspectors rated the services 'Good' from 'Requires Improvement' as the Service had:

- Completed the actions we required it to take following the inspection in June 2016
- Staff understood how to assess and manage the risk to young people
- Staff completed care plans to support the safe and effective care of young people on their caseload
- Staff demonstrated empathy, kindness and caring when working with young people.
- Staff actively encouraged young people and their carers to be engaged in making plans of care and to provide feedback on the service they received.

Substance Misuse Service was also visited in May

The Inspectors rated the service 'Good' from 'Requires Improvement' as the Service had addressed the issues identified following the June 2016 inspection. This included:

- Putting protocols in place for those who regularly did not attend appointments or disengaged from the service.
- There was clear and visible leadership and oversight across both services.
- Managers ensured staff attended mandatory training and received supervision and appraisals.

- Local and senior managers worked together to ensure the staff were supported in their roles to achieve positive outcomes.

The CQC have also carried out a number of unannounced visits to our Mental Health Wards and we have taken actions to address any issues they found which have included:

- Ensuring we promote, review and oversee patient collaboration with staff regarding its reducing restrictive interventions programme
- Ensuring that patient care plans are patient specific, reviewed and updated regularly, contain patient views, and that patients are given copies,
- Ensure that there is evidence regarding the approved/responsible clinicians' assessment of the patients' capacity to consent or otherwise

We welcomed a specific visit to our new Kite ward by the CQC Registration Team to ensure that the facilities were suitable for the patient cohort we look after there. More news about the new Kite Ward can be found on page 45 We also participated in two systematic reviews by CQC Teams. The first was a review of services for looked after children and safeguarding in Portsmouth in June. This included our Sexual Health, Mental Health and Community services. In March this year, we participated with colleagues in a Local System Review in Hampshire, to enable the CQC to have a better understanding of the pressures and challenges across the Hampshire system and identify any areas for improvement needed in health and social care services. The review focused on services for people over 65 and whether people using local services are provided with safe, timely and high quality care.

Our ratings posters can be found at:

http://www.cqc.org.uk/provider/R1C/posters

Information Governance

Information Governance Toolkit attainment - the organisation has completed an annual Information Governance Toolkit Assessment achieving 97 percent compliance. Further information about the IG Toolkit can be found www.igt.hscic.gov.uk

Freedom of Information (FOI) Requests – the number of FOI requests received within a financial year was 294. This remains consistent when compared to the number of requests received the previous year (2016/17).

This year we have achieved 91.9 percent compliance with the 20 working day response target, which is an increase in compliance when compared to 2016/17's compliance level of 87.1%. At this time, 9 requests are not currently due and have therefore been excluded from these figures.

We made significant changes to the way in which we process FOI requests in quarter three and four of this financial year and identified a dedicated resource to process these requests; this has improved compliance, which in these quarters rose to 99.3 percent.

Subject Access Requests (SARs) – the number of subject access requests received within a financial year has increased by 18 percent when compared to the number of requests received the previous year (2016/17).

This year we achieved 87 percent compliance with the mandated 40 day response target, with 67 percent of requests being responded to within the best practice timeframe of 21 days. Compliance has increased when compared to 2016/17's compliance level of 83 percent. At this time, 49 requests are not currently due and have therefore been excluded from these figures.

We also made significant changes to the way in which we processSAR requests in quarter three and four of this financial year and identified a dedicated resource to process these requests. This has improved compliance, which in these quarters rose to 95.5 percent compliance with the mandated 40 day response target, with 77 percent of requests being responded to within the best practice timeframe of 21 days.

Payment by Results (PbR)

The Trust was not subject to a PbR clinical coding audit during 2017/18.

Clinical Coding

Clinical coding is the translation of written medical terminology into alphanumeric codes. Each code from a source document is assigned the appropriate codes that represent the complete picture of a patient spell in hospital. This is in accordance with the NHS Data Dictionary and World Health Organisation standards set out in the Clinical Coding Instruction Manual - International Classification of Diseases version 10.

Clinical Coding is important for local and national monitoring of incidences of diseases and in acute Trusts it is used in the development of reference costing for contractual purposes. We are responsible for providing accurate, complete and timely coded clinical information to support commissioning, local information requirements and the information required for the Commissioning Data Set (CDS) and central returns.

Each year the coding process is audited by an external accredited auditor. We have achieved a top level three rating for the last three years. The audit examines the quality and completeness of clinical information available for coding as well as the completeness and accuracy of the coding itself.

Data Quality

During 2017/18, a new Data Quality Team was established to assist our services in the validation and improvement of their patient data. After the transition of our clinical record system in recent years, a high number of data quality legacy issues were created. Many of these issues have been resolved to date but work is still required in a number of areas to improve our data quality.

The first focus of the team was to validate patients who were being reported as waiting over 52 weeks for their first appointment for all services to ensure that there was clear oversight of the waiting list position across the Trust. Between October and December 2017, the team managed to reduce the number of incorrect waiters by over 3000 and have implemented monthly processes with services to help maintain a good standard of data quality in this area and to further reduce the existing data quality issues.

Data Quality Report
52 Week Waiters by Service Line

NHS Solent NHS Trust

Service Line	Week Commencing														
	02/10/2017	09/10/2017	16/10/2017	23/10/2017	30/10/2017	06/11/2017	13/11/2017	20/11/2017	27/11/2017	04/12/2017	11/12/2017	18/12/2017	25/12/2017	01/01/2018	08/01/2018
Adults Southampton	644	638	629	371	339	261	188	155	141	129	72	44	30	19	7
Primary Care	643	512	510	298	73	74	66	66	55	25	27	25	17	15	11
West Child & Family	1082	789	779	736	710	654	594	399	277	271	262	144	70	70	63
Adults Portsmouth	217	207	206	122	113	64	55	47	48	38	30	12	12	7	7
Mental Health	121	148	147	133	135	136	135	136	67	66	49	22	10	9	0
East Child & Family	806	743	741	677	653	542	542	535	334	321	98	102	48	45	34
Special Care Dental	5	5	3	3	0	TBC	TBC	0	4	0	0	0	0	0	0
Grand Total	3518	3042	3015	2340	2023	1731	1580	1338	926	850	538	349	187	165	122

The second part of the waiting list validation project for the Data Quality Team was to work with our services again to validate any patient reported to have been waiting between 18-51 weeks for their first appointment. Again, really good progress has been made by reducing the number reported by over half in Quarter 4 2017/18. Work will continue to reduce these further and validation will commence on all other waits during 2018/19.

Data Quality Report
18 - 52 Week Waiters by Service Line

NHS Solent NHS Trust

Service Line	Data correct as of											
	02/01/2018	01/02/2018	01/03/2018	02/04/2018	01/05/2018	01/06/2018	02/07/2018	01/08/2018	03/09/2018	01/10/2018	01/11/2018	03/12/2018
Adults Southampton	724	635	455	464	-	-	-	-	-	-	-	-
Primary Care	356	359	326	274	-	-	-	-	-	-	-	-
West Child & Family	493	140	110	136	-	-	-	-	-	-	-	-
Adults Portsmouth	287	270	169	126	-	-	-	-	-	-	-	-
Mental Health	170	153	146	138	-	-	-	-	-	-	-	-
East Child & Family	665	200	161	125	-	-	-	-	-	-	-	-
Sexual Health	20	10	4	7	-	-	-	-	-	-	-	-
Grand Total	2715	1767	1371	1270	-	-	-	-	-	-	-	-

Learning from Deaths

Recognising the importance of the National Quality Boards Learning from Deaths report, we implemented a Mortality Policy in July of this year. This has provided regular reports to our Assurance Committee and to our Board both in Public and Private.

We also acknowledged the importance of involving the bereaved family and our Policy describes:

- How we will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death.
- It also describes how the Trust supports staff that may be affected by the death of someone in the Trust's care.
- It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy has been reviewed and amended following the publication of the NHS Improvement Framework which was published to help standardise and improve how Trusts identify, report, investigate and learn from deaths. This has become the Learning from Deaths Policy which can be found at

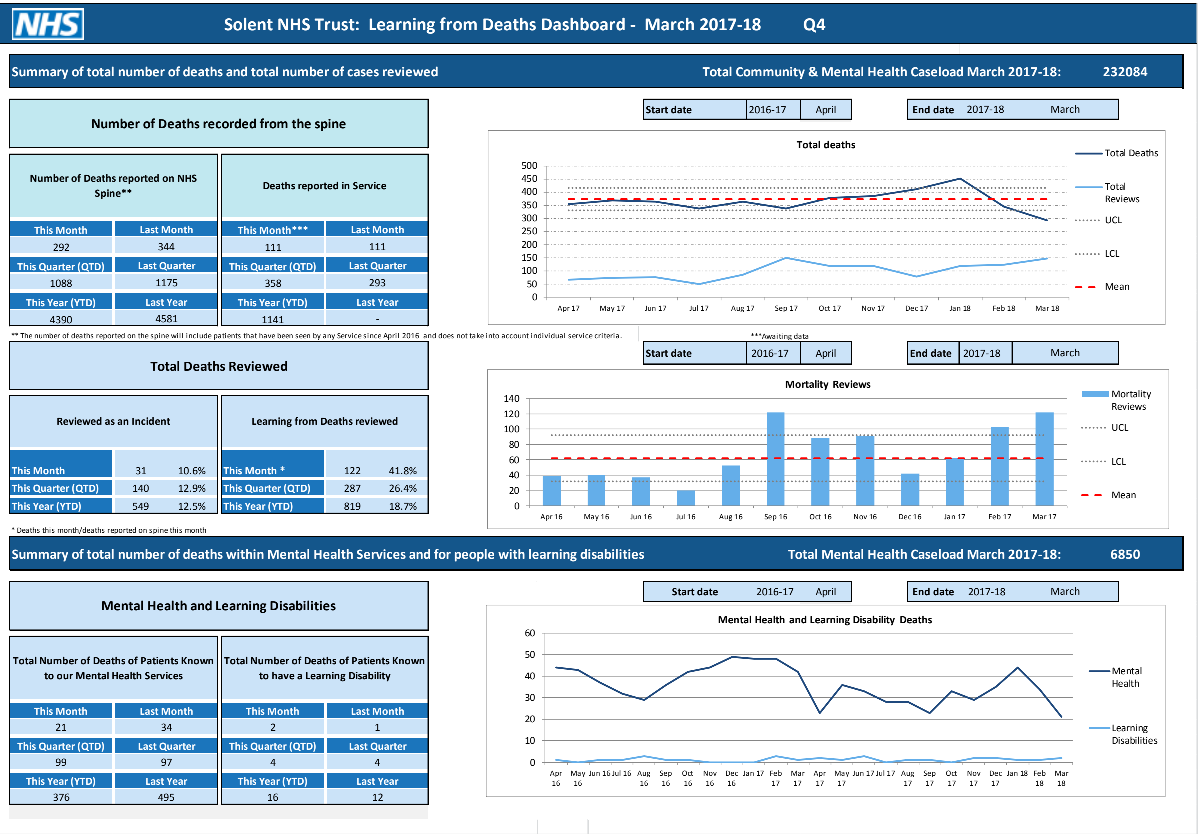
http://www.solent.nhs.uk/page.asp?fldArea=1&fldMenu=12&fldSubMenu=5&fldKey=592

Our Policy includes:

The trust's case record review process, including the method used, how the scope of deaths for potential review is determined and how deaths are selected for review.	How the trust responds to the death of someone with a learning disability or severe mental health needs, of an infant or child, or a stillbirth or maternal death.	How the trust decides which deaths – whether reviewed or not – require an investigation under the Serious Incident framework.	How the trust engages with bereaved families and carers, including how they are supported by the trust and involved in investigations where relevant.

We have also recognised the importance of completing a case record review, where clinicians review individual case notes to determine whether there were any problems in the care provided to a patient or if in any way the death was due to a problem in care. If problems are identified, we then use our Serious Investigation or High Risk criteria to complete an investigation. In order to ensure a systematic approach to these reviews, we have adapted the Royal College of Physician's National Mortality Case Record Review methodology. This will commence and be reported on from April 2018.

The Board has received regular reports and the aggregated report produced at the end of the year is detailed below



NHS Solent NHS Trust: Learning from Deaths Dashboard - March 2017-18 Q4

Summary of total number of deaths and total number of cases reviewed | Total Community & Mental Health Caseload March 2017-18: 232084

Number of Deaths recorded from the spine

Number of Deaths reported on NHS Spine**		Deaths reported in Service	
This Month	Last Month	This Month***	Last Month
292	344	111	111
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1088	1175	358	293
This Year (YTD)	Last Year	This Year (YTD)	Last Year
4390	4581	1141	-

** The number of deaths reported on the spine will include patients that have been seen by any Service since April 2016 and does not take into account individual service criteria.

***Awaiting data

Total Deaths Reviewed

Reviewed as an Incident			Learning from Deaths reviewed		
This Month	31	10.6%	This Month *	122	41.8%
This Quarter (QTD)	140	12.9%	This Quarter (QTD)	287	26.4%
This Year (YTD)	549	12.5%	This Year (YTD)	819	18.7%

* Deaths this month/deaths reported on spine this month

Summary of total number of deaths within Mental Health Services and for people with learning disabilities | Total Mental Health Caseload March 2017-18: 6850

Mental Health and Learning Disabilities

Total Number of Deaths of Patients Known to our Mental Health Services		Total Number of Deaths of Patients Known to have a Learning Disability	
This Month	Last Month	This Month	Last Month
21	34	2	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
99	97	4	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year
376	495	16	12

The Learning from Deaths Policy demonstrates how we identify lessons and make changes following a patient's death. In this context, 'learning' means taking effective, sustainable action to address key issues associated with problems in care.

These lessons have included:

Lesson Identified	Action Taken
Delegation and accountability- systems and process are not in place to guide decision making in relation to delegating care to a non-registered colleague.	We developed a Standard Operating Procedure (SOP) to support staff and to improve understanding
Need to keep the patient and family view in mind when writing reports	We changed the reporting template and way in which we present information in SI/HRI reports to ensure that it is easily understood
Positive learning: The most recent resuscitation in adult mental health services was managed well with the patients airway managed well including using non-rebreathe bag and mask	
Patient did not receive the appropriate or timely care following a fall	The service has implementing a falls 'toolbox' which will include an accessible checklist for AMH wards.

Information on what to do if the patient felt they were getting worse was not available	We are working to provide easy to understand advice to patients and record what has been provided in the patients records
There needs to be clear guidance and support to teams who provide end of life care in settings where this is not normally provided	The End of Life framework will ensure that we develop a resource package to provide information, support and supervision to teams to enhance end of life care in these environments
There is not a clear process for triggering a VTE Reassessment on AMH wards	The AMH teams will agree what point in a patient's journey will trigger review for VTE assessments. A template/proforma supported by a SOP will be assessed through an audit later in the year.
Positive Learning :Patients in community inpatient rehab wards benefit from seeing the same consultants through the pathways of care	

The Policy ensures that Board and Non-Executive Director responsibilities are met and ensure that the Organisation:

- learns from problems in healthcare identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care.
- Providing visible and effective leadership to support their staff to improve what they do.

2.3 Reporting against Core Indicators

Department of Health Mandatory Quality Indicators

We have reviewed the required core set of quality indicators which we are required to report against in our Quality Accounts and are pleased to provide you with our position against all indicators relevant to our services for the last two reporting periods (years). These indicators are specific to our Mental Health Services.

Indicator	2016-17	2017-18
Preventing People from Dying Prematurely - Seven Day Follow-Up	100%	99%
Enhancing Quality of Life for People with Long-term Conditions – Gatekeeping	100%	100%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	77%	64%
Improving access to psychological therapies (IAPT):		
a) proportion of people completing treatment who move to recovery (from IAPT dataset)	53%	58.6%
b) waiting time to begin treatment (from IAPT minimum dataset) i. within 6 weeks of referral	99.5%	99.8%
ii. within 18 weeks of referral	100%	100%
Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	98%	99%

Cardio-metabolic assessment

The Physical Healthcare Matron is the lead who ensures that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the service areas:

a) Inpatient wards

b) Early intervention in psychosis services

c) Community mental health services (people on care programme approach)

Staff are trained to assess physical healthcare and use the following tool:

Lester UK Adaptation | 2014 update
Positive Cardiometabolic Health Resource
An intervention framework for people experiencing psychosis and schizophrenia

Smoking
Lifestyle and Life Skills
Body Mass Index (BMI) Weight
Blood Pressure
Glucose Regulation
Assess by fasting blood glucose (FPG); random blood glucose (RBG); HbA1c
Blood Lipids

RED ZONE
Current smoker
Poor diet AND/OR Sedentary lifestyle
BMI ≥25 kg/m² (≥23 kg/m² if South Asian or Chinese) AND/OR Weight gain >5kg over 3 month period
>140 mm Hg systolic AND/OR >90 mm Hg diastolic
HbA1c or Glucose threshold: HbA1c ≥42 mmol/mol (≥6%) AND/OR FPG ≥5.5 mmol/l OR RPG ≥ 11.1 mmol/l
Total chol/HDL ratio to detect high (>10%) risk of CVD based on QRISK-2 Tool http://qrisk.org/ Note: CVD risk scores can underestimate risk in those with psychosis

INTERVENTIONS
Medication review and lifestyle advice to include diet and physical activity
NB Family history of diabetes and/or premature heart disease heightens cardiometabolic risk.
Refer for investigation, diagnosis and treatment by appropriate clinician if necessary.
Brief intervention
Combined NRT and/or varenicline
Individual/group behavioral support or specialist support if high dependency
Referral to Smoking Cessation service
Follow NICE guidelines for obesity http://www.nice.org.uk/CG43
Follow NICE hypertension guidelines http://publications.nice.org.uk/hypertension-cg127
Consider anti-hypertensive therapy
Limit salt intake in diet
At High Risk of Diabetes
HbA1c 42-47 mmol/mol (6.0% - 6.4%)
FPG 5.5 - 6.9 mmol/l
i) Offer intensive structured lifestyle education programme
ii) If ineffective consider metformin
Diabetes
HbA1c ≥48 mmol/mol (≥6.5%)
FPG ≥7.0 mmol/l
RPG ≥11.1 mmol/l
Endocrine review
Follow NICE diabetes guidelines http://www.nice.org.uk/CG87
Follow NICE guidelines for lipid modification
AND
Refer to specialist if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l)
AND
Consider lipid modification for those with CVD or Diabetes

TARGET
Stop smoking
Improve quality of diet
Contain calorie intake
Daily exercise of 30 mins/day
BMI 18.5-24.9 kg/m² (18.5-22.9 kg/m² if South Asian or Chinese)
<140/90 mm Hg (<130/80 mm Hg for those with CVD or diabetes)
Prevent or delay onset of diabetes
HbA1c <42 mmol/mol (<6%)
FPG <5.5 mmol/l
HbA1c 47-58 mmol/mol (6.5-7.5%)
Primary Prevention: consider statin treatment if ≥10% risk based on QRISK2
OR
Secondary Prevention: aim to reduce non-HDL chol by 40% and review in 3 months

Admission of Young People into Adult Mental Health Wards

During the year, we admitted 2 young people into our adult wards. Both were over 16 and were with us for less than 3 days. In each case we reported the admissions as a Serious Incident and completed an investigation. Neither young person came to any harm as a result of the admission and were well cared for by CAMHS specialists whilst an inpatient.

Ensuring that People have a Positive Experience of Care – Community Mental Health Patient Survey

The Health and Social Care Information Centre (HSCIC) provides patient experience indicator data for the annual national Community Mental Health (CMH) Survey. The CQC does not provide a single overall rating for each Trust for this survey, as it assesses a number of different aspects of people's care and results vary across the questions and sections.

In the patient survey report published by the Care Quality Commission (CQC), the results are presented as standardised scores on a scale of 0 to 10. The higher the score for each question, the better the Trust is performing. As can be seen from the table below, we have been rated as 'about the same' as most other Trusts in the survey by the CQC.

We consider that this data is as described as this Care Quality Commission (CQC) national survey was developed and coordinated by the Picker Institute Europe, a charity specialising in the measurement of people's experiences of

care.

The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.
The full survey is published at:

http://www.cqc.org.uk/provider/R1C/survey/6#undefined

Friends and Family Test (FFT)

Patient FFT

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
17/18	**95.89%**	1.46%	**18506**	14127	3617	367	131	139	125
16/17	**95.79%**	1.65%	**15335**	11711	2978	264	96	157	129
15/16	**94.95%**	2.17%	**13927**	10474	2749	263	116	186	139

Positive feedback received from carers and service users has continued to grow and improve over the last 3 years, with an increase in the proportion of respondents who would be 'extremely likely/likely' to recommend Solent services to Friends & Family. The proportion who responded they would be 'unlikely/extremely unlikely' to recommend has also improved year on year (target is a low score on this measure).

During 2017/18, additional methods for providing feedback via the Friends and Family test have been introduced, including email in settings where this is appropriate, and monkey survey for children and young people. This has resulted in an encouraging increase in the response rate overall. The number of free text comments has also increased from 12243 (during 2015/16) to 20818 (during 2017/18). These comments provide us with the insight to know what we do well and where we need to make improvements based on patient feedback. Comments related to 'caring and professional staff' and 'feeling listened to' are recurring themes.

Services share the feedback with staff that is often personally named by service users. The most frequently used words to describe Solent services have been aggregated below:

These are examples of complimentary comments

‘The team help in a quiet and friendly way; I feel that I can rely on their services.’

Adults Portsmouth

‘The service is very professional and friendly.’

Primary Care

‘Very supportive and give great advice.’

Child and Family

‘The dentists involved and her assistant are extremely friendly / helpful and supportive. This is an excellent service.’

Specialist Dental Services

‘The nurse was very friendly and helpful and explained everything to me.’

Adults Southampton

‘Extremely thorough personal service. Thank you!’

Sexual Health

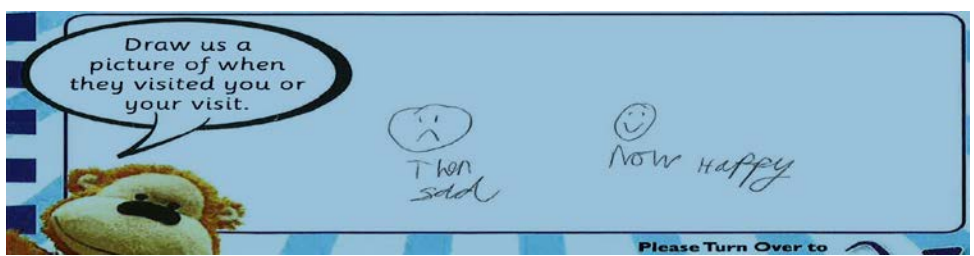
‘Great understanding of my situation; great eye contact. Overall great experience here as I feel listened to and respected like my views were valid.’

Adult Mental Health

Examples of 'YOU SAID - WE DID' learning and actions:

You said ……..	We did…….
Can never get appointments, change the way they accept calls.	The surgery is working hard to release more capacity and have reviewed the impact on the growing surgery list. This is an ongoing project and will keep the patients informed via the PPG Group
The process is timely and very frustrating, I feel it's a shame that it feels like a postcode lottery for different services and care that can be provided. The staff despite these pressures has been fantastic & we cannot fault their commitment.	The service is currently undergoing a transformation plan which aims to reduce the wait times for assessment and therapy. We are actively implementing wait list initiatives to reduce wait times and looking at staffing levels to help reduce wait times.

Feedback from children using Monkey Wellbeing:



What we have learnt…

1. It is important to agree clear expectations with patients about their care.
2. 'Same day appointment' works better than 'waiting to be seen' in Sexual Health.
3. On-going need for customer care training in some settings.

Staff Survey

For the second year running, we improved upon our NHS Staff Survey results, and when benchmarked with other Trusts, our scores are higher than average. Listening into Action, who rank Trusts based on 32 key findings around culture and leadership, ranked us as the best performing mental health, learning disability and community Trust and highlighted that we are demonstrating a positive trend in our results year on year.

A total of 1876 people took part in this survey. This is a response rate of 56% which is above average for combined mental health and community trusts in England (45%), and compares with a response rate of 55% in the 2016 survey.

Compared to last year, we saw a significant improvement on 12 individual question scores and a worsening of scores on only 2 questions. Out of 22 NHS key findings across comparable trusts, we scored better than average on 15 and none worse than average. Our results show that we have maintained the positive levels of engagement achieved in 2016/ 17 through the continuation of our Great Place to Work Programme and focus on improving the 'Top 3': Learning & Development, Effective Leadership and Genuine Involvement.

The opportunity in the year ahead will be to firmly embed our purpose at the heart of our strategy through our narrative, 'The Solent Story'. Engaging people from the bottom up in sharing their stories of how they make a difference in keeping more people independent, safe and well in the community.

You can read more about our staff survey results within our Annual Report.

Part Three: Other information

Achievements in 2017/18

We identified a number of priorities which are detailed below, however Services were involved in many other quality initiatives.

Priority 1: We will implement the Trust's professional frameworks so that our nurses and allied health professionals (AHPs) continue to deliver great care.

We will do this by: publishing a career framework and strategies by December 2017

We met this priority by delivering a number of actions for both nurses and AHPs:

- Our Nursing Conference in May launched the nursing strategy and we established Professional Advisory Groups
- Task and Finish Groups met and took action to progress each of the strategic commitments
- Launched a Career framework

This priority was met and we will develop it further as part of our business as usual and are now considering the development of a multi-disciplinary clinical strategy During the year

- We have delivered leadership and management development programmes for band 6 & 7 nurses across our community nursing and MH teams in Southampton and Portsmouth. Within this programme we have included sessions on professional responsibility and accountability linked to the code of practice and also covered professionalism. This strengthens supervision and support to clinical staff and therefore impacts on the quality of care received by patients
- We have developed a range of competencies and have a system for assessment, for example we have retrained support workers on administration of insulin in the community and all have been reassessed as competent to undertake this delegated task
- We currently have two trainee ANPs within our mental health services which are new developments and contribute to enhanced patient care
- We have introduced ANP roles in primary care in Southampton which enables us to triage patients and ensure they are seen by the most appropriate person and we also have ANPs undertaking home visits thereby ensuring more complex patients get seen sooner and their care appropriately managed. We are also offering training posts for nurses who wish to be practice nurses
- We have a pilot running in Southampton where patients who meet criteria re fast tracked to physiotherapy rather than taking a GP appointment. This frees up appointments for people who need to see the GP
- We have 8 support workers just embarking on the Nursing Associate programme
- We have developed Band 4 positions within AMH to support career development for this group of staff and to be in a state of readiness for progression to the degree nurse apprenticeships

Priority 2: We will deliver the Quality Improvement Programme to enhance patient experience and make a difference to people's health and wellbeing.

We will do this by: having 2 groups of staff completing the programme and publishing newsletters and programme outcomes every quarter

Quality Improvement Programme (QIP) has become embedded within the Organisation and we are now on Cohort 5. We have recruited both clinical and corporate teams to make a difference in a number of areas including:

This has been met and the Solent Quality Improvement (QI) Programme has been established to equip our staff with the confidence and skills to deliver improvements in their areas, and to be able to demonstrate how these have made a difference.

Those on the programme are encouraged to work with patients to identify and deliver improvement.
The programme has the following elements:
- A graduated programme of skills development (see below)
- A series of add-on masterclasses
- Bespoke facilitation and support to deliver Quality Improvement projects
- Support in placing the patient voice at the heart of improvement

Further information is available about the number of clinical teams that have participated, what changes have been put in place as a consequence of the QI programme, how it has improved the quality of care is detailed in our Research and Improvement: 2017-18 Annual Report which can be found as an appendix to the Quality Account.

http://www.academy.solent.nhs.uk/improvement/

Priority 3: We will continue to improve our services by using the learning from incidents, complaints and feedback.

We will do this by: launching an Organisational Learning Framework by September 2017

The delivery of this priority has been reframed to ensure that lessons are identified and learning is disseminated throughout the organisation. Clear actions and learning points are identified at the end of

- The Serious Incident Panel.
- The Learning from Death Panel (which was launched in July 2017) and the
- Complaints Scrutiny Panel

We also record what changes we would expected to see in Services and by when. Examples of learning from Serious Incidents can be found at page 33

The Organisation has invested in an electronic recording system which will capture these details, which will be in place from April 18

The Organisation is exploring all avenues of communication to share the learning; this includes newsletters, presentations, Solet and the normal Service Line governance processes.

Priority 4: We will implement the Trust's competency assessment framework to support our staff to consistently deliver safe and effective care.

We will do this by: developing a Trust library of competencies for Nursing and AHP workforce by July 2017

This priority was met by delivering the following

- We established a core framework of job descriptions across all bandings
- We developed a Trust library of competencies for Nursing and AHP workforce
- to date we have finalised a Band 5, 6 and 7 JD

With regard to competencies they cover a range of areas including:

- nutrition and hydration competency
- Insulin administration for support workers
- Competencies for band 3 support workers
- Competencies for staff in sexual health

The competencies are based on best evidence and so should lead to consistency of quality and standard of care delivered and thereby impact on improved outcomes for patients?

With the implementation of SolNet, these competencies can be published on this intranet to make them more accessible to all staff.

Priority 5: We will have a consistent approach to involving people in the development of our services.

We will do this by: launching our volunteer strategy and web site for volunteers by December 2017

This priority has been met by delivering the following:

- We launched our volunteer strategy and actively recruited volunteers.
- We developed and issued protocols to our services for the recruitment and deployment of volunteers

We launched the Volunteers website: http://www.solent.nhs.uk/page_sa.asp?fldKey=815

We currently have 105 volunteers (that includes the League of Friends in Portsmouth) with a further five currently going through the process .We currently have volunteers helping with the following roles.

- Meet & Greet volunteers (this includes gaining FFT and feedback)
- Memory Café volunteers
- Gardener – Snowdon Ward
- Front of house volunteer (Jubilee House)
- Befriender (Snowdon ward)
- Drinks volunteer (Jubilee House)
- HIV Peer support
- Pain Team Peer support
- Health Club Volunteer
- Trolley Service (League of Friends)
- Shop at St Marys (League of Friends)

The main service lines who have volunteers are Adults Southampton, Sexual Health Service and Adults Portsmouth .We will continue with this priority as business as usual next year by developing a community engagement strategy which we will launch in Q1 2018/19

Patient Experience Indicators

Complaints

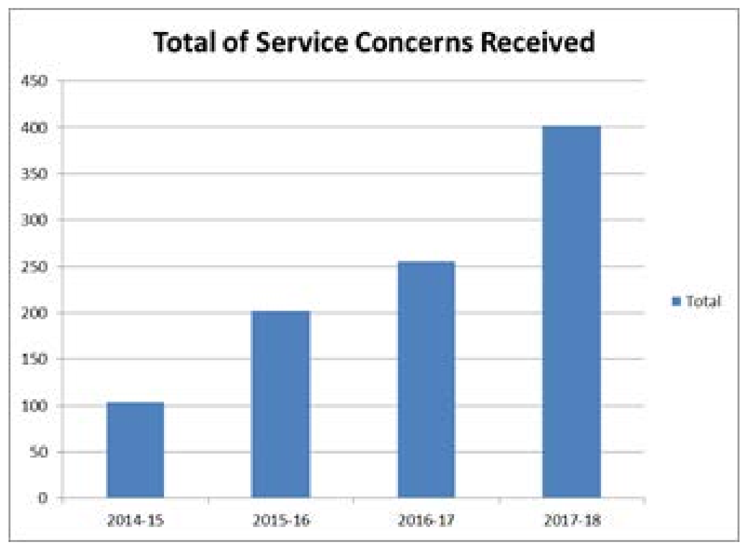
The approach to complaints handling in the Trust is based on the principles published by the Parliamentary and Health Service Ombudsman (PHSO). Their principles outline the approach the PHSO believe public bodies should adopt when delivering good administration and customer service, and how to respond when things go wrong. They underpin their assessment of performance, vision of good complaint handling and our approach to putting things right.

These are:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

Training is provided on a regular basis to staff to ensure that anyone making a complaint is supported; receives honest, timely communication; and is clear about the actions we are going to take next as a result of our learning from complaints.The Trust encourages the staff closest to the people receiving our services to, wherever possible and with the service user's consent, deal with concerns and problems at the local level, aiming to ensure that issues are resolved wherever possible at the earliest stage possible and in a way that is responsive to the service user's needs and circumstances.

Timely intervention can prevent an escalation of the issues raised and achieve a more satisfactory outcome for all concerned. However, if the complaint is initially dealt with as a service concern, it does not prevent the complaint being escalated formally should the patient remain dissatisfied with the initial outcome.

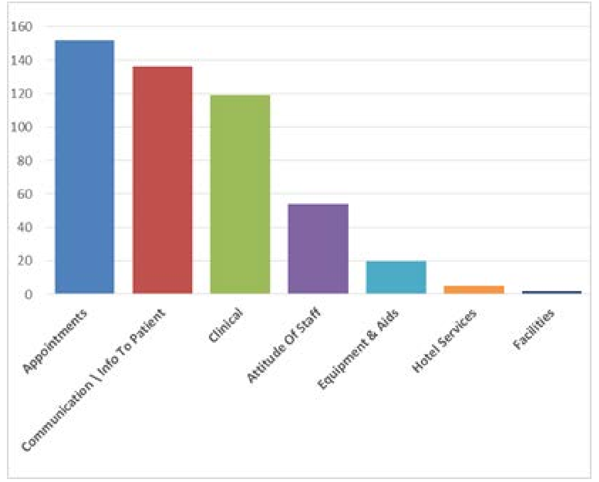


Number of Service Concerns received by Year

This chart shows that the number of service concerns received has increased year on year which, with the ongoing emphasis on resolving issues as early as possible as service concerns and preventing escalation to the formal complaints process, is an encouraging trajectory. Services are required to report all service concerns to the PALS and Complaints team so that there is a corporate overview to identify themes and ensure appropriate escalation and adherence to the Trust policy and procedures for managing complaints and concerns.

By placing an emphasis on resolving issues as they arise at the local level by the staff closest to the person receiving the service, we have seen a gradual reduction in the number of formal complaints received . Local resolution meetings are offered as part of both the complaints and service concern resolution processes and a Quality Improvement project is currently in progress working with people who have experienced these meetings to identify learning and improvements.

During 2017/18 there was a reduction in the number of people making contact with our Patient Advice and Liaison Service (PALS) for advice, signposting and general queries. We received 590 contacts compared to 682 in 2016/17.

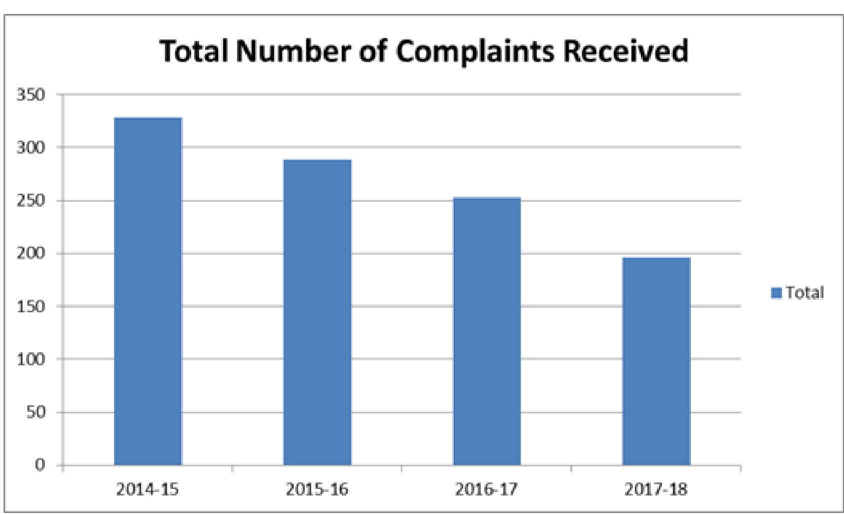


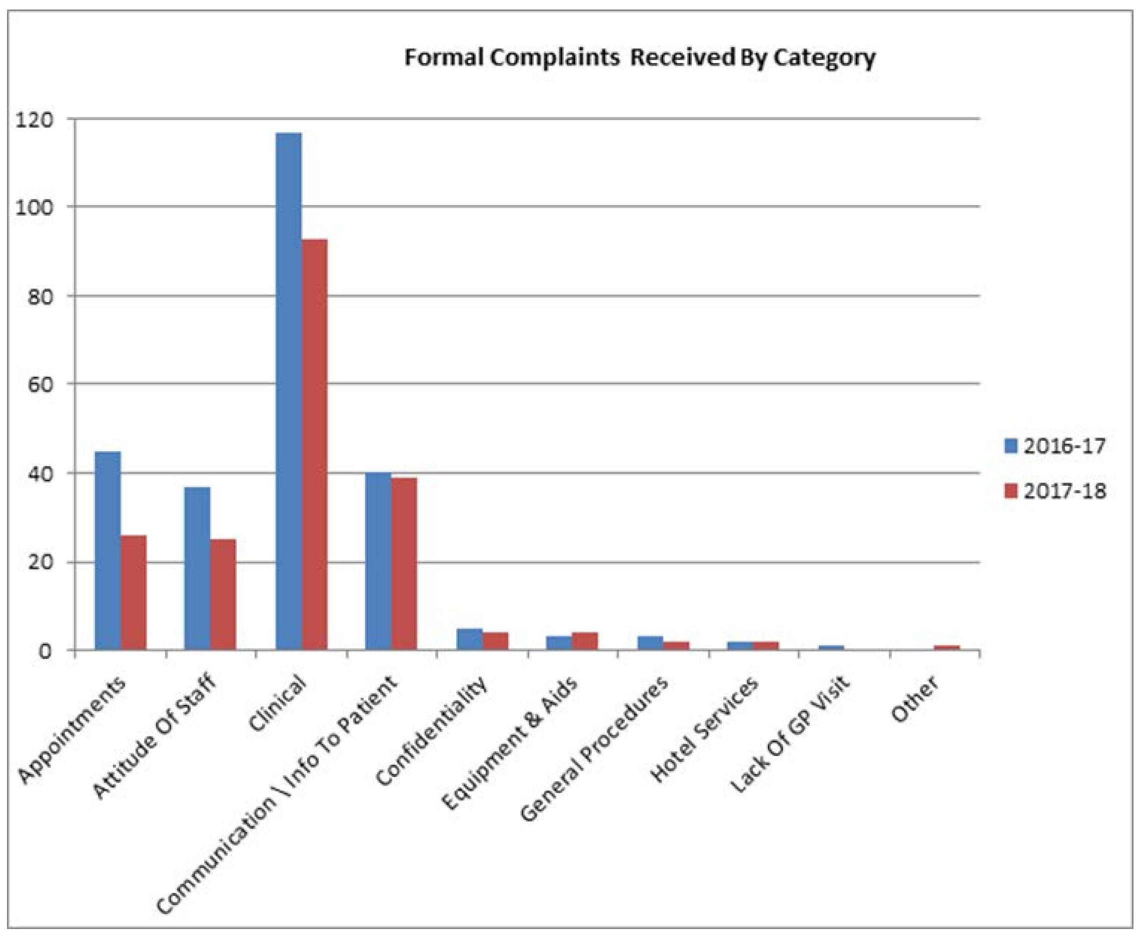
Service level concerns by category for 2017/18

This chart shows the range of categories for the service concerns received with appointments and communication being the most prevalent issues resolved via the service concern process in contrast to clinical issues which is the most prevalent complaint category.

Number of Complaints Received

As detailed above under service concern numbers, there has been a year on year reduction in the number of complaints in contrast to the increase in service concerns. This is the desired outcome with increased emphasis on resolving issues raised early to improve patient experience. Our Trust Board receives regular monthly reports and updates on the number, themes and learning from complaints and a member of the Executive team personally reviews each complaint response. In addition our quarterly Patient Experience Report, which includes details of complaints received and the associated learning and outcomes, is made available to the public via our website.





As an organisation we strive to embed and sustain the changes made as a result of complaints and concerns to enable long term improvement. Changes and outcomes are monitored within the services concerned and, to ensure learning across service lines, are shared at our quarterly complaints scrutiny panel. This was introduced to drive quality improvement and act as a mechanism for Trust-wide learning. This panel is chaired by one of our Non-executive directors and our Chief Nurse with members including a Healthwatch colleague (the consumer champion for health and social care) and senior clinical representatives from each of our service lines.

Some examples of learning shared through the panel include:

- Ensuring that patients' are provided with adequate amounts of medication, upon discharge from wards to home, to hopefully minimise the effects of what can already be a stressful situation
- When a formal complaint has been de-escalated to a Service Concern the Executive team should still be made aware of the outcome so that they are kept fully aware of the complaints resolution process.

Clinical issues is the highest category for complaints in 2017/8 and we will be carrying out a deep dive in 2018/9 to looking at the range of themes within this category and cross organizational learning.

Patient Led Assessment of the Care Environment (PLACE)

We had the highest scores for the South of England in the category registered for all of the assessment areas and improved on the scores achieved in 2016. However, this does not mean we cannot improve further.

National Overview

	Solent Score	National Score
Cleanliness	99%	98%
Food Score	98%	90%
Organisation Food Score	98%	88%
Ward Food	98%	90%
Privacy, Dignity and Wellbeing	91%	84%
Condition, Appearance and maintenance of buildings	97%	94%
Dementia	92%	77%
Disability	93%	83%

In Summary for our Organisation

- All our wards improved in one area or another from last year
- We want to improve in the areas of Privacy, Dignity and Wellbeing , Dementia and Disability
- All locations continue to monitor and review action plans following the visits in 2017 and progress will be monitored

Future Plans

Looking forwards, the Trust will continue to improve/maintain high standards in all assessment areas to the benefit of patients and maintain its position as one of the highest achievers in the assessment areas for the PLACE inspections.

We will be looking to:

- Identify how we can further improve dementia awareness in all locations including
  - what learning can be identified from areas that achieve higher scores;
  - Involvement of patients and service users.
  - Reflecting on the dementia awareness improvements that have been implemented since the visit which should lead to an improvement in the scores in the planned 2018 inspection.
- Improve the Privacy, Dignity and Wellbeing and Disability scores on the wards at the Royal South Hants.
- Improve the condition, appearance and maintenance of buildings-in areas where Solent are not the landlord. This is a challenge and we will continue to support services to challenge the landlord regarding the general appearance and up keep of buildings that our patients are seen in.

Same Sex Accommodation Requirements

There have been no breaches during this year.

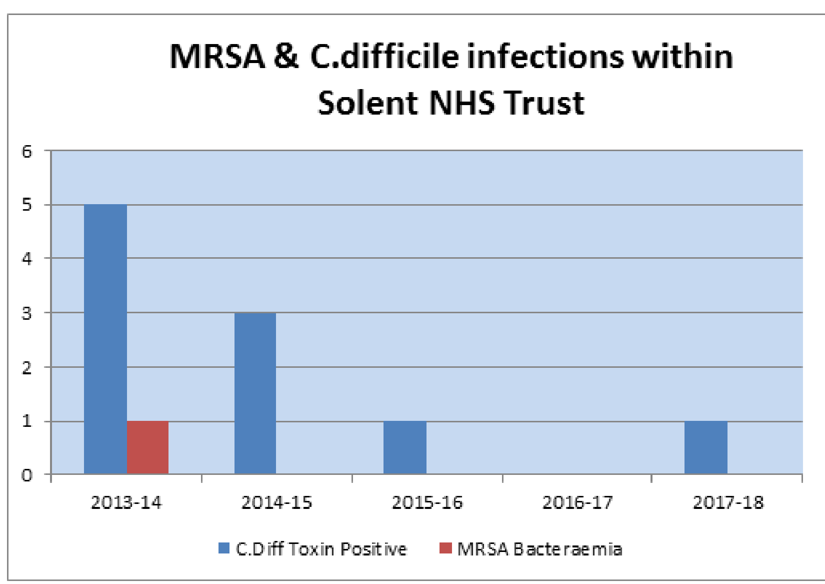
Avoidable Healthcare Associated Infections (HCAI's)

We continue to be committed to a zero tolerance approach to any avoidable Healthcare Associated Infections (HCAI's). Through a variety of forums and processes, we are able to ensure that all aspects of infection prevention and control remain embedded in practice.

As a community organisation, we are not given reduction targets for HCAI but if and when they occur, each case will undergo careful scrutiny to ensure that any lapses in care are addressed and actions put in place and monitored. There was one case of a MRSA bacteraemia across multiple providers this year, that including Solent NHS Trust, which was attributed to the CCG and one case of Clostridium Difficlie (C.difficile) that was fully investigated and actions for learning shared. We have taken part in the investigation and any learning from this event will be embedded within in our Organisation. The prominent learning was the common theme of communication. The MRSA case was particularly complex as it involved multiple providers from different areas of the country. Therefore actions are focused on how we can be more efficient at sharing key information across the health economy. We are looking internally at improving electronic systems and creating templates specific for infection.

With regards the C. difficle case we provided in-house training on obtaining good quality samples and how it is the clinicians responsibility to follow up any test results they have requested. In addition to this our current organisational work on NEWS and deteriorating patient aims to assist in the follow up actions of both cases.

There have been no ward closures due to any outbreaks of infection during the year.



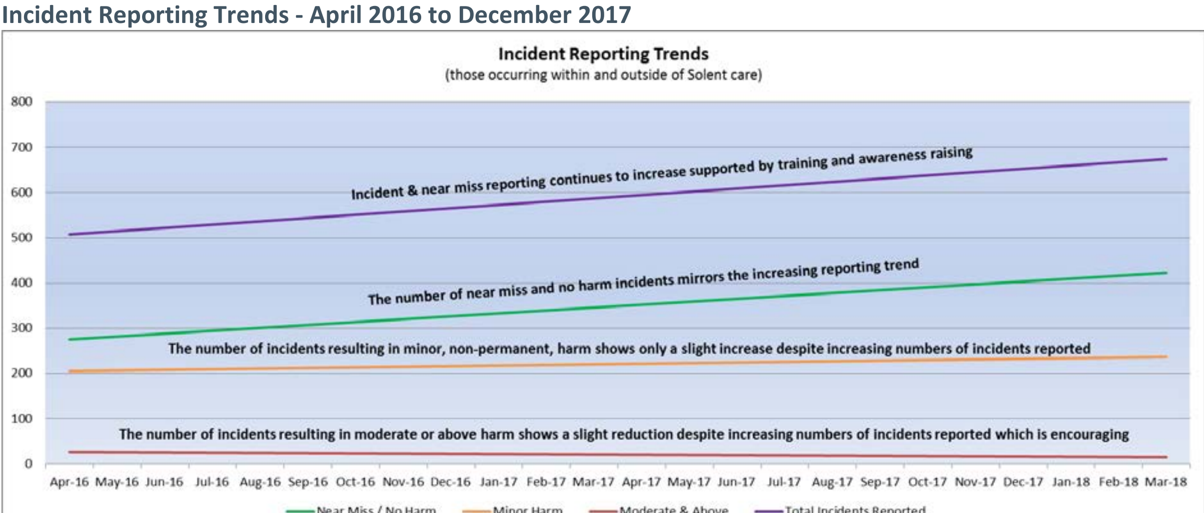
Patient Safety Indicators

Reducing Patient Harm

What it means in Practice

We have continued to invest in ensuring there is a culture of reporting incidents and issues within the Organisation, and we use an electronic system to capture and report incidents from all areas. We have improved our reporting culture and we have developed Serious Incident Panels to ensure that staff feel able to learn from mistakes.

Incident Reporting Trends - April 2016 to December 2017



Serious Incidents (SI)

A total of 78 Serious Incidents, all were subject to a full investigation and were heard at the Trust SI panel which is held monthly. The lessons learnt from each SI are shared with the service line and commissioners. These have included:

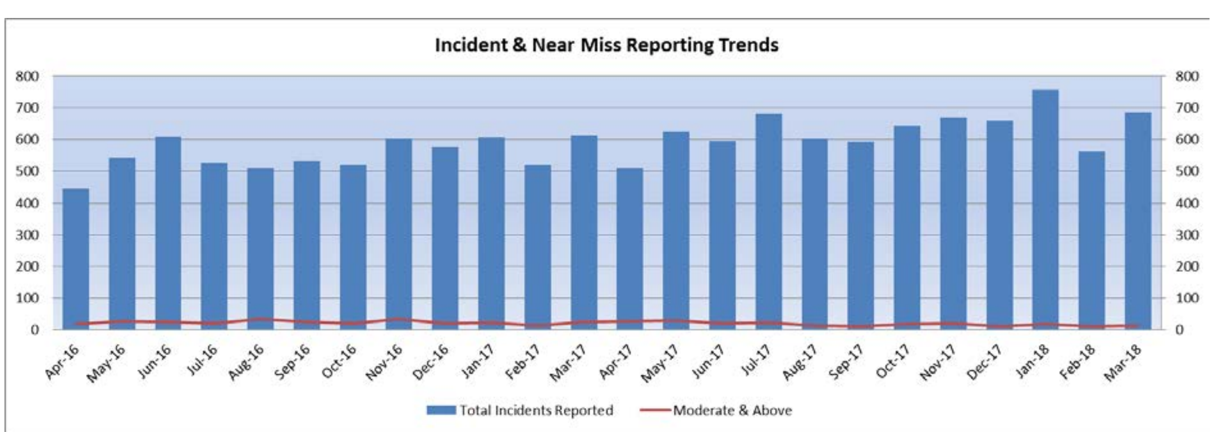
Lessons identified	Action taken
Documentation needs to be complete, accurate and contemporaneous	This has also been highlighted in several reports and challenges noted regarding the collation of evidence as recording has not always been completed effectively. The importance and professional responsibility of all staff to ensure that patient records are accurately maintained and updated has been re-iterated to staff and within Service lines.
Staff must ensure that they adhere to policy and procedures either local or national (or both)	Services have taken an action to ensure that staff are aware where to access SOPs/policies/ national guidance and the importance of following as per service guidance. The implementation of our new Intranet has provided a place where all clinical teams and services can store documents and where staff can easily access them
Ensuring that patient wishes in regard to Do Not Resuscitate (DNR) are recorded correctly.	The importance of discussing, documenting and highlighting the DNR status of a patient and communication with the teams who are providing care to that patient to avoid unnecessary and distressing attempts at resuscitation has been reiterated to services
Care plan management is paramount when organising care and visits	Staff have been reminded that they should ensure that appropriate care plans are created to support the safe delivery of care and to ensure that subsequent visits are plotted according to the need identified from the care plan(s). They check that the electronic record is maintained as an up to date and accurate reflection of care provided

Importance of ensuring that staff have attended training regarding tissue viability and have signed competencies, including the understanding that a TIME assessment is completed on the patient's first visit	Staff have been reminded that the specialist Tissue Viability Teams can be contacted to review new PU's and support in the grading of Pressure Ulcers, and that value of a photograph of the wound is an effective way of monitoring improvement or deterioration (with patient consent).

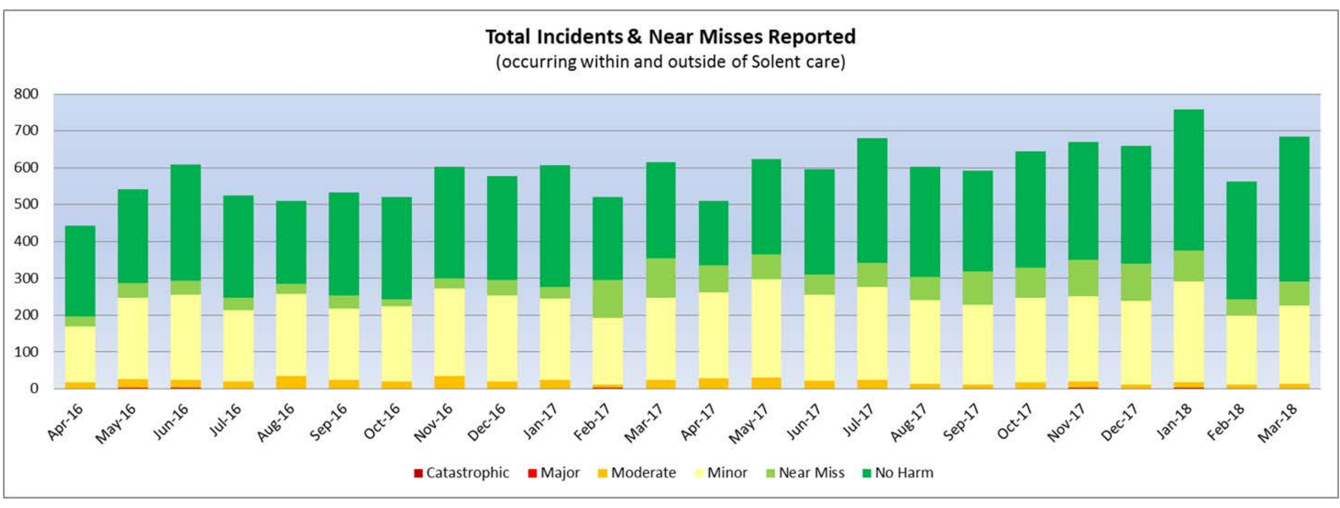
Number of SI raised per month

There have been no incidents that have resulted in the death of a patient.

Incident and Near Miss Impacts



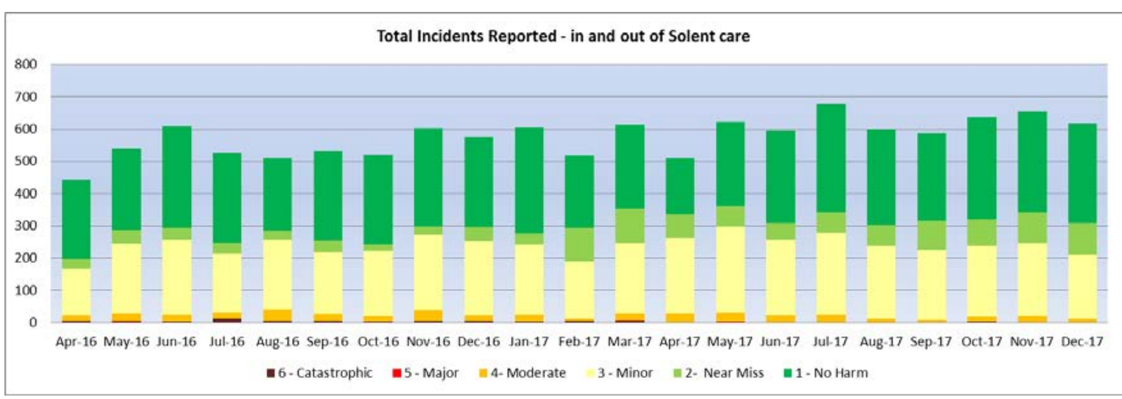
The increase in the number of incidents reported as moderate and above can be attributed to the consistent validation of incidents following the reintroduction of incident reporting training for staff.



Reduction in Harm

Reporting levels are showing a steady increase since April 16. The number of moderate incidents reported this quarter has decreased and the number of no harm incident has increased, this indicates a positive and open reporting culture.

Total number of Incidents reported April 2016 to December 2017

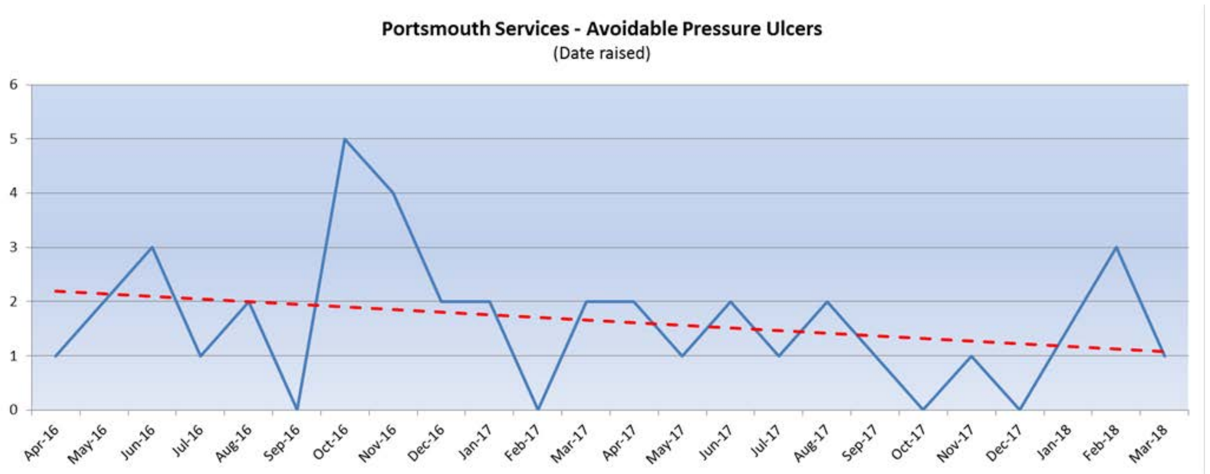


Pressure Ulcers (PUs)

The number of PUs reported as incidents has increased over the year to 242 of which 79 were initially indicated as being Grade 4 PUs. All Grade 4 PUs are validated and undetermined or " in our care" are reviewed at the PU Panel . The number of validated Grade 4 PUs is identified below.

Service Line	Pressure Ulcer	16-17	17-18*	Trend
Mental Health	**Avoidable**	**2**	**0**	↓
	Unavoidable	1	0	↓
	To Be Determined	*0*	*0*	*N/A*
Adults Portsmouth	**Avoidable**	**22**	**14**	↓
	Unavoidable	31	7	↓
	To Be Determined	*0*	*7*	*N/A*
Adults Southampton	**Avoidable**	**9**	**4**	↓
	Unavoidable	39	4	↓
	To Be Determined	*0*	*0*	*N/A*

* new process introduced – only undetermined or avoidable PU go to panel



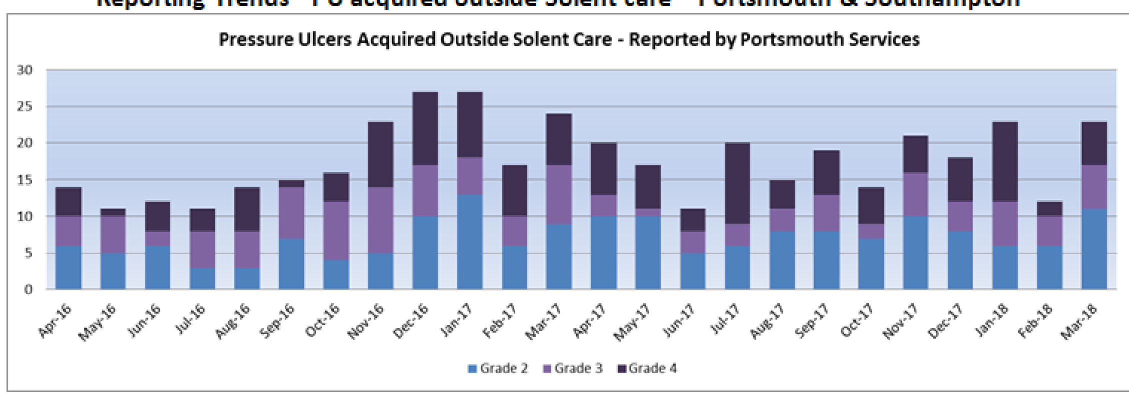
**It should be noted that the 'spike' in Oct 16 was due to a backlog of incidents being reported*

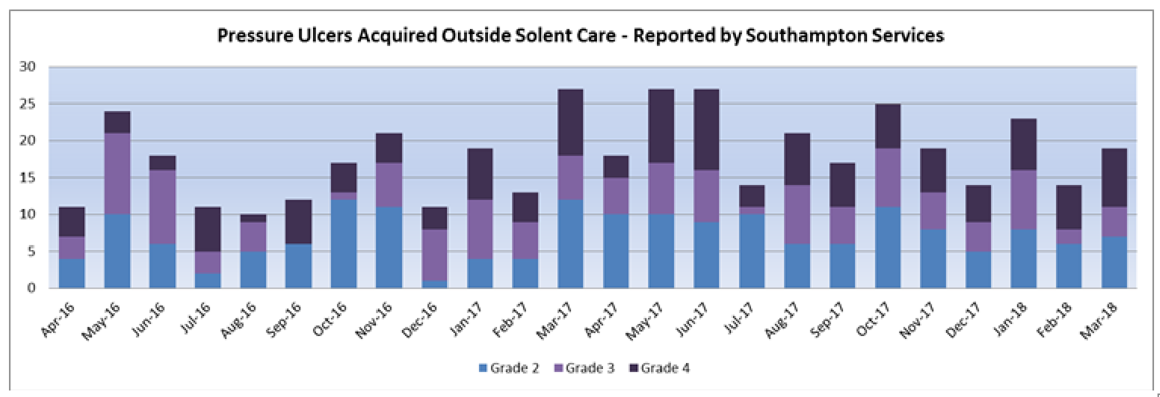
The majority of pressure ulcers "out of our care" occur while the patient is in hospital or a care home. The Trust is working with Fareham and Gosport CCG to plan how to triangulate data for the pressure ulcers that have occurred out of the Trust's care and how to improve outcomes for patients.

Reporting Trends - Pressure Ulcers acquired outside Solent care

By Grade	16-17	17-18	Trend
Grade 2	154	191	↑
Grade 3	133	110	↓
Grade 4	118	150	↑
Total reported	405	451	↑

Reporting Trends - PU acquired outside Solent care – Portsmouth & Southampton

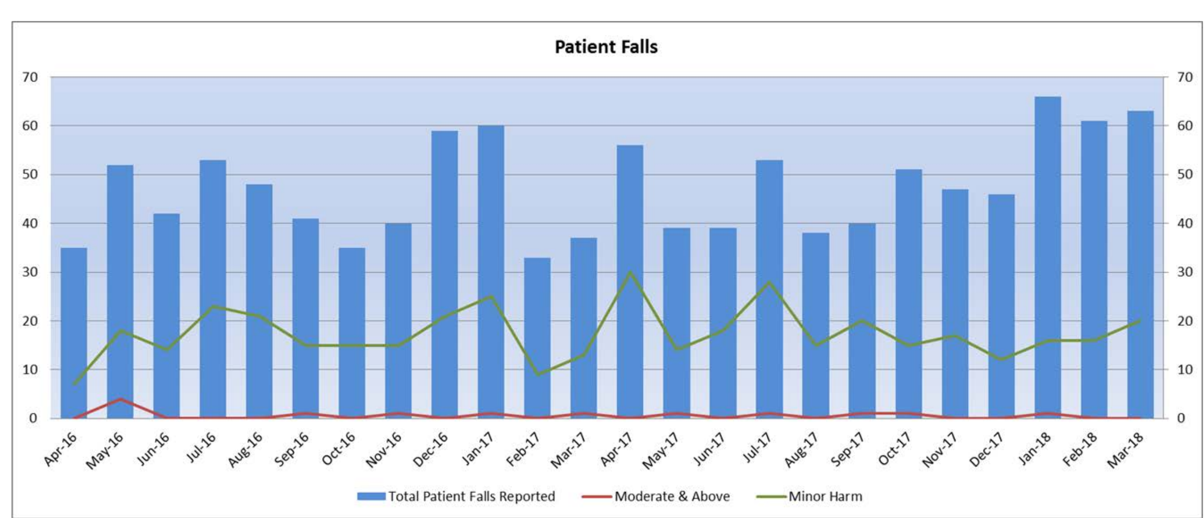




Falls graded minor or above

Adults Portsmouth, Adult Mental Health and Adults Southampton, continue to report the greatest number of patient falls. Moderate incidents remain low and minor incidents are on the decline.

Number of patient falls, per month April 2016 to December 2017



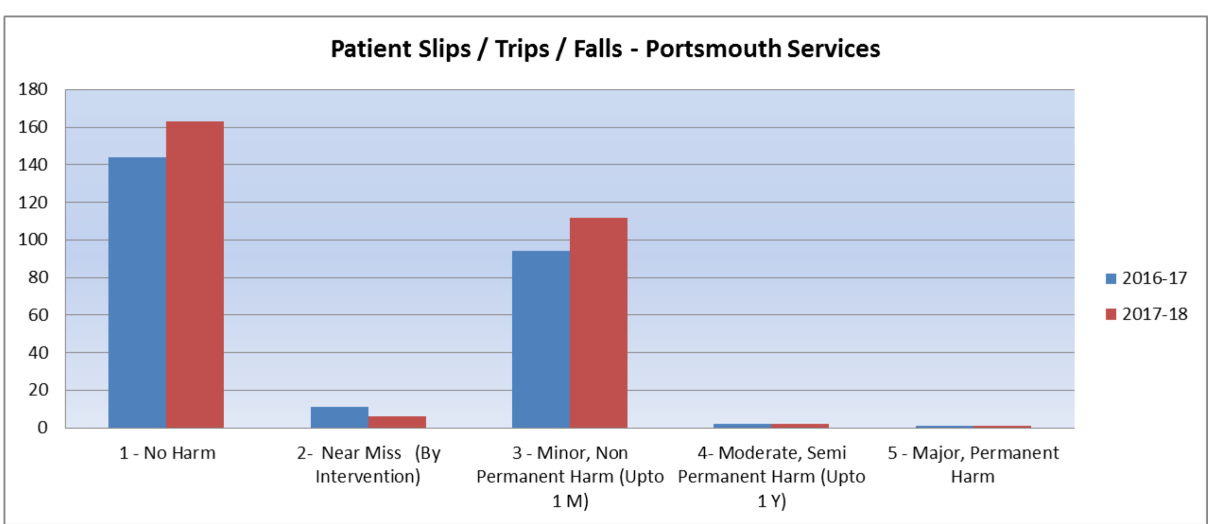
Falls reduction

A Falls Thematic Lead is now in post and the Trust Slips, Trips & Falls policy has been updated and made available for staff. This policy includes plans for Falls Champions and an E-learning module on falls in addition to a cascade training model for staff in falls prevention and management.

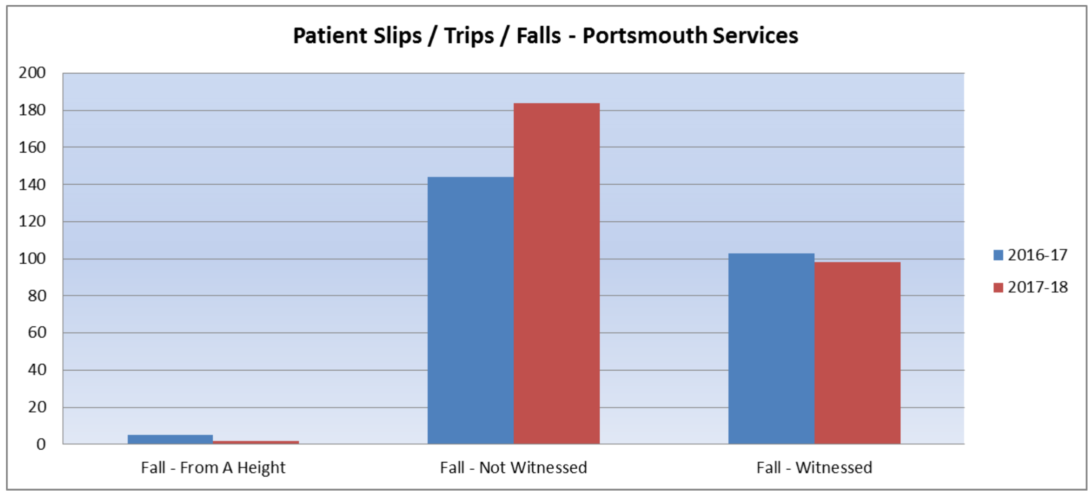
Patient falls resulting in harm

	16-17	17-18	Change	Trend
Portsmouth	97	115	19%	↑
Southampton	106	111	5%	↑

Further review of the Portsmouth data has shown a reduction in the number of 'No harm' or 'Near miss', however there has been a rise in the 'minor' harm category.

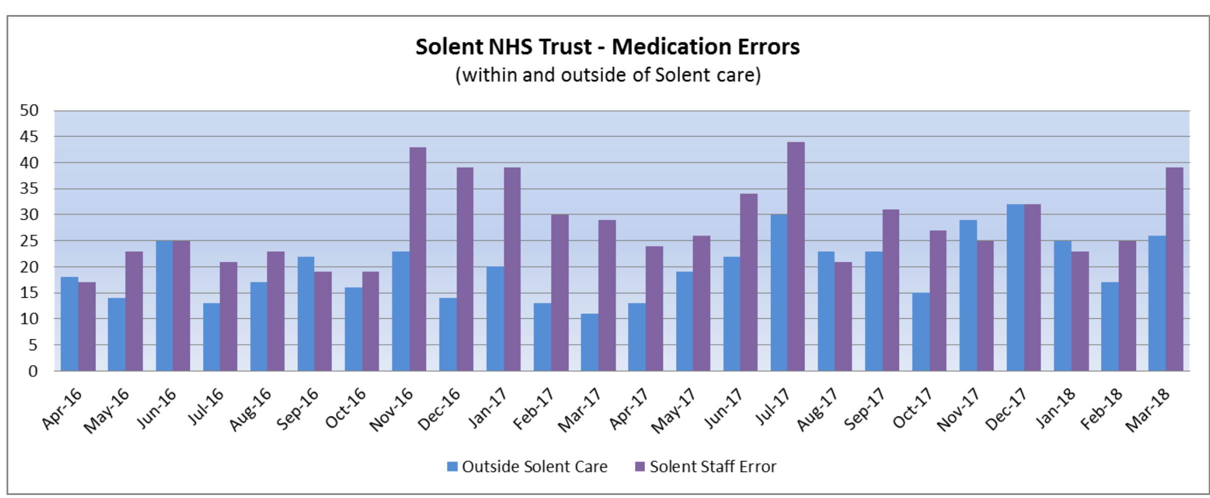


Further analysis shows that the increase in minor / non- permanent harm relates to an increase in the reporting of unwitnessed falls.

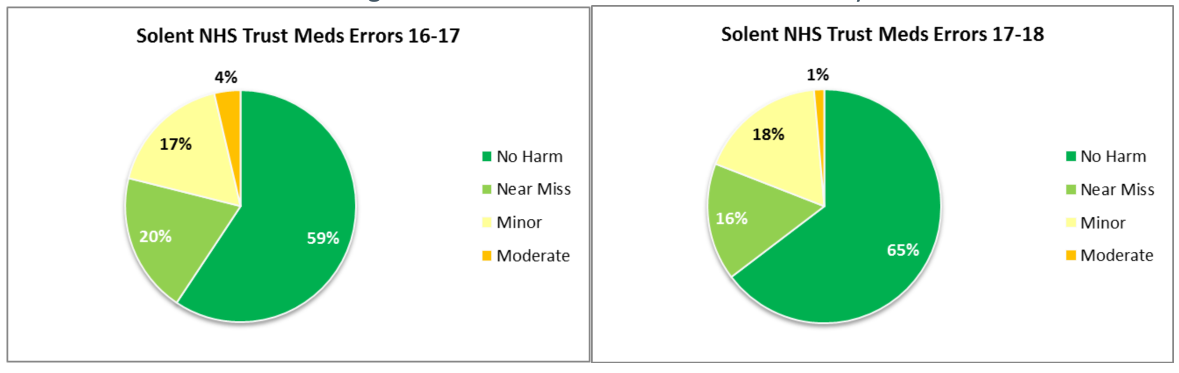


Medication incidents resulting in minor or above harm

There has been a slight increase in medication errors in Solent care; however the majority continue to be reported as no harm.



The medication errors resulting in all levels of harm has decreased this year.



Always Events®

In January 2018, Solent NHS Trust joined NHS England Always Event® as part of cohort 5. Always Events® focus on the experiences that our patients, carers and service users identify that they should always have when accessing our services. As emphasis is placed on experiences, Always Events® are generally relationship orientated, rather than related to clinical processes. To date, Always Events® have taken place in our Sexual Health service to explore the experience of adults with learning disabilities getting help with sex and relationship; and within our Complaints services to explore the experience of people who have been through the complaints process. More activity is planned throughout the year.

Clinical Effectiveness Indicators

We have already reported on our clinical effective indicators which were:

- The implementation of the Trust's professional frameworks so that our nurses and allied health professionals (AHPs) continue to deliver great care.
- The delivery of the Quality Improvement Programme to enhance patient experience and make a difference to people's health and wellbeing.
- Implementation of the Trust's competency assessment framework to support our staff to consistently deliver safe and effective care.

Spot light on other Quality Improvements

Spot light on other Quality Iniaitives

Accessible Information (AI)

The impact of the compliance of the Accessible Information Standard (AIS) supports our Trust values - 'Everyone counts' and 'Respectful' of people with communication and information needs. Across the Trust, the increase in the availability of AI has:

- Improved patient and carer experience illustrated in feedback and plaudits.
- Increased concordance with treatment and care plans.
- Provided person-centered care for people with communication and information needs.

We have also have improved the provision of Easy Read resources produced in line with the corporate standards, and co-produced accessible self-help resources for CAMHS and LD. It is hoped that there will be multiple impacts including improved patient satisfaction and improved productivity. Our external engagement continues to promote our national reputation.

Our stepwise approach to the implementation of the AIS is supported through the on-going commitment for Trust-wide leadership and dedicated assistant time.

More staff are discussing communication and information needs with their patients and recording the outcome – System One data reports illustrate that in 2016/17 there were an average 31 screens completed per month. In 2017/18 the average to date is 146, and there has been a steady increase throughout the year. Findings from the AI screening illustrated that Easy Read was the second highest format of information requested by patients in 2017/18 (needing information verbally was the most common). Funding for a part-time accessible Information assistant and the up-skilling of staff has meant that Easy Read resources have been produced in-house, which is a cost effective and sustainable model.

Trust-wide AI audit:

The survey received 494 responses therefore the findings are representative of 16% of the total workforce across the service lines.

• 61% of the respondents are aware of the AIS requirements.

• 61% of the respondents are routinely screening patients' communication and information.

• 49% of staff who use informal methods to identify patients' communication and information needs do so through conversation.

• 87% of the respondents reported that they were able to meet the communication and information needs of their patients.

Until all staff have access to electronic screening and are routinely completing the screen with patients and carers who access our services, information and communication needs will remain potentially hidden. Promotion of a consistent approach to the conversation that safeguards against limiting the options that should be made available to someone remains an on-going objective. The roll out of electronic screening on all electronic patient record systems will hopefully improve compliance.

Falls

We have a number of Thematic Leads that work across all service lines and across both cities. The prevention of falls continues to be a priority for us and our thematic lead is working with many services to reduce the occurrence and impact of falls, especially in our frail and elderly patient groups who are the most vulnerable. This year, we have updated and re-written the Prevention and management of Patient Slips, Trips and Falls Policy and commenced Trust-wide Inpatients' staff falls meetings with matrons and champions.

Our training has also been focussed on the management of patients post-fall and bespoke face to face falls training. We are also developing a Screening tool for community staff in Portsmouth which signposts staff as to correct referral processes for falls risk assessment and links to the Multifactorial Falls Risk Assessment

End of Life

An End of Life Trust Wide Audit was completed and collated data collected in relation to the decision making and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and reviewed the Trust wide audit. The audit raised awareness of the importance of decision-making documentation and observing patients' wishes in relation to DNACPR. The results from the audit have formulated an action plan around training

The development of the end of life policy and strategy will provide all professionals, who work in Solent NHS Trust who have a responsibility for providing end of life care, with support to provide the best care to patients and those important to them at the end of their lives.

Recovery & Peer Workers

Previously there has been an identified need for additional peer workers and in order to address this we have:

- Promoted the Peer Volunteer procedure within the Volunteer Policy
- Developed the Peer Volunteer Role descriptions & Peer Worker (paid) role to ensure progression pathway
- Developed the recruitment process
- Developed the framework for a Peer Volunteer training package

The thematic lead has promoted and raised awareness within and external to Trust about the nuances and value of coproduction as a means to engaging with people who use services. A replacement of Patient Reported Outcome Measure in Adult Mental Health Services has also been implemented.

Homeless Healthcare

During 2017, it was the 25th Anniversary of the commencement of the Homeless Healthcare Service within Southampton City. The team has evolved over the years however what remains at its core is the commitment to support the vulnerable service users who may experience discrimination and inequality in their lives due to their current situation.
The Homeless Healthcare Service works in partnership with local charity, Two Saints, as well as Southern Health Foundation Trust who support the mental health provision for the service. The team are also supported by Health Visitors. In partnership, the services aim to provide healthcare, with onward referrals to secondary services, support with accommodation, encouragement and guidance to support service users to find employment.

In conjunction with the above teams, a celebration event was held in July with previous members of staff and supporters of the service as well as past and current service users invited to attend. A major supporter of the service, Laurie McMenemy (former Southampton FC Manager), was in attendance and gave a rousing speech; he also spoke to service users who were keen to have their shirts signed by Laurie. Whilst the event was a celebration, it was widely acknowledged that the challenges faced by the homeless were still as current today as they were 25 years go. Solent NHS Trust staff supported a Christmas campaign for the Homeless, with shoe boxes being filled by members of staff with items such as toiletries, gloves, socks and food not only for the service users but for those who have pets-especially dogs. In excess of a 100 boxes were donated and this was much appreciated.

The Homeless Healthcare Team also participated in 2017 / 2018 the Solent NHS Trust Quality Improvement Programme in order to utilise improvement methodology to increase the conversion of referrals to secondary care for the Homeless. This is traditionally an area of challenge and the programme helped to identify areas for improvement in the pathway.

Primary Care Services

We host three GP Surgeries based throughout the Southampton City. The GP Surgeries functioned as individual surgeries each with their own ways of working and had no shared functionality although the operational and professional leadership was shared across the three. Recognising the benefits of extending the sharing of staff and processes, the surgeries merged from April 2017. Whilst the official merging was completed and patients informed within April 2017, work continues to merge the processes and standardising ways of working.

The Solent GP Surgery has developed a “back office” to ensure that documentation, reports and results are actioned from secondary services as well as internal communications. There are plans for this to be extended and this will, in turn, support the Reception Staff to be released to concentrate on patient facing activities.
The Surgery also continues to develop its workforce and has developed a trainee Advanced Nurse Practitioner programme and will develop a similar programme for Practice Nurses.

The GPs within the Surgery are also keen to develop their ability to support “trainee” Registrar GP capacity acknowledging that GPs are challenging to recruit.
Whilst the merger has been positive, there continues to be work on-going throughout the coming months to further embed the single surgery identity.

Sexual Health Services

Staff identified there was an increasing number of men who have sex with men disclosing that they participated in chemsex (chemicals to enhance sexually intercourse). They identified that the service was not meeting the needs of this population so set up a QI project to address this.
The project aim was to:

- Decrease harm from chemsex
- Support staff within sexual health teams to ask appropriate questions about chemsex as part of the sexual history
- Provide brief interventions to reduce risk

Outcome:

- Questions added to the sexual history in the integrated service and the online testing service to identify men that use chemsex
- Training provided to staff on new assessment questions
- Pathway put in place for at risk patients to be referred to the health advisor for brief intervention to reduce risks

Adult Services in Portsmouth

The Portsmouth Enhanced Care Home Team Pilot is a service developed collaboratively with Solent NHS Trust (Solent), Portsmouth Primary Care Alliance (PPCA), Portsmouth Clinical Commissioning Group (PCCG) and Portsmouth City Council (PCC). The pilot service is provided jointly by Solent and PPCA and Portsmouth City Council PCC Medicines Management Team.

The pilot was based upon the seven core elements for success within the NHS Framework for Enhanced Health in Care Homes:

1. Enhanced primary care support
2. Multi-disciplinary team (MDT) support including coordinated health and social care
3. Reablement and rehabilitation
4. High quality end-of-life care and dementia care
5. Joined up commissioning and collaboration between health and social care
6. Workforce development
7. Data, IT and technology

The service was designed to improve the quality of life for individuals and improve the care and support they receive whilst living in one of the Portsmouth Care Homes. The following outcomes were designed to be monitored throughout the pilot implementation:

- A reduction in urgent care resources utilised by the Care Homes receiving the Medical Model of Care
- A reduction in urgent care resources utilised by the Care Homes receiving the Clinical Model of Care
- Releasing capacity within Primary Care
- All residents to have a Care Plan in place and an Advance Care Plan where appropriate
- A reduction in the number of patients on oral medications and a reduction in the prescribing costs
- Increased satisfaction of residents and their carers within the services
- To provide equitable access for all residents in Care Homes to community Services and NHS Primary Care Survives.

The new model started to be delivered in 7 homes in Portsmouth in July 2017. Two of the seven homes are receiving a fully integrated model with increased GP support. Five homes are receiving enhanced nurse led support.

Early analysis of data showing differences in the pilot homes in the year before implementation and the first six months of implementation shows a 32% reduction in 999 calls in the pilot homes and a 26% reduction in conveyances. Homes that were not included in the pilot showed a 90% increase in 999 calls and a 60% increase in conveyances.

The project has also shown a saving of £8, 121 in medicines for the pilot homes as a result of medicines review.

A business case is being written to roll out the model to all 27 Portsmouth Homes.

Adult Services in Southampton

Kite Unit

After many months of consultation, engagement and planning, we are delighted that the 10 bedded Kite Unit, previously situated on the St James' Hospital site in Portsmouth has now moved to its new home at the Western Community Hospital in Southampton. The unit provides specialist neuropsychiatric and neuro behavioral rehabilitation services for patients across the health economy.

Although care delivery in Portsmouth was excellent, the previous building was no longer fit for purpose with ligature risks, inhibited lines of sight, and a dated environment with limited space for treatment intervention and limited provision for female patients. Our new unit has been purpose built to address all of the issues mentioned above and we now have an environment that strikes the right balance between being calming and stimulating to aid patient rehabilitation.

Internally we now have a fully equipped patient kitchen and a laundry room where patients are encouraged to be as independent as possible. There are designated spaces for therapeutic interventions and a small gymnasium. Patients have good connection to outdoor spaces and the unit is light and airy with careful design features for signage and use of colour incorporated. These factors have known positive benefits in terms of reducing medication and challenging behavior.

Staff too are benefitting from co-location with colleagues, having an area where they can take much needed breaks and also, from a safety perspective, have access to newly designed door controls and alarm systems for emergency use.

The successful relocation has already demonstrated positive benefits for patients, their families and staff and we look forward to building on these over the coming year.

Children and Families Services

Our Child and Family Teams are currently working with young people in Portsmouth and Southampton to look at how services are currently delivered and how we can together shape the future of the service for children, young people and families in the delivery of care. The meetings sparked a wealth of discussion and debate between professionals and young people about preferences for NHS provision and their opinions as to what is essential to young people's lives. The young people brought a lot of questions and plenty of their own experiences and perspectives of our services to the meetings.

Following on from the inspiring meeting with the 'Solent Young Shapers,' 7 young people are helping the service review their environment that children and young people are seen in by completing the '15 Steps Challenge'. The information gained from these visits to service delivery sites will be used to redesign the environments and also link into the Always Events. This is a national programme that the Child and Family service have engaged with to develop consistent ways to meet the individual needs of patients to make sure that care is patient centred and delivered in partnership with them and their families.

Children and Family teams have also been running a digital innovation project in the 0-19 School Nursing and Health

Visiting service. As part of this project, engagement with parents, young people and the public has been a central theme; listening to feedback and using this to drive improvement. We engaged with 83 parents and 91 young people during this process; their feedback included how they wanted the service to communicate with them, digital options which they wanted available to give choice, what they did and did not like in website design and content, what they thought of virtual face to face contact and how they wanted to provide feedback to us. Based on this feedback, we designed a new website, built a bespoke SMS Text service for clinical advice and queries, promoted apps which are reliable with features to help parents and young people, created new feedback mechanisms and commenced live interaction sessions through the website which are advertised on social media.

Mental Health

In Adult Mental Health in-patient wards, we have developed the psychological skills and knowledge of our staff. A series of psychological skills workshops were delivered to staff by our psychology team. The topics covered in these workshops were:

- Essential counselling and validation skills
- Anxiety Management
- Dialectical Behavioural (DBT) skills
- Motivational Interviewing
- Behavioural activation and problem solving.

Feedback from staff has been extremely positive with increased staff knowledge and confidence in using psychological tools. Staff have told us that they are using the interventions taught to better support service users in our care.

Due to the success of this, we are continuing this programme of workshops into the coming year, with 90% of Adult Mental health inpatient staff (bands 2-6) either already completed a set of workshops or booked to attend one.

Special Care Dental Services

National Guidelines, Public Health and Domiciliary Dental Teams have long identified that oral care for patients in Rest/Care homes is not comparable to other settings. Staff turnover in domicillary settings is rapid and there is no existing organised training. Originally commissioned in 2013, this quality project was re-commissioned in 2017. The Oral Health Promotion team based in the Eastern Locality are leading with this pilot study that aims to be rolled out to the whole of Portsmouth

Aims of the Project:

- This project aims to `train the trainer’ so that staff trained can cascade their knowledge to their colleagues.
- This meets the challenge of limited NHS resources educating many carers in various Rest/Care homes across the city.
- A pilot study in one Rest Home to be undertaken, then adaptations made before larger scale training. This includes auditing care plans and gathering other information.

Outcomes of the Project:

- An `oral assessment' tool has been developed. There is an existing `Australian' tool that is used in the community setting. This is found to be too complicated and the new tool will have more visual guidance.

- A `train the trainer' book has been written to support `face to face' training. This encompasses
    - what is expected for good oral care according to national guidance;
    - other medical conditions that poor dental health can cause;
    - causes of tooth decay;
    - good tooth brushing; denture care; problems and causes in soft tissues/tongue and
    - how alcohol and smoking affect oral health.

Annex 1:

Statements from commissioners, local Healthwatch organisations and overview and scruitny committees

Healthwatch Southampton Comments on Solent NHS trust Quality Account 2017/18

Healthwatch Southampton welcomes the opportunity to make formal comment on the draft of Solent NHS Trust Quality Account 2017/18 as it applies to the services provided by the Trust in Southampton. This includes in-patient care at the Western and Royal South Hants hospitals as well as GP practice surgeries and several outpatient clinics and community services.

The Quality themes and priorities section is clear and are welcomed, but given the importance of these priorities we would have wished to see a little clearer narrative rather than the bulleted statements and we would have liked them to be put in context by referring to progress made in meeting the priorities for improvement set out for 2017/18 in last year's quality account. As it is, these are given Part 3 Other Information

The decision by the CQC to improve the rating of CAMHS is of course welcomed however our information is that the waiting time to access this service is long and we would hope to see this improve in the coming year. We are also concerned that there are no beds for children with mental health issues in Southampton in which means that young people may be admitted to an adult ward.

We understand the importance of accurate clinical coding and it is pleasing that the Trust has achieved level three rating.

The friends and family test is rather a blunt tool but nevertheless it is good that the rating for the Trust has continued to show improvement. Similarly, it is good that the staff survey results also show an improvement in rating.

It is good to see that the trust achieved many of the priorities set last year. Launch of the website and the recruitment of volunteers is a good initiative and these volunteers can make a big difference to the patient experience.

Handling complaints is important, and it Is quite right that the trust is emphasising the need to resolve the concern at the earliest opportunity and at a local level; the fact that this approach has resulted in fewer formal complaints show the value of the approach. This is reinforced by the creation of the complaints scrutiny panel with Healthwatch as a member. However, we note that there is almost no reduction in the formal complaints associated with communication / information to patients and this is a cause of concern.

Healthwatch Southampton has been involved for several years in the PLACE process in Southampton. We are not surprised that the Trust scored so highly, and this reflects our observation. We will continue to play our part in these assessments and are pleased that they are taken as a positive learning opportunity. We are particularly pleased that special mention has been made in improving the condition, appearance, and maintenance of buildings where Solent is not the property owner.

It is very important for all trusts to take the Accessible Information Standard seriously and it is pleasing to read that by doing so it has increased the patient experience resulting in improved feedback. Healthwatch Southampton continues to pursue this cause and will assist where we can. Similarly, we continue to receive comments from the public about the lack of clarity surrounding DNACPR and we will work with Solent NHS trust to improve communication on this subject.

We were delighted to be invited to the 25th anniversary of the Homeless healthcare project within Southampton

City. This is a great, caring, project supporting the most vulnerable people and we wish those associated with the project well in the future.

Now that the three primary care practices run by Solent are co-ordinated, we are surprised that there is no mention of a Patient Participation Group either in the quality account or in their website and we would encourage them to develop their PPG. Healthwatch Southampton have started a PPG network that is beginning to show good results in getting patient involvement in primary care.

The description of the new Kite unit at the Western hospital suggests it is good facility. It is not clear if this facility has an increased number of beds from the one it replaced in Portsmouth. We look forward to including it in our list of venues to visit as part of the PLACE process.

We look forward to continuing an effective relationship with the Trust and will do what we can to help the trust achieve its objectives.

Harry F Dymond MBE
Chairman Healthwatch Southampton

Steve Beale
Healthwatch Southampton

*** It should be noted that the beds for children with mental health issues in Southampton are provided by Southern Health Foundation Trust*

Healthwatch Hampshire response to Solent NHS Trust Quality Account

As the independent voice for patients, Healthwatch Hampshire is committed to ensuring local people are involved in the improvement and development of health and social care services.

Each year, we are asked to comment on seven Quality Accounts from NHS Trusts. In the past, we have allocated scarce time to read drafts and give guidance on how they could be improved to make them meaningful for the public.

We recognise that this process is imposed on Trusts. However, as the format has largely continued to remain inaccessible to the public, we have concluded that it is not a process that benefits patients or family and friend carers unless the format is changed. So we will no longer comment on Quality Accounts individually.

This will release time for us to use our resources to challenge the system with integrity, so we can create more opportunities for local people and communities to co-producing service change. For example, this year, we are again running our "Community Cash Fund" to offer local organisation and charities the opportunity to carry out projects that help people to stay well both now and in the future. We are currently accepting applications until the end of May.

If you have not already done so, we would ask you to look at the guidance on involvement from Wessex Voices (www.wessexvoices.org.uk) which aims to make sure local people are involved in designing and commissioning health services. Five Local Healthwatch alongside NHS England (Wessex) have produced a Wessex Voices toolkit to support patient and public involvement in commissioning. You can use this to ensure that your quality processes are in line with patients' views, and with the guidance from NICE (www.nice.org.uk/guidance/ng44) and Healthwatch England. (www.healthwatch.co.uk/reports/5-things-communities-should-expect-getting-involved)

If we can help you in planning co-design and participation in future activities, we'd be pleased to hear from you. We will continue to provide feedback to the Trust through a variety of channels to improve the quality, experience and safety of its patients.

Thank you for inviting us to comment

Healthwatch Hampshire
Westgate Chambers
Staple Gardens
Winchester
SO23 8SR
Tel: 01962 440262
Web: www.healthwatchhampshire.co.uk

11 May 2018

Sue Harriman
Chief Executive
Solent NHS Trust
Highpoint
Bursledon Road
Southampton
SO19 8BR

Dear Sue

Solent NHS Trust Quality Account 2017/18

Southampton Clinical Commissioning Group (CCG) is pleased to comment on Solent NHS Trust's Quality Account for 2017/18; for the services that they commission. The CCG has continued to work with the Trust over the past year in monitoring the quality of care provided to the local population of Southampton and identifying areas for improvement.

The account reports that achievement has been made against four out of the five 2017/18 priorities, with priority three, improving services by using the learning from incidents, complaints and feedback, being reframed for continue into 2018-19. The Quality Account provides details of how the priorities have been met and outlines how priority three will be taken forward in 2018-19.

Solent's 2018/19 priorities have been set under headings of six key themes including involving people, safer lives and spreading excellence. However the Quality Account does not include key milestones or measureable key performance indicators for each of the priorities, which makes it difficult to understand exactly what the priorities are trying to achieve and how the Trust will know it has been successful. It is noted that the priorities do cover areas that will support improvements where there have been recent key concerns.

It is positive to note the Trust's participation in national clinical audits and confidential enquiries by being involved in 11 out of 12 they were eligible for. There were also 109 local audit and service evaluation projects completed with the report providing some clear examples of learning and improvements made.

The Trust also demonstrated a positive performance against the Commissioning for Quality and Innovation schemes (CQUIN), including a significant improvement with the influenza vaccination rates for front line staff.

The CCG notes the improvements seen in the Care Quality Commission ratings in 2017/18 for both Child and Adolescent Mental Health Services and the Substance Misuse Service, which is a move in the right direction.

The Quality Account includes required adherence to the new requirements around learning from deaths. The Quality Account regulations also require Solent to report performance against a specific set of core indicators; these are included, although some of the 2017/18 performance data is not yet available in the draft report, so we are unable to comment further on this.

NHS Southampton City Headquarters, Oakley Road, Southampton, SO16 4GX
Telephone: 023 8029 6904 Fax: 023 8029 6960 Website:www.southamptoncityccg.nhs.uk

It is positive to note the Patient Led Assessment of the Care Environment (PLACE) results which were all scored above 90% and the Trust's continued committement to further improve in the areas of Privacy, Dignity and Wellbeing, Dementia and Disability.

Patient falls resulting in harm increased in 2017/18 compared to the previous year. There is now a Falls Thematic Lead in post and the Trust Slips, Trips & Falls policy has been updated and made available for staff. The CCG is pleased this is a continued priority and looks forward to seeing improvements over the coming year.

In terms of patient and staff feedback, the Trust has continued to improve the Friends and Family Test percentage of patients that would recommend Solent. The Trust should also be proud of the continued improvements in the staff survey responses, with a significant improvement in 12 questions and being ranked as the best performing mental health, learning disability and community trust.

The Trust should be congratulated on the continued development of the Homeless Healthcare service which is now in its 25th year. This service demonstrates positive partnership working and the CCG is keen to see Solent's community services continue to engage with the wider local health and social care system to drive improvements for all patients across Southampton City. To support the Trust's overarching theme of "involving people", for community development it will be key for Solent to work alongside others in the many initiatives already underway

The Quality Account meets the minimum national requirements, although the CCG would like to have seen some further narrative regarding how the Trust is working to improve the quality of services. The Quality Account refers to services being involved in many other quality initiatives, but these are not discussed within the report.

The Quality Account would also be strengthened through the inclusion of patient stories and this is something the CCG would like to see in future reports.

Overall Southampton CCG, are satisfied with the Quality Account for 2017/18 and as previously stated is keen to see the detailed measures behind the priorities for 2018/19 so that next year's Quality Account can provide more robust metrics to demonstrate how priorities have been achieved against the measures identified.

The CCG looks forward to continue working closely with Solent NHS Trust over the coming year to further improve the quality of service for the people of Southampton.

Yours sincerely

John Richards
Chief Officer
Southampton CCG

CC: Stephanie Ramsey – Director of Quality and Integration / Chief Nurse
Carol Alstrom – Associate Director of Quality / Deputy Chief Nurse

NHS Southampton City Headquarters, Oakley Road, Southampton, SO16 4GX
Telephone: 023 8029 6904 Fax: 023 8029 6960 Website: www.southamptoncityccg.nhs.uk

CCG Headquarters
4th Floor
1 Guildhall Square
Portsmouth PO1 2GJ

Tel: 023 9289 9500

18 May 2018

PRIVATE & CONFIDENTIAL
Sue Harriman
Chief Executive
Solent NHS Trust
By Email

Dear Sue,

NHS Portsmouth Clinical Commissioning Group (Response in 17/18 Quality accounts)

NHS Portsmouth CCG supports the Trust in its publication of the 2017/18 Quality Account. Having reviewed the mandatory detail of the report, we are satisfied that the Quality Account incorporates the mandated elements required, based on available data.

The CCG welcomes the six quality themes identified for 2018/19 linked to the Trusts strategic aims which includes this year the development of a learning framework, and the replication of the excellent elements from the outstanding LD service across the organisation as part of its 'Spreading excellence' theme. A recent visit to the LD service by Commissioners support the CQCs decision to rate as outstanding with clear evidence that the service user is the absolute focus of what they do and a team which is cohesive, motivated and innovative.

During 2017 the Trust was re-inspected by the CQC as a result of three service lines receiving an overall rating of 'inadequate' in 2016. The CCG are pleased to acknowledge the positive outcomes of the robust action plan put into place to address these issues and that the re-inspection resulted in two services being rated 'good' and the third inadequate to 'requires improvement'.

Achievement of identified priorities for 2017/18 have been noted in particular to the Quality Improvement Programme (QIP) which commissioners have been both invited to the organisations celebration of completed programmes and also to partake in a QIP alongside the Home Oxygen Team and the implementation of an Organisational Learning framework which is ongoing.

During the Portsmouth CQC CLAS inspection inspectors identified some good practice across Solent Services. Solent NHS Trust engaged well with the inspection and took on board and addressed the recommendations from the inspection.

The CCG recognises the ongoing work to embed the Patient safety agenda into practice across all its services and the continuing improvement in the management of its risk and incidents. There is continued progress with the quality and timeliness of investigations. This includes the additional assurance provided by representation at the CCG SI panel. The Trust has a robust review process for Learning from Deaths and the CCG welcomes the proactive and innovative approach; one which commissioners are openly invited to attend.

The CCG notes the progress made with IG toolkit assessment and is delighted with 97% compliance. It is evident that the learning from SI is being embedded across the organisation following a 'cluster' of IG SIs.

The CCG welcome the organisations PLACE outcomes and its accolation of highest score in its assessment areas in the South of England. This is also evident when commissioners visit sites as part of our assurance visits.

The Trust continues to engage positively and proactively with the CCG. The changes to joint management processes between both organisations have also seen a reduction in duplication of work and data submissions working towards a much more efficient way of working and both organisations will develop this further in the coming year.

Overall, NHS Portsmouth CCG is content with the Quality Account and look forward to working with Solent in the coming year.

Yours sincerely

Dr Linda Collie
Clinical Leader and Chief Clinical Officer, NHS Portsmouth CCG

Councillor Sarah Bogle
C/O Mark Pirnie, Democratic Services
Southampton City Council
Civic Centre
Southampton SO14 7LY

Direct dial: 023 8083 3886
Email: mark.pirnie@southampton.gov.uk

SOUTHAMPTON CITY COUNCIL

Date: 14 May 2018

Sue Harriman
Chief Executive
Solent NHS Trust
Highpoint
Bursledon Road
Southampton
SO19 8BR

Dear Sue,

Solent NHS Trust Quality Account 2017/18

The Southampton Health Overview and Scrutiny Panel welcomes the opportunity to comment on the Solent NHS Trust Quality Account for 2017/18.

The Panel were pleased to see positive progress reported against a number of priorities set for 2017/18, including delivering the Quality Improvement Programme to enhance patient experience and make a difference to people's health and wellbeing.

The Panel welcomes the findings following the re-inspection by the Care Quality Commission of Child and Adolescent Mental Health Services and Substance Misuse Services in 2017/18. Having both services now rated as 'Good' from 'Requires Improvement' represents a positive development and reflects well on the Trust.

Progress continues to be made in terms of patient and staff feedback. The Trust has once again improved the Friends and Family Test percentage of patients that would recommend Solent. The Panel were also informed at the meeting that the Trust is now the best performing mental health, learning disability and community trust with regards to staff survey results. This is a significant achievement and the Trust should be applauded for the work that they have undertaken actively encouraging employer engagement and supporting staff development.

The Southampton HOSP look forward to working closely with Solent NHS Trust over the coming year to ensure that progression is maintained and that the quality of services continues to improve.

Yours sincerely

Cllr Sarah Bogle
Chair of the Health Overview and Scrutiny Panel
Southampton City Council

Switchboard 023 8083 3000 **www.southampton.gov.uk**

Annex 2: Board confirmation of Quality Account preparation

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

• the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance

• The content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period April 2017 to 17th April 2018
- papers relating to quality reported to the board over the period April 2017 to 17th April 2018
- feedback from commissioners dated 11th May 2017
- feedback from local Healthwatch organisations recevied on 4th May2018 and 11th May 2018
- feedback from Overview and Scrutiny Committee dated 114th May 2018
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, as shared with the Board on 31st July 2018
- the latest national staff survey – as reported to the 26th March 2018 Board
- the Head of Internal Audit's annual opinion of the trust's control environment – as reported to the 24th May 2018 Audit & Risk Committee
- CQC inspection report dated 30th November 2017

• The Quality Report presents a balanced picture of the trust's performance over the period covered

• The performance information reported in the Quality Report is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

and

• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

..............................Date..Chairman

Appendix A - National Clinical Audits and Confidential Enquiries

National Clinical Audits & Confidential Enquiries that Solent NHS Trust was eligible to participate in during 2017-18 are as follows:	Solent participated?	Number of cases submitted to each audit or enquiry as a percentage of the number required (or just number if percentage not applicable)
National Audits		
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation ORGANISATIONAL Audit	Yes	Adults Portsmouth & Adults Southampton submitted as required
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation CLINICAL Audit	Yes	Adults Portsmouth (21 cases) Adults Southampton (52 cases)
Prescribing Observatory for Mental Health Quality Improvement Programme: 17a - Use of depot / Long-acting antipsychotic injections for relapse prevention	Yes	Mental Health (10 cases)
Prescribing Observatory for Mental Health Quality Improvement Programme: 15b - Prescribing valproate for bipolar disorder	Yes	Mental Health (15 cases)
National Clinical Audit of Psychosis (NCAP) (NICE CG 178)	Yes	92 / 100 (92%)
Physiotherapy Hip Fracture Sprint Audit (PHFSA)	Yes	Clinical audit: 5 cases Home rehab 2 cases Next Step Facilities audit: East - Spinnaker Ward West - Royal South Hants
NHS Bench-marking network: "National audit of Intermediate Care" (NAIC)	Yes	Adults Portsmouth – two teams submitted as required
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Stroke ESD Team - 149 cases Stroke 6 month Reviews - 129 cases (Most recent official figures available for August 2016 – July 2017)
National Diabetes Audit - Adults: National Footcare Audit	No	Data collection using electronic records was not possible during the audit period. This has now been set up for 2018/19.
National Confidential Enquiries		
NCISH: The assessment of risk and safety in mental health services	Yes	Survey completed
Child Health: Chronic Neurodisability Clinical Review	Yes	1 / 1 Clinical case note questionnaire completed
Child Health: Young People's Mental Health Clinical Review	Yes	2 / 3 Clinical case note questionnaires completed

Appendix B – Research and Improvement: 2017-18 Annual Report

Research and Improvement: 2017-18

Annual report

Trust overview

Activity in numbers

Research		Quality Improvement	Dragons' Den	Audits and Evaluations	
55 studies	2356 participants	22 teams/projects	16 projects underway	19 national audits	93 local audits/ evaluations

Solent Academy of Research and Improvement

The Spring of 2018 sees the launch of the Solent Academy of Research and Improvement. This will provide a hub for innovation, learning and improvement across our Trust.

The academy will support:

- *Research*
- *Quality Improvement*
- *Clinical Effectiveness (Audit, Evaluation, NICE, Outcomes measures)*
- *Dragon's Den*
- *Involving patients in improvement*
- *Shared learning and using evidence*

We both develop and deliver these activities, and support our teams and patients to do the same. We provide training, showcasing events, bespoke facilitation and an annual conference. Our aim is to equip our staff and patients with the skills and confidence to identify areas that could be improved, employ techniques to manage projects and measure impact, and share and celebrate learning.

A prospectus and website have been developed as supporting resources. A new strategy has also been co-written with our patients, staff and partners.

Community and patient engagement

Working in partnership with patients, service users, their families and community colleagues sits at the heart of all research and improvement activity.

The Research and Improvement team have a well established patient and carer leadership group, Side-by-Side, who in the past year have:

- co-designed our annual conference, helping us to become the first NHS organisation to achieve international "Patients Included" Accreditation
- run our annual awards scheme
- helped write our business plan and strategy, setting priorities and vision
- written a charter for partnership working
- started to support growth in partnership working in other areas of the Trust, and particularly the QI programme

This work is extending across the Trust – there is currently a mapping exercise underway to assess the extent and types of activity across the organisation. This will feed into case studies and the development of a toolkit to support staff across the Trust to work increasingly with patients and colleagues to continuously improve their services.

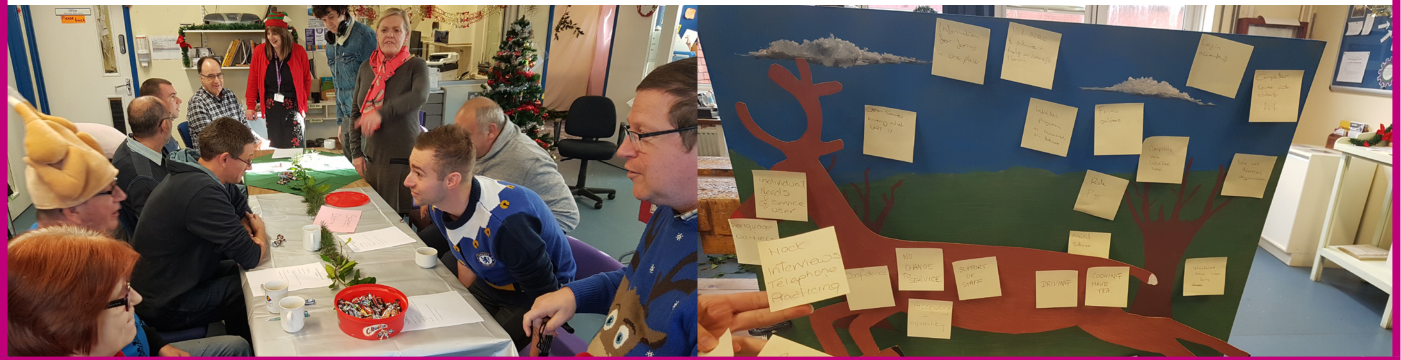
CASE STUDY

Understanding patient outcomes from Vocational Rehabilitation through Co-production

The Vocational Rehabilitation Service (VRS) supports people with neurological conditions to return to work. The service has been working together with its patients to develop outcome measures for the service. This work started in June 2017 and so far, the outcome measure has been written and tested.The group have now been to Dragons' Den and successfully bid for funding to put this into a web-based format that can link to Systm1 and the clinical record.

The service have also held sessions with the group on how the service might be improved, co-writing a vision and priorities.

"Listening and involving patients in our service development has provided clarity in the vision and direction of the service. Co-production, working together with patients has been really empowering for us all."



Embedding a learning culture

The Research & Improvement team are supporting the cultivation of an organisation that can capture on-going learning and improvement. We are committed to supporting staff to be able to demonstrate that as a result of events, projects and feedback, we have made changes that have led to improvement for people.

This worksteam includes:

- A review of the sources of learning, how we capture them, analyse them and measure improvement
- Changes necessary to extend opportunties for learning, and to make processes simple and engaging
- Increasing opportunities for patients and staff to give ideas for improvement
- Skills training via the QI and other programmes in measurement and demonstrating improvement
- Changes to governance processes, including meeting templates to ensure the focus is on learning rather than task.

Learning from Excellence

We spend a lot of time on what goes wrong, often at the expense of learning from the many more events that go very well in our care. We are supporting the launch of a focus on learning from excellence – this is in its set up and planning stage, but will include:

- Reverse SIRIs (IRISs) – appreciative enquiry of what has gone very well. Our first IRIS will take place in Children's Services with another identified in Adults Services Southampton
- Favourable/positive event reporting – a pilot planning group is working on a process for staff and patients to report events that go well and others can learn from.

Research

Solent continues to grow its research activity and opportunities for involvement, increasing both the scope and number of studies that we run.

Portfolio activity	2016/17	2017/18
Studies	48	55
Partcipants	1513	2356

**Not year end figures*

In Solent we both host (act as a research site) and lead trials. There is often rather a lag between the running of those that we host and having access to published results and so impact is not always direct. There is a wealth of evidence, however, that by just being research active, Trusts have better general patient outcomes and higher quality services. It raises awareness of evidence in practice, of innovation, and it gives staff opportunities to learn new skills. It also often gives patients access to interventions that would not otherwise be available. In recognition of the impact on quality, in 2018/19, research activity will be incorporated into the CQC frameworks. As a Trust we are linked into the development of this.

We are increasing both the number and type of studies that we host, and importantly also have an increasing number of Solent led research, generated via our Clinical Academic Programme.

Community Research Partnership

In 2016, we formed a Care Home Research Partnership in Portsmouth. This was designed to increase access to research, and was a reciprocal agreement where we provided training and all governance of research, and in return the Care Homes supported us with the delivery of trials. This was phenomenally successful, and has led to a national interest in Care Home Research at Solent, and the design of a number of studies with this population. It has also resulted in changes to consent processes, making research easier to access and better designed around the patient. These are now being shared with the national Health Research Authority.

This year, we have extended this model to other community partners, and created a Solent Community Research Partnership model – this includes local schools, care agencies, private nursery providers, dental practices, children's play groups and community groups across health and social care including charity partners.

This has resulted in successful recruitment to a number of studies across our different partners in ways that are mutually beneficial. Care homes, for instance, have received training in Dementia and Falls; the University of Portsmouth Dental Academy has access to research delivery expertise and training; and we have held interactive science events on antibiotic resistance and 'the workings of a microbiology lab' in schools.

We intend to continue to grow this partnership together with colleagues in our communities.

Count Me In

Over the past year, the Count Me In initiative has been rolled out across the Trust. This aims to increase access to research, and ensure that our clinicians will know if their patients are participating in studies. It has two interlinked elements:

a. A research unit on Systm1 which links with other clinical record systems to flag patients in studies
b. A process where patients can opt out of being contacted about opportunities to participate.

Trust-wide research

Carriage Rates and Antibiotic Resistance

This in an on-going study across multiple sites, which is sampling bacteria from the upper respiratory tract (URT), in order to determine community carriage levels of common respiratory pathogens and the prevalence of antibiotic resistance. Antibiotic disc diffusion tests are being used to analyse the antibiotic resistance of bacteria to commonly prescribed antibiotics.

This was a proof of concept study last year, using the 'community' for the first time, and sampling healthy participants. It explored feasibility of collecting samples across a county from a variety of populations (babies to care home residents to those that are homeless).

The success has led to interest from both large research centres and Industry partners to work more with Community Trusts, with particular interest in our Community Research Partnership. To date we have recruited over 1500 participants, and started an education project between the lab and schools and colleges in the county on antibiotic resistance, part of the current science curriculum.

Adults Services Research

Falls intervention trial for patients with Parkinson's disease (PDSAFE)

The PDSAFE study was a national trial run by the University of Southampton, which investigated the effectiveness of a personalised, home based exercise programme to reduce falls in patients with Parkinson's Disease. 131 patients had access to a novel intervention, which was found to reduce falls in those with moderate disease progression. Patients also reported increased confidence, motivation to stay mobile and coping skills.

LIBRE – a diabetes monitoring device

Only two years ago, Solent were part of a trial of a device to improve the quality of life and safety of diabetic patients. This device is inserted under the skin, and measures blood glucose automatically, saving patients the need to do constant finger prick tests. Our patients and the community diabetes team were part of the testing for safety and efficacy. This year, this device has been commissioned locally and the Solent Diabetes team are able to offer it to their patients.

Implementing and evaluating the Genie tool in the Southampton Integrated COPD Team
The GENIE study is led by a Solent clinical academic PhD student, and offers patients with COPD the chance to use a social mapping tool to increase opportunities to socialise and get day to day support outside of the health service. If successful, this has the potential to be extended to others with long term conditions. This piece of work is also informing a redesign of methods for gaining consent for research, increasing accessibility.

Intrathecal Baclofen Study

Hayden Kirk, Clinical Director for Adults Services, is leading research on a home based model for monitoring patients with neurological conditions who are receiving intrathecal (directly into the spine) baclofen. This was in response to a concern that it may be placing some patients at risk of respiratory difficulties. The study is investigating ways to monitor patients overnight in their own homes rather than in a sleep lab and has resulting in the identification of a number of patients with significant night-time breathing difficulty. This suggests patients with neurological conditions should be routinely assessed for respiratory capacity – a larger study is now being put forward for national funding.

Musculoskeletal, Podiatry, Pain

Nerves – treatment for back pain

The NERVES study aims is to find out if local anaesthetic and steroid injection (TFESI) can provide a faster, cheaper and more effective treatment for patients with persistent sciatica than an invasive surgical procedure. It compares both approaches – this is a complex study for a community organisation, and is being carried out collaboratively across Wessex, led locally by Dr Cathy Price, Clinical Director. Despite being a community organisation, we are one of the highest recruiting centres in the country.

Prove

Patients suffering with osteoporotic vertebral fractures have been able to take part in the PROVE study and trial different physiotherapy interventions in an attempt to ease pain and get back to normal activities of daily living. This study has been done with the PHT orthopaedic surgery department – we have co-ordinated the study and provided the physiotherapy. Formal results are awaited, but patients report increased mobility and reduced pain:

"It was great to be on the PROVE course. I did the exercises which I found really useful and have improved my back pain. As with many patients I'm sure, I have multiple mobility problems and various ops throughout my time but I certainly feel my quality of life is improving."

Diagnosis and treatment of forefoot neuroma

A Solent podiatrist has used her clinical academic PhD programme to develop and validate a clinical assessment protocol for diagnosing forefoot neuroma in clinical practice. She has recently been awarded her PhD and been part of developing a research delivery team within podiatry.

CAPTOE – a new device study

This is the first trial of a new medical device that Solent has led and sponsored. A commercial group has developed a plasma device, which in this first phase is being used to treat fungal nail infections. If this proves to be safe (we have had no adverse incidents in 79 patients), this device has implications for tissue repair. Solent will be supporting the group to further develop the device.

Ageing

Preventing Falls in Care Homes

As part of the Community Research Partnership, we have been working with Care Homes in Portsmouth to deliver and evaluate a specialised Falls Prevention Programme (GtACH). As part of being involved care home staff receive training to use the GtACH tool, how to manage and prevent falls and develop research knowledge and skills.

Tai Chi for People with Dementia

Patients with mild to moderate dementia and their carers are able to try a free 6 month course of Tai Chi as a way to prevent falls as part of the TACIT trial.

Adult Mental Health

Voices Impact

The VIS study offers patients a chance to try out a new patient reported outcome measure assessing the effectiveness of psychological interventions for hearing/ distressing voices. The measure focuses on capturing the impact of interventions on reducing distress and improving quality of life rather than just how loud or frequent the voices are. A recent participant said

"I've never been asked these sorts of questions before and I feel empowered by talking about it and knowing I am contributing to a change in the way clinicians work"

Smoking Cessation (SCIMITAR)

A bespoke intervention to support those with severe mental health illness to stop smoking has been trialled in our mental health services. This is a population for whom quitting is particularly difficult, but who often suffer physical health problems. The formal results are yet to be published, but anecdotal evidence from the Solent participants are positive, including one gentleman being able to quit after many years of trying. This study has also explored recruitment to trials in a previous seldom heard population, and Solent's contribution has been recognised with a national publication for our Clinical Trials Assistant.

Veteran Occupation Evaluation

This study aims to explore if military service has an impact on health and wellbeing in later life with a view to possible adaptations to working practice. We have worked with over 100 veterans on this project and are awaiting the formal results. Early indications are that this population would benefit from more intervention to support mental health.

Liaison and Diversion Service Evaluation

These services are part of a national evaluation of impact on reconviction, health service utilisation and diversion from the criminal justice system. This is a joint service with SHFT, and team in this service delivered this delivered this study independently, managing to recruit nearly 300 clients into the study.

Sexual Health Research

Text messaging to promote safer sex behaviour in young adults

A national trial investigating whether using text messaging to promote safe sex behaviour is effective in reducing infection. This study fits within the service ambition to deliver more of its service digitally, in line with the needs of its key demographic.

HIV prevention study

PrEP Impact is a high profile national trial looking at people who are at high risk of acquiring HIV, taking a tablet to reduce their risk. It is open in all three of our sexual health service hubs, and has been very enthusiastically received by both service users and staff. In just two months, we have recruited 55 participants.

Evaluating a new point-of-care test for gonorrhoea

The Southampton team are supporting the evaluation of a new point-of-care (instant results) test for a number of Sexually Transmitted Infections including gonorrhoea.

Research with children

100,000 genomes

Solent is one of the only Community Trusts to be participating in this national initiative to sequence 100,000 genomes from approx. 70,000 patients with rare diseases. The aim is to create a genomic medicine service for the NHS. It offers the chance of diagnosis and treatment where this wasn't available before. Solent is running this through their paediatric services, offering families a unique home based service for seriously ill children. It is popular, with 14 families having participated. To date, it has led to one new diagnosis (intractable epilepsy) and treatment plan.

Drooling Reduction Intervention

Children with serious disabilities often suffer from extreme drooling. This study trialled a medicine, which was found to be effective and provided evidence to help GPs prescribe appropriately. This has acted as a catalyst for other paediatricians to support research in the Trust, and was very positively received by parents.

Strength and resistance training for children with Cerebral Palsy

Children with CP were offered a novel physiotherapy programme to improve strength and resistance, to aid walking and mobility. Following participation in this programme, an 8 year old boy was chosen to participate in a junior swimming team.

Supporting Vaccine Development

Following the success of our community partnership, Solent is now part of a programme looking at the effectiveness of or development of childhood vaccinations. The first one is evaluating the meningitis vaccine by investigating commonly carried bacteria in our noses and throats. To date, we have recruited 260 children to this study. We anticipate this will be the first in a series of studies in collaboration with the University of Southampton and UHS.

New Forest Parenting Programme

Solent's Children and Adolescent Mental Health Services developed a parenting programme to support parents with children who had challenging behaviour (or ADHD). This programme has been the subject of a range of research studies, both in the UK and internationally (Japan, Denmark, South Africa). The programme has been found to be effective in managing behaviour, and is used both in clinical practice locally, but now all over the world.

It has led to related work, such as the establishment of an ADHD register and tissue bank, and some emergent work on Adults with ADHD.

It is now moving into a phase to develop an online/ app version of the programme.

Quality Improvement

Extended Quality Improvement Programme

Solent launched a Quality Improvement Programme in July 2016. This aimed to bring teams together to work on improvement ideas of their own, with training in QI methods and support to deliver their projects. To date we have run 4 cohorts of 8 teams from across the organisation. A core element of the programme is working in partnership – both with patients and service users, and with colleagues from partner organisations.

In response to feedback and demand, the QI programme has now been extended into a stepped programme of skills development. The amended programme offers 4 stages to the QI development (see diagram below).

Since the creation of the QI programme, we have seen just shy of 120 people come through the QI practitioner stage and 60 through the Foundation QI stage

Alongside this sits:

- Bespoke facilitation to carry out QI projects at team level
- Analytic support for more advanced QI techniques
- A series of master-classes on QI tools, presentation skills, social media and much more
- Facilitation to utilise QI tools to maximise the outcome from audit and
- evaluation projects

On-going showcase and celebration events are held to share learning and congratulate teams on their progress.

Foundation QI

Projects under this programme, and improvements include:

- Introduction of a ted tabbard with 'Drug Round in Progress, Do Not Interrupt' printed on, to be worn during drug rounds on Snowdon Ward to reduce drug errors that were occurring as a result of staff being interrupted.
- Admiral Nursing standardised the completion of Nursing Assessment Forms to comply with standards set out by Dementia UK. Completeness of documentation has risen from 57% to 97%.
- The Palliative Care Team in Southampton held a tea party with families to discuss how the service was delivered, and provide ideas for improvement. The outcomes of this were a need for information following a death on what to do next. This has been put into place. Two of the attendees of the tea party have since attended the Foundation QI training and are working with the clinical team on further aims for improvement.

Quality Improvement Programme (QI Practitioner)

Improving indwelling urinary catheter care for all patients under the care of Solent NHS Trust: Infection Prevention team, Corporate Services

Data demonstrated that indwelling urinary catheter care documentation for many patients across the Trust was either not in place or of poor quality. The project aimed for 100% of Solent NHS Trust patients with indwelling urinary catheters to have readily accessible and accurately completed catheter care documentation. Standardised catheter care paperwork was developed and implemented on Systm1. The paperwork was tested with Adults Southampton services. Data collection indicated a 28% improvement in the accessibility and standard of documentation. The documentation is now being spread to Adults Portsmouth services. Key learning for the team was the need to continually reinforce changes to ensure they are embedded into practice. The variable quality of handover paperwork from acute services further contributes to the problems regarding catheter management.

Improving processes for recalling patients for follow up appointments: Special Care Dental Services

Special Care Dental Services did not have a service process for recalling patients to attend regular dental appointments. The project aim was for 100% of patients registered at Gosport Dental Clinical to receive a recall letter. Data showed that for the 24 months prior to September 2017, 28.7% of Gosport patients had not received a recall appointment. The team developed an accessible information patient questionnaire and asked their patients how they would like to receive their recall appointment. They used this information to design accessible information patient letters within the dental records system. The new patient recall process has been fully tested. 100% of vulnerable patients are now being contacted to ensure that they are recalled as necessary.

Key learning for the team was the importance of consulting their patients and using an appropriate communication format.

Improving access to Fareham and Gosport sexual health services: Sexual Health Services

A range of data sources for the Fareham and Gosport sexual health services, including the patients' Friends and Family feedback, complaints, patient redirection rates, patient waiting times from booking in to being seen and staff feedback, indicated the service model of wait-to-be-seen clinics was not adequately meeting patients' or staffs' needs. The project aim was to improve access to the Fareham and Gosport sexual health services. Results of a token system asking patients to vote on their preferred service model showed

an appointment based model was preferred. This model was implemented and review of the data sources listed above show it has resulted in improved patient and staff experience. This service model has now been rolled out to Aldershot Centre for Health, Oak Park and Winchester, Eastleigh and Andover sexual health services. It was found that in larger hubs this service model required a nurse in charge role for the day to support the running of the clinic and ensure good patient flow.

Reducing rates of falls and the seriousness of falls related injuries on Brooker ward: The Limes, Older Persons Mental Health

Brooker ward cares for patients with acute organic dementia. Ward staff were concerned about the high rate of patient falls. The project aimed to reduce the rates and seriousness of falls related injuries on the ward. Following consultation with staff and patient's families/carers a number of changes were made. These included discussing falls in ward rounds, improved recording of the date of the last fall, amended care plans, linking risk events and highlighting them in Systm1. Data analysis using Statistical Process Control charts showed that in the 6 month period prior to these changes the mean number of patient falls per 100 bed occupancy days was 3.2 per week. Analysis of the 6 month period following the changes shows the mean number of falls has reduced to 1.8 falls per week. This project was led by a multi-disciplinary team and this resulted in the whole ward team engaging in the changes so that there is now an integrated daily review of patient falls.

"I think we did things that we didn't know were possible. I didn't know it was possible to get together a team from a big diverse team and actually make this happen. I didn't think we could do it but we did and that was great. The QI programme gave us more credibility when we were feeding back our results to the rest of the MDT"

"From the beginning we felt very privileged to be given this chance which increased our motivation, to be here, to be in Solent and to be supported to do this."

Improving Attendance: a journey to improve health outcomes for Looked After Children aged 11-16yrs: Looked After Children's service, Children and Families

The Looked After Children's health team identified that a high rate (35%) of children aged 11-15yrs were not being brought (WNB) for initial and review health assessments. The project aimed to reduce the percentage of children aged 11-15 years not being brought to health reviews. Staff consulted service users (young people), foster carers, social care staff, and all the Looked After Children team members to gain their ideas on why this was a problem and to suggest potential solutions. Changes made included later appointment times, sending a personalised invitation to attend to the young people, extending the notice period for appointments from 2 to 4 weeks and developing a Clinic Support Worker role to support this process. Results show a reduction in the children aged 11-15 years not being brought to health reviews from 36% to 25.18%. Extensive patient engagement underpinned the success of this project with the team working outside of their normal hours to visit youth groups and consult with young persons.

Hepatitis C patient journey: Homeless Health service, Primary Care

Rates of Hepatitis C are high amongst the Homeless Health service patients. Data showed that of the 26 patients referred by this service to Hepatology following a positive blood test in the past year, 14 had booked to attend treatment, 12 hadn't booked and only one patient was in treatment. The project aimed to increase the number of patients attending their appointments. Patients were contacted and interviewed to get an understanding of their individual journey. Patients were also asked what the service could do to support them to attend their appointments. All Homeless Health service staff members were also invited to identify potential barriers and enablers.

Changes currently being tested include weekly reviews by the team to look at hepatology referrals and their booking status, using a separate folder for Choose and Book referrals to hepatology so they don't get mixed with other mail, offering patients a further appointment with the Homeless Health service to support with booking the hepatology appointment. The Homeless Health team have identified that a positive working relationship with partner agencies and the hepatology service is crucial in being able to effectively support patient to book and attend appointments.

Reducing rates of patient falls in a Portsmouth Care Home: Care Home Team, Adults Portsmouth

Solent's Care Home Team is a new and innovative multi-disciplinary team working in partnership with residential and nursing care homes in Portsmouth. The team observed that these care homes were experiencing regular patient falls and that these falls often have a significant negative impact upon patient outcomes. The team are working with a specific residential care home with the aim of reducing rates of falls. They are currently in the diagnostic phase of the project in which they are using a range of quality improvement methods and data analysis to explore and understand why, when and where patients are falling. This is being conducted in partnership with care home staff. Potential solutions are also being identified.

Improving the referral process to Solent Neurological Rehabilitation Service: Snowdon Neurological Rehabilitation Service, Adults Southampton

Service staff identified that clinicians were spending an excessive amount of time processing referrals from external referrers. A staff survey asked staff members to identify why this was the case and to suggest potential solutions. Results identified the problem as being due to the poor quality information on the forward facing website for external referrers and potential patients, the lack of a standardised referral form and lack of a standardised referral process. Changes to date include development of a generic electronic referral form which has been implemented on Systm1 for internal referrals. A successful application was made to Dragon's Den for funding for website development and this is currently underway. This will include addition of the generic referral form to the website. A project aim is now for 100% of referrals to follow an electronic process. Additional key indicators of success for this project will be a reduction in administration time processing referrals and a reduction in time from referral to the processing of referrals. Follow up data collection is planned.

"For us it's been a fantastic opportunity, to put the focus back on quality in our practice again and to look at measuring that. It's also been a great opportunity to feel accountable for making change happen in our practice.
Most importantly it's been an opportunity to develop our skills as leaders and co-leaders, to think about how people experience us and to make the most of our team and their considerable talents".

Clinical Effectiveness relates to both assurance of the standard of care via clinical audit, and review against NICE guidelines, and improvements where standards aren't being met. Evaluations are used to measure effectiveness and patient experience of either current or new services.

Planning for Improvement

Each year, the Trust is required to produce a Clinical Audit Plan. This is then monitored for improvement and outcomes.

This has traditionally been done by service lines in isolation, and for 2018/19, a slightly different approach was taken. To support shared learning and priorities, an afternoon workshop was held with representation from each service line. Information was collated and reviewed from:

- NICE guidance and the need for any re-audits
- incidents, SIRIs, complaints
- patient feedback
- staff ideas (via a survey)

This has resulted in a number of Trust wide priorities for the organisation 2018/19. These include:

- increased patient and community engagement
- a focus on record keeping
- clinical supervision
- development of demand and capacity tools

Clinical outcome measures

During 2017-18 we have conducted a survey of outcome measures in the trust. This has received 114 responses and identified examples of outcome measure use and development across the organisation. Developments have concentrated on the use of patient reported as opposed to clinical rated outcomes and the integration of outcome measures into system 1.

In 2018/19, we will produce a summary of outcome measures, support services to use Systm1 to automate the monitoring of outcomes and develop a guide to the development of measures.

Developing Single Point of Access processes improved the speed and quality of referrals for Adult Speech and Language Therapy

A 2016 audit identified that SLT referrals were slow to be received and the quality of information within them was poor. The service increased the promotion of the Single Point of Access and made modifications to the referral form. This included mandating certain fields. The 2017 re-audit showed significant improvements:

	2016	2017
Time to respond to referral	8 days	3 days
% requiring follow up calls	58%	10%
Use of SPA for referral	29%	60%
Urgency included in referral	29%	65%
Patient History included in referral	65%	80%

This audit and re-audit highlights the value of using SPA with referrals placed directly into the clinical records system. It also highlights the potential to prioritise patients more accurately from higher quality referral information. Future actions include the development of a centralised triage to ensure this is conducted more equitably across areas.

Staff and case based evaluation of a new risk stratification tool confirmed it was reliable and sensitive to frailty rather than age

The existing risk stratification tool used to identify complex cases for referral to community matrons and case managers in

Southampton was old and based on a patient's age rather than their frailty. It was also thought to be overly weighted towards chronic diseases. A new tool was developed with staff and trialled alongside the existing one for 53 cases. Staff reported a preference for the new tool and that they appreciated being involved in its development.

This evaluation has led to an improved tool which is sensitive to frailty (a more relevant index than age) and less weighted towards chronic disease. Further action is planned to encourage use of the new tool across referrers.

Bi-annual audit of parental consent for dental treatment shows continuous improvement across the last three audits

It is important that dental records accurately record who (e.g. with looked after children) is able to consent to treatment.

This audit was conducted across 16 specialist dental clinics. Accurate record of parental responsibility for consent has improved at each audit period from an average of 44% in January 2017, then 65% in June to 83% in December 2017. Improvement has been demonstrated in each clinic.

Improvement and further action rely mostly on communication highlighting the importance of this information in team and individual consultation. Further re-audit is planned.

Introducing a physiotherapy led MSK telephone triage service into GP surgeries can reduce the number of GP consultations required and the time taken to refer into MSK physio

Patients with MSK conditions make up between 25-30% of GP consultations. Approximately 60% of these cases are referred for advice or intervention from the MSK Physiotherapy service. Potentially, access to MSK via GP services results in additional consultations, increased administrative tasks for referral and appointment booking, delayed treatment and poorer patient satisfaction.

This project, conducted in two GP surgeries over 6 months, evaluated the impact of a physiotherapist-led telephone triage and advice service. Patients with MSK conditions were directed by the GP receptionist to the triage service. 63% of patients with MSK complaints who contacted the surgery for GP appointments were managed effectively by the MSK physiotherapist without any GP involvement. This equated to a 35% (136 patients) reduction in GP consultations. The number of overall referrals into MSK remained unchanged. 50% of patients given self-referral advice actually went through the self-referral process, and of these 80% attended the MSK Physiotherapy department.

Based on this evidence of effectiveness, a plan to continue providing this route for referral into MSK has been developed.

Awareness of and processes for managing high rates of children who were not brought (WNB) to initial appointments in CAMHS leads to significant improvements one year later

A 2016 audit investigated the prevalence and management of children not brought to appointments at Solent CAMHS (West). Following the audit, the service adopted the Trust guideline for management of WNB children in paediatrics, and this has led to a significant reduction in the numbers of children not bought to appointments.

WNB	2016	2017
Initial appointment	47%	5%
Follow up appointment	9%	8%
Overall	13%	8%

Future actions include the development of a text based reminder service and further staff education on the use of system 1.

Raising awareness across a wide range of professionals as well as credit card sized prompt cards contributed to a significant improvement in assessment of self-harm (and compliance with NICE clinical guidelines)

Self-harming inpatients in acute mental health wards are at high risk of increased self-harm and suicide at the time of and during admission. In the original audit conducted in 2014, compliance with NICE criteria for self-harm assessment was 44%. On re-audit in 2017, compliance had increased to 100%.

Guidelines developed from an initial audit on the management of pelvic inflammatory disease have contributed to significant improvements in diagnosis and treatment within Sexual Health Services

The aim of this audit was to identify if the diagnosis and management of patients with pelvic inflammatory disease had improved in accordance with the recommendations and standards and BASHH guidelines since an initial audit in 2016.

	2016	2017
Pregnancy was excluded	45%	72%
Offer of written information documented	11%	12%
Correct antibiotics prescribed	57%	98%
Partners attended treatment	<1%	16%

Results from this audit have been shared broadly and individually with staff. Further actions include education to staff to improve documentation, signposting and partner notification.

Physical Health monitoring and medication review in people with Learning Disability

A national Prescribing in Mental Health Audit in 2015 showed that in some areas of physical health monitoring for those with learning disabilities were not being met. In January 2018, this audit was repeated, and improvements have been made across all of the standards.

	2015	2018
Indications for treatment with antipsychotic medication documented	96%	100%
Annual reviews for patients on antipsychotics undertaken	98%	100%
Antipsychotic side effects reviewed annually	80%	97%
Patients with measurement of		
a. Weight	40%	90%
b. Blood pressure	30%	83%
c. Blood Glucose / or HbA1C	20%	57%
d. Lipid Profile	30%	50%

Dragon's Den is a fund for small scale innovation projects identified and designed by staff. Applicants can apply for up to £10,000 to invest in, pilot and evaluate an innovative idea in their service. Each funded project is assigned a corporate sponsor to support them with issues such as IT, procurement and evaluation.

Dragon's Den has run eight panels since June 2016, received 37 applications and approved 22 projes. This has resulted in 16 funded projects that have been delivered or are underway – a number of projects have been signposted for support elsewhere.

Feedback on Dragon's Den has been positive – as a result of suggestions, we are putting in easier processes and guidelines on how to claim funding, and the procurement process.

"Brilliant support and encouragement. Really great, very motivating to have this to develop new innovative services. Great to involve a whole team as well."

"Everyone on the panel and since have been very encouraging and positive and although it may appear a little scary I would encourage others to have a go if they have an idea for service improvement "

"We have been really pleased to be able to deliver this treatment for a condition for which there is very little to offer in terms of treatment".

Health passports for adults with learning disability

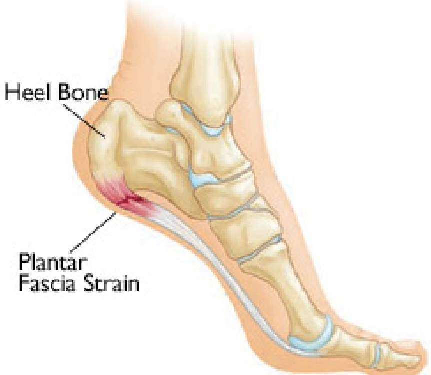
Health Passports in accessible formats have been developed in partnership with service users and carers in the learning disability service. The aim is to help service users co-ordinate care they receive from multiple agencies, and to have information readily available at additional hospital appointments. The passport was piloted, and now been printed up professionally for full distribution.

Lending libraries for sensory integration equipment in Learning Disability Services

A lending library of sensory integration equipment has been established to enable service users to trial equipment to see what is most suitable before they invest themselves. An accessible version of a lending agreement has been written, the equipment purchased and the library set up

Other services (Spinnaker, Jubilee, OPMH and Adult Mental health) are exploring the possibility of adopting a similar service.

Extra Corporeal Shockwave Therapy for the treatment of Plantar Fasciitis (Podiatry)



This bid was for a piece of equipment to deliver a new therapy (Extra Corporeal Shockwave Therapy) to patients with

"plantar fasciitis" that weren't responding to conventional conservative treatment had previous been offered either a corticosteroid injection or surgical opinion/ secondary care referral. This offered only short term relief of symptoms and included risks such as: infection, pain, rupture, skin depigmentation, fat pad atrophy and the potential for it to not work at all.
The team have used Dragon's Den to buy a machine to deliver extra corporeal shockwave (ECSW) therapy. This provides patients with a viable alternative and reduces the number of secondary care referrals. Currently the outcomes are being evaluated. To date, 28 patients have been treated, with no adverse events.

Community Outreach Bus – Sexual Health

The Sexual Health Promotion team have a bus which previously was covered in purple spots with 'Sexual Health' written all ove r it. It was rather conspicuous and they were getting feedback that this was preventing people using it. They have now used Dragon's Den money to make it white, and to buy some shelter so it can be used more widely across their services in community outreach. It has been used for community health promotion events, and also in partnership with the police to identify working girls and give them support and advice.

Positive Behavioural Support, CAMHS (Portsmouth)

The PBS (Positive Behavioural Support) approach has evidence-base as an intervention for reducing challenging behaviour (Gore et al, 2013), included in NICE guidelines. The team sought training to be able use this innovative approach with their young people, and then to deliver training to other local professionals. It was hoped that it would also support the development of the new clinical care pathway for challenging behaviour with integrated multi-agency teams.

The clinical team are currently undergoing the training – when finished, they plan to run courses to other professionals in the city. They are already running the parent workshop.

Pedometers in COPD

Some COPD patients struggle to attend their Pulmonary Rehab programmes as a result of agoraphobia, work/home commitments transport difficulties and dislike of group interventions.
The team wanted to offer these COPD patients a way of monitoring and encouraging physical activity at home with the use of pedometers. Pedometers can also be used for those patients being discharged from hospital and also for those attending Pulmonary Rehab to encourage them to continue with their exercise when not supervised.

The pedometers have been purchased and are being used – an evaluation of use and impact is underway in partnership with a research team at UHS. The pedometers are being used during Pulmonary Rehab . Several patients to date have purchased their own

after seeing the benefits of using something visual. From March the team hope to extend this as encourage pedometer use with post hospital discharge patients .

Production of a Mindfulness CD for staff and patients

A CD with 22 mindfulness tracks was produced in a professional recording studio at Solent University, involving a number of staff as the 'actors'. The cover was designed from the results of an art competition for service users.

To date, 2,309 double CDs have been ordered and distributed, and the CD put on Youtube. These videos have been played nearly 10,000 times all around the world

Students from Solent University will also be making short films of two former service users on 'How mindfulness helped me' to add to youtube. They will be doing this for dissertation projects so this will be free of charge for the trust.

Children's Eating and Drink Assessments in Clinic

Speech & Language Therapists receive referrals to assess children's ability to eat and drink safely (reduce risk of choking and food and drink entering the airway) and to develop their skills in eating and drinking. These children were traditionally all seen in the child's home, school or nursery. They used Dragon's Den to move the some assessments into clinic so that they could see more children in a day (5 rather than 3).

These clinics are now running in three locations across Hampshire, and attendance is good. Parents have been willing to come into clinic rather than have a home visit. A full evaluation is forthcoming.

Development of virtual reality to enhance exposure work in adult mental health

Many people experience phobias or other mental health conditions that make their inclusion in 'real life' difficult. Exposure to these 'real life' situations is key to therapy – this currently happens slowly because it involves real situations. This project proposes virtual reality for a first step to prepare people to cope with fears/ anxieties/ phobias. This is controllable, can happen anyway, can use real film and is very cost effective.

Before making the bid, Tom, the applicant did a small case study pilot on Sue. Sue is 54 and suffers from complex anxiety, suicidal thoughts and agoraphobia. She has barely left her house for 7 years. She has severe physical health problems and is obese. The ultimate goal was to get Sue out more, but the first step was proving very difficult. In this pilot, VR was used in her home (with real video of the doorstep and street outside her house. Early input of VR has seen that it becomes easier with time, and helps Sue cope with her anxiety. Tom says it means he has been able to speed up recover and therapy by a considerable margin, as it starts in the safety of the home.

Sue: "It's frightening, but once my anxiety is under control I'm more focused on what I can see with new eyes. I can appreciate the little things and I want to be in that place. It could do a lot of good"

The VR equipment has been sourced, and the Pt Systems team are working with the applicant to roll this project out.

Item 12

NHS Solent NHS Trust

Title of Paper	CEO Report – May 2018							
Author(s)	Sue Harriman, Chief Executive Officer							
Link to strategic Objective(s)	x Improving outcomes		x Working in partnership		x Ensuring sustainability			
Well Led KLoEs	W1 Leadership Capacity & Capability	x	W2 Vision & Strategy	x	W3 Culture	x	W4 Roles & Responsibilities	x
	W5 Risks and Performance	x	W6 Information	x	W7 Engagement	x	W8 Learning, Improvt & innovation	x
Date of Paper	18th May 2018		Committees presented		N/A			
Action requested of the Board	X To receive		For decision					

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

1. Statement on quality, finance and performance

This is covered in full within the integrated performance report.

2. Strategic update

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

The System Reform Review for Hampshire and Isle of Wight (HIOW) is coming to its conclusion and system partners spent a focused 30 hour period considering its implications and next steps. While there is still much to be considered and agreed, broadly there is overwhelming support for the integration of services around communities and the optimisation of our acute services across Hampshire. These two elements are fundamental principles in the Trusts established Strategy.

The work in the Portsmouth and South East Hampshire system has been established on these drivers for over 12 months and the Board has been intrinsically involved in this strategy from the beginning. This strategy is also emerging in the Southampton system, again with our Trust fundamentally involved. The STP System Reform Review advocates that these reforms happen at pace to enhance outcomes for our communities and while they must be designed for local needs they must ensure services for HIOW are fair and equitable.

System Partners in PSEH are now ready to make clear statements about their desire to work collaboratively and as such in Part two of this Board we will consider a Statement of Intent about how we can practically make that happen whilst always adding value to our services.

External engagement

The below provides some examples of recent key engagement activities the executive team have been involved in;

- The Executive Delivery Group of the STP met twice this month with all Health and Care leaders in HIOW as well as Leaders from NHSI and NHSE.
- The Trust has actively contributed to a number of multi-agency reviews conducted by CQC, PWC and Newton Europe. Outcomes will be shared when available.
- We have been engaging our partners over the last month regarding our Quality Account (QA) - including presenting to the Southampton Health Overview Scrutiny Panel on 26th April. Comments from our partners are incorporated into the QA, which is presented separately to the Board for approval this month.

In Southampton

- We have been working closely with colleagues from across the health and social care system to design and implement a more streamlined approach to driving the transformation programme, Better Care Southampton. A key part of this work has been getting system buy in and agreement to the appointment of a full time Programme Director, who has now been recruited and who starts on 21 May.

In Portsmouth

- Solent is embarking on a second year of Multispecialty Community Provider (MCP) transformation alongside Portsmouth Primary Care Alliance (PPCA), Portsmouth City Council (PCC) and the Clinical Commissioning Group (CCG). We have an exciting programme of funded transformation for the year ahead. In addition, we are providing infrastructure support to the business of PPCA.
- We are about to begin the development of our new neighbourhood model using an interventionist approach alongside the city council. This development in adult services will be critical to expanding the capacity and capability to keep people safe and well at home.
- We have begun conversations with PCC about the future funding profile for 0-19 services, focusing on infrastructure and overheads in the first instance.
- We are also working closely with Southern NHS Trust and Northumberland, Tyne and Wear NHS Foundation Trust on the development of new pathways for mental health with an intensive couple of weeks of workshops underway. The aim of the 4 workshops is to propose designs for community mental health services that improve access to mental health advice and strengthen support in crisis. All workshops include NHS, Local Authority, third sector partners and people with experience of using services. At the conclusion of the design process in June – the proposals will be presented to Executives and senior leaders from the local health economy, to agree the next steps toward implementation.
- We look forward to establishing productive relationships with the new leader of Portsmouth City Council, Councillor Gerald Vernon-Jackson, and the new cabinet members, following the annual meeting on 15th May 2018.

Update regarding Board appointments

Chief Nurse Appointment

Following a successful assessment centre day on Wednesday 18th April, I am delighted to announce that we have appointed Jackie Ardley, who has been working with us in an interim capacity for the past four months, to the role.

Jackie has already built really strong relationships with people in our organisation. We are pleased that she has accepted the substantive position and we look forward to working with her to take the organisation from strength to strength. Jackie has a wealth of experience having worked in acute, community and mental health trusts, including Bradford and West Herts. Jackie has been a leader in the NHS for some time and was previously Director of Service Improvement at the National Institute for Mental Health, before joining us as our Interim Chief Nurse. She has a range of skills and knowledge in patient experience, quality governance, regulatory compliance and risk management. (Ref to BAF# 62 and 57)

Reflection on 2017/18 and looking forward

You can read more about our overall performance and our key successes during 2017/18 within our Annual Report which is presented separately to the May Board for approval. In particular I would encourage colleagues to read the Research and Improvement Annual Report which is annexed to the Quality Account, within the Annual Report, which highlights examples of where we have embedded our learning culture, examples of our research activity and how our Quality Improvement Programme is making a positive difference.

Looking ahead, we acknowledge that the future organisational form for Solent, as we are currently constructed, is unclear and that there is significant uncertainty in relation to the medium and long-term configuration of health and social care services within Hampshire and the Isle of Wight STP – this will undoubtedly become clearer during 2018/19 with the development of a System Reform proposal. We know that services will need to be radically transformed in order to ensure services are fit for the future – in terms of ensuring enduring quality and safety, meeting demand as well as achieving efficiencies.
Ensuring we are able to maintain 'business as usual', attract and retain an engaged workforce (building on the success of our staff survey results last year), remain a credible partner and continue to strive to achieve excellence in all we do, will be key for us during such times of significant change. We must not get distracted.

Ensuring that Solent provides great care, is a great place to work and provides great value for money remain our priorities.

Southampton and County Services

Adults Southampton

We continue to work with our commissioner colleagues review service specifications and to identify appropriate funding to ensure our community services are sustainable. (Ref to BAF# 59 and 55)

Primary Care / MPP service line

We are still experiencing difficulty in achieving the targets set within the Behavioural Change contract, largely due to challenges converting our activity into actual behavioural changes associated with addictive and ingrained behaviours. (Ref to BAF# 59)

We are continuing to liaise with our commissioners regarding the high demand we are experiencing within our Musculo-Skeletal Service (MSK) which is affecting our performance target, as well as high demand for diagnostics which is causing cost pressures. (Ref to BAF# 59)

The introduction of a text messaging service within our GP Surgery is having a positive effect and we have seen a decrease in patients who do not attend appointments as patients are now able to cancel via text rather than phone.

Children and Families (West)

A fully integrated service for children aged 0-19 in Southampton has now been established and is being mobilised following the formal signing of the Section 75 agreement between Solent NHS Trust and Southampton City Council.

Our Child Outreach Assessment Support Team (COAST) remains closed. The small team (3 nurses) is vulnerable to absence, and a combination of vacancy, planned leave and sickness has meant that we were unable to deliver a service. In early May we shared a number of options for future service provision with Commissioners and they have asked us to further analyse two of these. (Ref to BAF# 55 and corporate risks register concerning staffing)

We have identified options on ways to provide a better service for health checks and assessments for Looked After Children placed in other areas of the country. We will be discussing these over the next few weeks with our system colleagues.

Our performance against the 18 week target for assessment of children and young people referred to the Children's and Adolescent Mental Health Service is continuing to improve, achieving 72% in March against the 90% target.

Sexual Health

The service continues to deliver well and is performing above expectation in both Southampton and Portsmouth – as a result we are in discussion with commissioners accordingly.

Special Care Dental Services

Our waiting times are becoming a concern with demand being greater than our capacity to deliver our service and we continue to seek options with partners for theatre space to allow us to provide care to those who need dental services under General Anaesthetic. (Ref to BAF# 59 and corporate risk register concerning clinical care)

Portsmouth System

Maples

An incident on 8th May has resulted in the closure of the unit for urgent and significant estates works. The 136 suite is also temporarily closed. A full mitigation plan is in progress with daily updates to executives.

Staffing

- Staffing pressures in mental health are partially mitigated by well-trained agency staff, and good recruitment from September and the development of the advanced nurse practitioner roles and assistant practitioner development programme.
- A challenge in recruiting to permanent posts across community children's services is being mitigated by the use of additional agency staffing and daily huddles. Service transformation is underway to create a more resilient

children's community service by ensuring that staff skills can be deployed across a wider range of settings, rather than in small specialist teams.

- Locality team reported turnover remains high (above 25%), on a rolling 12 month basis; however sickness levels have improved over the past six months – including the winter period – and staff survey results showed good and improved engagement. The professional lead is continuing to undertake an analysis of reasons for staff leaving. (Ref to BAF# 55 and corporate risks register concerning staffing)

Mental Health estate

Mental Health services have commissioned an external inspector to review current mitigations and estates work to date and suggest any further actions that could be taken to improve compliance and in addition are being advised by Sussex Partnership Trust on roof anti-climb measures with proposals for capital bids to carry out any necessary additional work. (Ref to BAF# 27 and corporate risks register concerning estates)

Portsmouth Looked After Children (LAC) Health Assessments

The service has completed a capacity and demand analysis of Looked After Children (LAC). A change to the referral to assessment clocks now starts on receipt of referral by Solent in line with the national standard. In the March reporting period this would have led to full Key Performance Indicator (KPI) achievement. Portsmouth CCG have also agreed to the funding of additional Paediatrician sessions in order to address underlying capacity issues and additional locum capacity has been sourced. The service intends to deploy a specialist nurse practitioner time to fulfil some of the physical health assessment duties, with a view to them beginning this work in September 2018, following specialist training and development.

Health Visiting Performance

During that latter half of 2017/18; Solent and CCG Commissioners negotiated new Health Visiting KPIs, based on a more targeted offer – focussing on families with greatest need. This has required staff training, planning for new types of delivery models and the collection and reporting of new data sets. At present, not all KPIs are being reported accurately, due to data definitions and extraction problems and some new KPIs are still being progressed towards. However, the service are confident that the current reported performance does not reflect any safety or quality deficits in delivery and commissioners are continuing to be satisfied with the development of the service. The service changes are backed up by a comprehensive set of quality indicators (including soft intelligence) to detect any emerging clinical risk. A plan for data quality improvement is being implemented between the performance team and service line and will begin to show increasingly more accurate outputs as the year progresses. (Ref to BAF# 59)

Portsmouth Adults – Speech and Language Therapy (SALT)

This service was subject to contractual changes in 2017/18 that resulted in the provision being split between Portsmouth Hospitals Trust and Solent NHS Trust. Solent retained only 9 staff, in a community focussed service. During 17/18, referral demand has outstripped capacity and in March 2018, 15 patients were waiting over 18 weeks for treatment, with the longest validated wait (one patient) now being at 42 weeks. Patients are effectively triaged into 5 priority categories to minimise clinical risk and waiting lists are reviewed weekly. There is an emerging consensus amongst all parties that some smaller services, including SALT should be delivered by Solent and Southern Health FT together in Portsmouth and South-East Hampshire. Meetings will take place in May and June between NHS partners to further develop proposals. (Ref to BAF# 59)

Portsmouth and South-East Hampshire Systems update

Winter-related pressures in the Portsmouth and South East Hampshire system have eased considerably throughout April– with an overall systems trend toward OPEL1 (Green) and elimination of all escalation beds within the hospital. The proactive work of senior Solent managers and good co-ordination with City Council partners has led to Medically Fit for Discharge (MFFD) levels being maintained at the lowest levels recorded at Queen Alexandra (QA). Capacity and demand analysis across the system is now underway to understand a sustainable out of hospital model.

Finance

A good start to the financial year has been achieved with an adjusted deficit of £137k (plan deficit of £244k).

Estates

Following the announcement of Wave 3 Capital for the St Mary's and St James' redevelopments, work is nearing completion on finalising the designs and placing of orders.

The outline business case for the redevelopment of the Western Community Hospital is with NHS Improvement for approval.

ICT

We have been experiencing significant disruption to our business e-mail functionality over the past few weeks. Clinical systems have been unaffected, but the disruption has caused frustration with the system being extremely slow or unavailable at times. We continue to work with our IT partner, CGI to resolve the technical issues - CGI are creating a brand new e-mail architecture for the Trust in order to resolve the problems and we anticipate being back to normal within a couple of weeks once that set up has been built, tested and all users have been successfully migrated. We are continuing to communicate with staff. (Ref to BAF#13 and corporate risk register concerning IT)

3. Current news

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

4. Complaints

This report has been written following an extraction undertaken by the Solent Patient Advice & Liaison (PALs) and Complaints Service on 01 May 2018 of complaints data received during April 2018.

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

- 19 formal complaints, MP Queries, or Professional Feedback
- 37 service level concerns.
- 56 advice and signposting requests and
- 51 plaudits

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

Service Line	Formal Complaint	MP Query	Professional Feedback	Total
Adults Portsmouth	2	1		3
Adult Mental Health	1			1
Adults Southampton	3			3
Children's Services	6			6
Sexual Health Service	3		2	5
Specialist Dental	1			1
Total	**16**	**1**	**2**	**19**

There were 24 themes recorded amongst these complaints, and they are detailed in the table below;

Appointments	2
Attitude	4
Clinical	11
Communication	7

There has been a significant change to the number of complaints received in the last two years, which is partly as a result of the continuing emphasis placed on resolving complaints at a local level and as a result of the increased levels of reporting by service lines.

	2016/17	2017/18
Total Number of Complaints Received:	253	195
Total Number of Service Level Concerns raised	255	402

At the end of April 2018 there were

- 39 open complaints.
- 13 complaints were closed in the month.
- 2 of the complaints were closed as not upheld,

- 2 were closed as partially upheld, 6 were found to be upheld,
- 2 complaints were closed as withdrawn as no consent was received and
- 1 complaint was withdrawn by the complainant.

Learning from April's closed complaints includes the following:
- The Mental Health service are developing a carer's engagement strategy to address concerns that may arise during the discharge process.
- The Sexual Health service is reviewing the process for maintaining their website during periods of staff leave. This is to ensure changes and developments to clinic times are updated.
- Within Primary Care the Pain Management Service will be offering greater support and advice to GPs to ensure that patients' are appropriately referred to them.

During April 2018 an Always Events® was held in respect to involving patients' who have gone through the Complaints Process so that the team can learn from their experience, and work in partnership to improve the experience of people who access Solent's PALS and complaints service.

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

A summary of the significant business transacted and matters discussed at the TMT meeting held on 25th April is as follows

- The Committee received an update concerning the development of a Community Engagement Framework, which is due for agreement at the July Board meeting.
- A workshop on 'Working Culture Change' was held led by Lesley Munro, Programme Director where Lesley was joined by two front line staff members who reflected on their experiences of using mobile technology. The group reflected on learning and actions to be taken including the establishment of a mobile working group.
- Exception reports from reporting groups were received including notably;
  - From the COO Portsmouth and SE Hampshire who highlighted the improved urgent care system position and Solent's contribution. A progress report presented to Portsmouth CCG on 'Delivering the Portsmouth Blueprint Commitments' was shared
  - A workforce update was shared, including the positive impact of the staff flu vaccination programme and subsequent reduction in days lost due to sickness.
  - From the ICT Group where TMT were informed of an asset investigation currently being undertaken in relation to laptop identification and storage capacity issues concerning Outlook (email)
  - Other key operational matters are highlighted via the Performance Report.

An update of business discussed at the 23rd May meeting will be provided at the meeting.

6. Board Assurance Framework and Corporate Risk Register

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

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

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

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

Corporate Risk Register

The new Risk Management Framework has been approved by Board. Risk Management Training for all staff will be available on ESR by the 31st July. We will be beginning and ongoing face to face programme commencing in June. Managers will still be required to attend face to face training to use Ulysses, to log risks.

As of the 4th May there were 107 open risks on the Risk Register

Key Risks	
Clinical care	22
Estates and facilities	16
Staffing	19
Information Technology	15

There are 12 risks that are scored 15 and above, and of these:

- 9 relate to Clinical Services,
- 2 are the Board Assurance Framework risks and
- 1 risk relates to People services.

The clinical services risks relate to all service lines with the exception of Mental Health. The principle risks are:

- The safety of patients who are receiving home oxygen therapy but who still choose to smoke
- The provision of wheelchairs
- Services achieving financial balance
- Finding alternative venues for clinics

The two Trust Board risks relate to Workforce Sustainability and the Future Organisational function of the Trust. The People Services risk relate to a number of issues affecting our workforce.

Sealings - No items to report

Signings as reported to Finance Committee since last Board meeting

Solent as Provider (Service Line)	Commissioner	Description of service
Children and Families	Southampton City Council	Section 75 partnership agreement for the integrated provision of 0-19 services
Adult Mental Health	NHS Portsmouth Clinical Commissioning Group	Main CCG Contract – Funding for increased staffing on PICU (Psychiatric Intensive Care Unit) on Maples and 136 Suite.
Sexual Health	Hampshire Hospitals NHS Foundation Trust	Provision of Pathology Services
Sexual Health	Hampshire Hospitals NHS Foundation Trust	Provision of Pathology Service

Sue Harriman
Chief Executive

Item 13

Presentation to	X	In Public Board Meeting			Confidential Board Meeting		NHS Solent NHS Trust	
Title of Paper	Six Monthly Board to Floor summary							
Author(s)	Ellie Lindop			**Executive Sponsor**	Jackie Ardley, Chief Nurse			
Date of Paper	21st May 2018			**Committees presented**	---			
Well Led KLoEs	**W1** Leadership Capacity & Capability	x	**W2** Vision & Strategy		**W3** Culture	x	**W4** Roles & Responsibilities	x
	W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement	x	**W8** Learning, Improvt & innovation	x
Action requested of the Board	x	**To receive**		**For decision**				

Overview of Board to Floor Visits

Over the last six months the Board to Floor visits six visits have been completed , as well as Board members being involved in the Quality Review week that has held in November. One visit had to be cancelled at short notice due to staff shortages on the day and the service was not able to accommodate the visit. All the visits have noted a high quality of care, dedicated staff and the hard working teams across all the teams. The visits have been 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.

After each visits a report is produced and is approved by those completing the visit. The report is shared with the service .The reports identify areas of good practice as well as areas for improvement. The Service is then asked to discuss the report with the team, discuss any findings and produce an action plan to address the findings.

In the last six months   the following service lines were visited, Adults Southampton, Adults Portsmouth, Primary Care , Special Care Dental and Adult Mental Health. A timetable for fun confirmed and Board members have these commitments in the diary.

Board Visits:

Portsmouth's Turner centre

This included the Community neurological rehabilitation team (Adults Southampton) and pulmonary rehabilitation and Oxygen at Home teams (Adults Portsmouth).

Community Neuro Team, the Board noted the following positive areas:

- excellent awareness of best practice and up to date knowledge of current treatment/drugs/intervention's
- evidence of compassionate and sensitivity towards patients and good multidisciplinary working arrangements.

An area highlighted as a challenge was that the specialist nurses' workload included interventions that are not currently commissioned, which then had an effect on the actual commissioned work.

When visiting the Pulmonary rehab and Oxygen at Home team the Board noted

- positive feedback from patients and carers
- clear risk assessments undertaken and
- good awareness of research and national guidelines.

There challenges centred around staffing levels, the complex referral processes and the practicalities of working with the Turner Centre .

The Service line has discussed these issues

<u>Southampton Community nursing team</u>

The Board recognised the

- The commitment and dedication of staff to provide a good service to their patients;
- good development opportunities and
- good internal team communication.

Areas highlighted as challenges included staffing and capacity; policy awareness for example lone working and awareness of the Whistleblowing and Speak up Guardians.

<u>Homeless Health care team</u>

The positive areas identified included

- clear dedication and commitment to this client group who lead complex and chaotic lifestyles;
- staff are clearly responsive to need and have excellent collaborative working partnerships with other providers including the acute sector.

Areas highlighted as challenges included future succession planning for the team lead and IT difficulties. An under reporting culture of incidents as staff "accepted" that they worked in a high risk area and didn't consistently report verbal and physical threats.

<u>Dental team in Eastleigh</u>

Positive areas highlighted included

- how enthusiastic and dedicated the team were;
- had a comprehensive induction programme and
- an effective DNA process.

Areas highlighted as challenges included FFT completion and future succession planning with a high number of dental officers due to retire.

Maples ward at St James

Positive areas highlighted included

- the warmth and compassion of the staff and provision of regular support and supervision to staff, especially in regards to physical and verbal aggression.

Areas highlighted as challenges included the continued programme of ligature points; environmental concerns including infection control issues and the need for staff to be able to access systems for other partners involved in joint care packages.

It should be noted that as a result of the recent closure of the ward the report following the visit is not currently being actioned.

The arrangements for Board to Floor visits have been strengthened however it has been recognised that assurance of the completion of action plans can be improved. In future Service lines will be asked to report and escalate any areas of concern to Quality Improvement and Risk Group

Item	14

Presentation to	Public Board Meeting							
Title of Paper	Trust Board Performance Report Part I– April 2018							
Author(s)	Alasdair Snell		Executive Sponsor		Andrew Strevens			
Date of Paper	18/5/18		Committees presented		Trust Management Team			
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy	x	**W3** Culture		**W4** Roles & Responsibilities	
	W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement		**W8** Learning, Improv't & innovation	

Executive Summary

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

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

Key Decisions/ Action(s) requested

To receive.

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Business Plan End of Year Report 2017 – 2018

Corporate Programme Management Office

By Aaron Scott and Matthew Rowsell

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1. The Solent Story

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

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

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

Our Business Objectives for 2017-18 were aligned to our vision of providing great care, creating a great place to work and delivering great value for money and this report provides an overview of Solent's performance against these objectives.

2. Executive Summary

Key points for 2017-18

163 Business Objectives with 660 milestones:

- Over 100 Business Objectives were successfully completed.
- 21 Business Objectives were closed and removed from the plans.
- 39 Business Objectives have been deferred to 2018-19.
- Out of a total of 660 milestones, 464 (70%) were successfully met.
- An average 61% of milestones were met each month.
- 68% of completed objectives aligned to Trust Strategy:

3. Objective Summary

3.1 Successes

Overall, 103 (64%) Business Objectives were completed by April 2018. This in turn meant that 464 milestones were successfully met and delivered. Of the 103 completed objectives, 33 (32%) were directly associated with providing great care to our service users.

Quality – The team implemented a competency framework and established a formal process for reviewing existing and approving new competencies for use in clinical areas across the Trust. The competencies are developed based on best evidence which results in delivering consistent standards and quality of care achieving better outcomes for patients.

Research and Improvement - A Community Research Partnership scheme was launched to increase access to research across Southampton and Portsmouth. This has enabled extra training for staff and the opportunity for 1000 people to be involved in trials. One piece of work on carriage rates and antibiotic resistance has led to a change in policy around vaccination rates and will lead to bigger studies in the future.

Sexual Health Service – The service developed an innovative, award winning web-chat facility for our HIV patients, improving access for patients who required advice. Due to the success of the web-chat facility, the Sexual Health service are now looking to roll this out in 2018-19 for the wider service so that this facility is available for all Sexual Health Service patients.

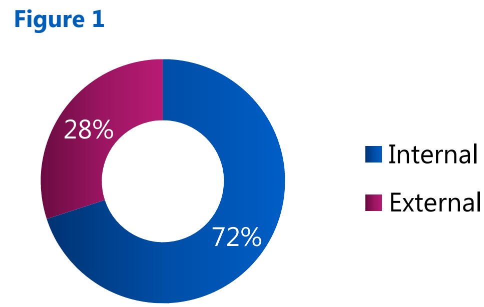
Specialist Dental Services – The service implemented accessible information tools for patients and staff to give a better experience and understanding of treatment for patients with accessible needs requirements. They produced materials for the clinics to use with patients and this has been a great success, embraced by both patients and staff.

3.2 Deferred to 2018-19

Following an end of year review, 39 (24%) objectives have been deferred to 2018-19. 11 (28%) objectives have been deferred due to external factors such as changes in specifications from CCGs, and STP alignment however, 28 (72%) objectives have been deferred as a result of internal factors including service line resources, change in priorities or pathway re-design, see Figure 1.

Within Primary Care Services, 6 of their objectives have been deferred to 2018-19. In particular, their proposal to integrate the pain service across 5 CCGs as fundamentally reliant on Southampton CCG and how they plan to shape the service specification, which is expected to be confirmed in 2018-19.

Figure 1



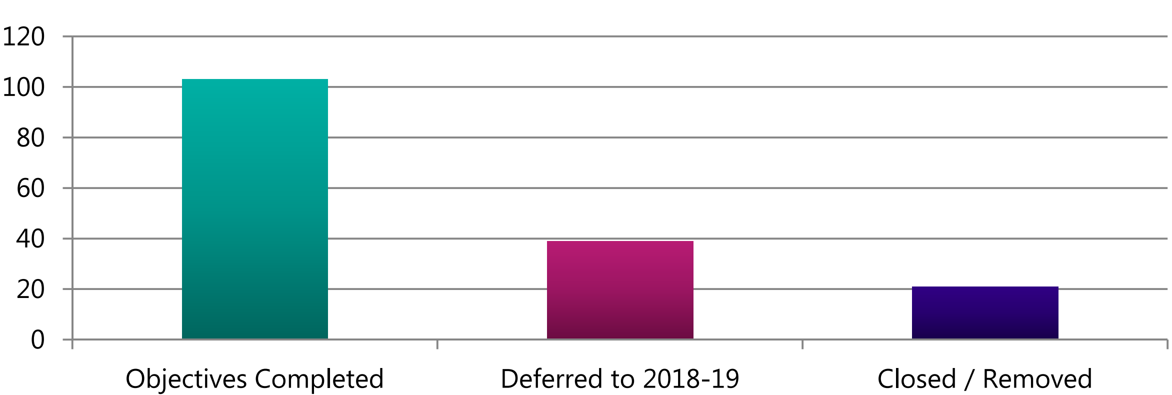
As highlighted above, some objectives have been deferred due to service line resources. As a result, improving staff retention continues to feature as a key objective for People Services in

2018-19, in order ensure we have the best people to provide quality patient care and improve patient experience and provide business support to service lines.

3.3 Closed/Removed Objectives

A total of 21 (12%) objectives were formally closed and removed from 2017-18 Business Plans following authorisation from the Chief Executive Officer and Director of Finance (see Figure 2).

Figure 2



In instances where a service line has changed direction strategically, a business objective may no longer be considered relevant in order to fulfil the overarching goals of the service line. An example of this was demonstrated in Adults Southampton service line whereby 8 (33%) of their objectives were formally removed from their 2017-18 Business Plans.

Adults Southampton originally intended to roll out 6/7 day working to support prevention and discharge models within the community rehab service. However, as this service specialises with ongoing rehabilitation, providing medium to long term services, there was limited evidence to suggest that it would have been more effective for this service to operate 7 days a week. Therefore, following a cost analysis project and discussions with Solent's Southampton partners, it was evident that this would have a negative impact on Solent's pay spend and deemed impractical to be the sole provider working to the extended week.

4. Additional 2017-18 Projects

4.1 Integrated Care Partnership

The CPMO are assisting the Integrated Care Partnership work which covers the Portsmouth area. This work brings joint working across local NHS organisations including, NHS Portsmouth CCG, NHS South Eastern Hampshire CCG, Southern Health NHS Foundation

Trust, Portsmouth Hospitals NHS Trust, NHS South, Central and West CSU, South Central Ambulance Service NHS Foundation Trust and Solent NHS Trust. The CPMO involvement will be to specifically provide PMO support to the Mental Health Programme and its contributing Projects.

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

4.2 Dashboard Creation

The CPMO is working alongside the Solent Performance and Business Intelligence Team to create Dashboards for Corporate Team Performance. 2017-18 saw the team create dashboards for the Human Resources Department, the Communications Team and the Finance Department and has also provided advice and guidance to the Estates Department on how to manage the key metrics generated in their department, using innovative infographics turning information into intelligence that is understandable by all.

4.3 Corporate Feedback Tool

The CPMO has developed a corporate feedback tool utilising SharePoint 2013 to enable the Trust to actively monitor Service Standards across all corporate support functions. By developing the tool in house using existing technology recently deployed in the Trust the team was able to save the costs of using an external agency to gather the information. The tool is due to be launched in Month 1 of 2018-19.

4.4 Quality Impact Assessments (QIA)

The CPMO team worked with the Chief Nurse to revise the QIA form and process. This simplified the mechanism of submitting the relevant form and conducting assessments. This process is going to be reviewed in the coming months to explore the possibility of placing the form on the Verto system (see below) and linking it with the project Management functionality to ensure that all projects go through the QIA process before proceeding through the next project gateway to strengthen the Trust's governance process.

5. Going Forward

5.1 Business Objective Focus

Following lessons learned from 2017-18, the guidance for setting 2018-19 Business Objectives was updated to be more robust. Service Lines were advised to have no more than 5 Business Objectives, with a common sense approach to the number of milestones for each.

This was to ensure that Objectives were more explicit and milestones were more Specific, Measureable, Achievable, Realistic and Timely (SMART).

The Solent NHS Trust Business Objectives for 2018-19 break down in the following way:

Figure 3

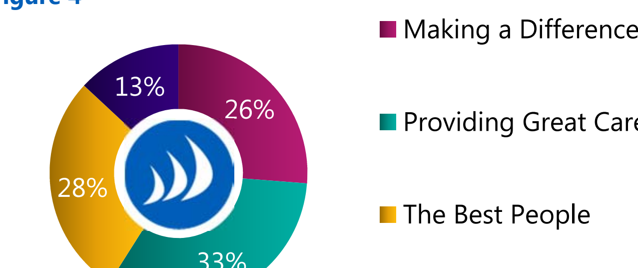
	Number of Objectives	Number of Milestones
1. Adults Portsmouth	5	24
2. Adults Southampton	4	14
3. Child & Family	5	11
4. Commercial	3	20
5. Dental	5	27
6. Estates & Facilities	5	28
7. Finance & Performance	4	17
8. People & OD	4	34
9. ICT	4	19
10. Mental Health	5	25
11. Primary Care Services	5	34
12. Quality	5	28
13. Research & Improvement	3	28
14. Sexual Health	4	45
	61	354

Figure 3 shows a reduction of 102 Objectives and 306 Milestones compared to 2017-18. This decrease will allow the Trust to focus on delivering quality objectives over quantity and will alleviate reporting volumes per month to enable clinical and corporate teams to focus on other initiatives. Objectives are now broader in scope but with more SMART milestones.

5.2 Alignment to Our Story

Our 2018-19 Business Objectives have been aligned to the Solent Story (see Page 3), thus ensuring our vision is at the heart of our business plans throughout all Service Lines and Corporate Teams. Figure 4 demonstrates how our objectives have encapsulated the 4 key themes of the Solent Story.

Figure 4



5.3 Verto

2018-19 will see the introduction of a new Project Management System called Verto to Solent NHS Trust. The system will enable Service Lines to record and manage their own Projects with the senior management and the CPMO able to maintain oversight. The system was chosen not only because of its Project Management functionality, but also its ability to record Business Objectives and their progress, as well as actions that arise from various meetings across the Trust.

2.1 Solent NHS Trust Performance Report - Operations — April 2018/19

Activity

			Same Period 2017/18
14,681	New Referrals in month*		12,973
56,998	Attended Contacts in month*		47,764
3,221	DNA'd Appointments in month*	4.3%	4.4%
41	Delayed Patients in month (DTOCs)		68
793	Delayed Days in month		2,448
14,027	Discharges in month*		17,090

Key Performance Indicators

202	KPIs due in month
163	KPIs achieved in-month

CQUIN Schemes

15	CQUIN schemes
64	Milestones due YTD**
35	Milestone Achieved YTD

1	Contract Performance Notices (CPN) open

* Data reported for Community and Mental Health Services only. IAPT, Substance Misuse and Specialised Services data not included.
**CQUIN Q4 submissioins are due to the CCGs on Friday 27th April 2018 - awaiting formal response.

Hotspots

- CAHMs & Paediatric Continence services. vacancies
- COAST Closure
- DTOC Admissions
- MCA Training Compliance
- Children's GA - increasing waiting list and capacity concerns.
- Pharmacy Consultation
- Wheelchair Delays

2.2 Chief Operating Officer Commentaries – April 2018/19

Portsmouth System

- A roadmap of the programme key milestones will be produced to describe to other stakeholders when elements of the new models of care in Portsmouth would be in place.
- Some outstanding issues relating to implementation of the new 24/7 integrated out of hours service have resulted in the go live being delayed by 1 month to July.
- Joint work with SE Hants, Fareham & Gosport, Portsmouth Hospital Trust (PHT) and SCAS is being completed on the data set to be used to monitor and evaluate the impact of the enhanced care home team projects.
- The MCP Board approved the 2018/19 finance plan for the MCP Programme, noting that some lines could only be 'budget' figures until business cases were agreed.
- The MCP Programme is contributing to the development of the Health and Care Portsmouth communications and engagement developments, including a new website to keep people informed and to enable them to contribute to the development of services in the city.

Portsmouth Care Group Hotspots

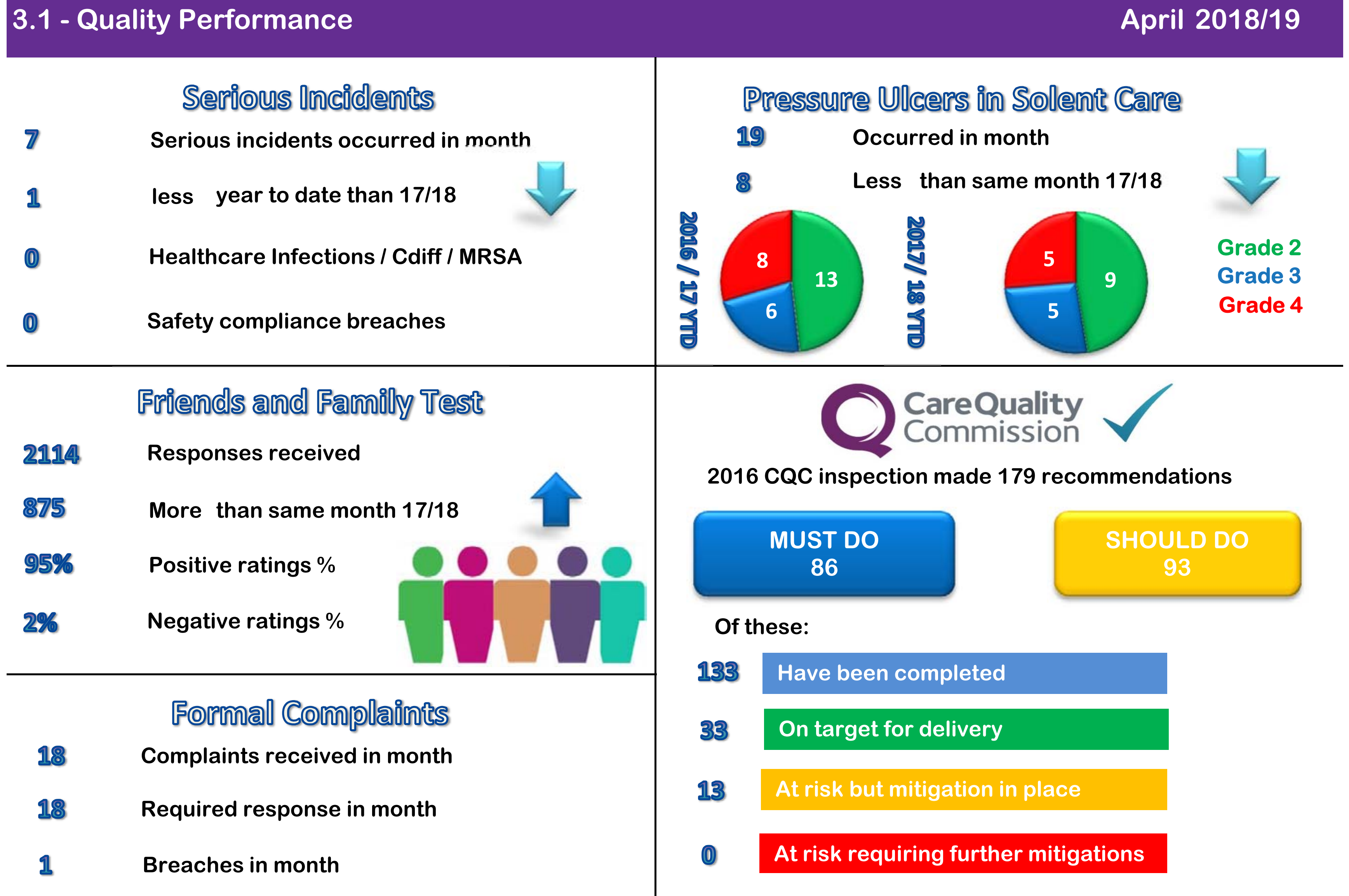
- MCA training compliance continues to be a concern for some services. Plans have been submitted to address non-compliance, which includes a proposal for additional face to face training.
- There is a continuation of inpatients with an existing delay being admitted into Solent wards as a bridge, transferred from the acute provider PHT. Discussions continue with commissioners as whilst the transfer is aiding system wide working, there is an impact on Solent.
- The future model and sustainability of our Pharmacy provision is currently under review - a Pharmacy consultation paper is due for discussion with directors in May.
- As discussed with commissioners, a number of CAHMs vacancies are being activity recruited to, but having an impact on waiting times as a consequence in the interim.

Southampton System

- In Southampton we have concluded a review of the Better Care programme governance structure, and from April 18 are governing the programme using the Better Care Southampton Steering Board and Better Care Southampton Working Group.
- We have successfully appointed a full time programme manager to help the system drive progress towards making the operating model a reality on the ground. The successful candidate will start work for the system from the end of May 18.
- At the April 18 Steering Board, the principles, concepts and broad direction for a future out of hospital operating model were agreed. Some details need to be added and agreed before the model will be brought through each contributing organisation's governance processes for sign off.

Southampton & County Wide Care Groups Hotspots

- The demand on our specialised paediatric dental services that require a general anaesthetic has been increasing month on month for the last 4 months. Demand continues to outstrip theatre capacity and the Trust are currently pursuing all possible opportunities to acquire additional theatre space.
- The establishment and mobilisation of fully integrated services for children 0-19 in Southampton between Solent and Southampton Council has now been formalised by signing a section 75 agreement between Solent NHS Trust and Southampton City Council.
- The Southampton COAST service continues to remain temporarily closed to new referrals. This service is commissioned to deliver via a very small team of less than 3 WTE making it vulnerable to staffing pressures. A combination of a vacancy and staff sickness has left the service depleted. The service continues to work with commissioners regarding future provision options, and have shared initial thoughts in early May 18 – as a result further work on developing two potential ways ahead is under way.
- Solent continues to work under the Contract Performance Notice for the Behaviour Change service; performance has improved markedly during 2018, albeit still falling short against the contract targets.
- Solent has a number of vacancies in Southampton CAHMs and Paediatric Continence services. Whilst service quality is being maintained it is having an impact on staff morale and continuing professional development (CPD).


3.1 - Quality Performance
April 2018/19
Serious Incidents
7 Serious incidents occurred in month
1 less year to date than 17/18
0 Healthcare Infections / Cdiff / MRSA
0 Safety compliance breaches
Pressure Ulcers in Solent Care
19 Occurred in month
8 Less than same month 17/18
2016 / 17 YTD
8
13
6
2017/ 18 YTD
5
9
5
Grade 2
Grade 3
Grade 4
Friends and Family Test
2114 Responses received
875 More than same month 17/18
95% Positive ratings %
2% Negative ratings %
CareQuality Commission
2016 CQC inspection made 179 recommendations
MUST DO
86
SHOULD DO
93
Of these:
133 Have been completed
33 On target for delivery
13 At risk but mitigation in place
0 At risk requiring further mitigations
Formal Complaints
18 Complaints received in month
18 Required response in month
1 Breaches in month

3.2 Chief Nurse Commentary - 2018/19 Month 01

Significant Events

There has been a significant event on Maples Ward with substantial damage being caused by a patient. Staff kept the remaining patients safe whist managing the situation extremely well. The ward has been temporarily closed whilst the damage is repaired and patients have been transferred to other units. The Chief Operating Officer (COO) and the Chief Medical Officer (CMO) attended the incident and are monitoring the management of the closure. No patients or staff were harmed during the incident.

Quality at a Glance – April Exceptions

Across the Trust we have seen a gradual increase in reporting trends for incidents and near misses from 6,589 in 2016/17 to 7,623 in 17/18. The number reported in Month 1, 575, is the second lowest in the last 6 months, and we will monitor this to ensure it doesn't become a downward trend. The percentage of patient incidents that are graded as moderate is the lowest for the last two months and is significantly lower than this time last year. 12 cases in Month 1 compared with 27 for the same period last year.

Within Mental Health Services, despite the increase in the number of patient incidents and an increase in patient acuity, incidents resulting in moderate harm or above has halved year on year for the last 2 years and the service has reported the lowest number of serious and high risk incidents in the last 6 months. There have been no patient harm falls that has resulted in moderate or above harm for the last 3 months.

The number of grade 3 and grade 4 Pressure Ulcers acquired in our care has declined over the last 2 months and we will continue to monitor this positive trend.

The reduction in the number of Serious Incidents not completed within 60 days continues to reduce and is below the lower control level for the first time in 3 months. This in an indication of the improved systems and processes in place across all service lines and within the Quality and Professional Standards Team.

The FFT response rate for inpatient wards has improved this month and appears as a spike in activity however this increase is due responses received after the March deadline and which have now been included. The total number of service line responses for FFT has been above the upper statistical control level for the second time in a quarter, and we have received the highest number of responses in month (2114) that we have ever received.

Staffing

A challenge in recruiting to permanent posts across many services remains the top rated risk within service lines. The situation is improving in Mental Health with the appointment of newly qualified staff that will join us over the coming months. We are looking closely at the level of staffing likely to be available across the GP surgeries (both GPs and ANPs) into the future, and are working to establish a baseline for safe staffing against which we can model and recruit into the future.

Pressure Ulcers Acquired in our Care

Despite increased overall patient contacts and an increased level of overall patient acuity in both Portsmouth and Southampton, pressures ulcers acquired in our care has reduced in both cities. Portsmouth Adult services reported a 16% decrease and Southampton a 15% reduction over the last year. Improvements in the levels of substantive staff, better comprehensive assessment and good learning from adverse events all appear to have contributed to this improvement.

ICT

Over the past few weeks, the Solent e-mail service hosted on Outlook has been unreliable, being unable to cope sufficiently with the volume and level of e-mail transactions being processed. The issue impacted on the e-mail system only and was more of an impediment to business than clinical practice, with no clinical systems affected and no patient incidents reported as a result of the issues. The CGI and Solent ICT teams have been working collaboratively to restore services which has received the highest level of visibility and escalation support from inside the CGI & Solent organisations, with all specialist resources drafted in to support key activities.

The project of work to re-establish appropriate asset management governance and control over laptop stock continues, with a report on progress due to go to Audit Committee this month. The immediate issue of being able to issue laptops to new joiners is now resolved.

The project to roll out improved mobile devices (ie smartphones), increase the number of smartphones in use and provide enhanced functionality (cameras, e-mail, calendar and apps - which will be released in phases) is on track with roll out now well underway.

Estates Issues within Mental Health

The ongoing actions and review of 'blind spots' on the wards is being progressed with a review by an outside expert which will also encompass a review of the roof issue. The service will then make a final recommendation to Directors with regard to the blind spots, roofing, garden issues and ligatures risks. The approach will then be discussed with our CQC Mental Health Lead Inspectors to ensure that they are fully aware of our plans.

Spiritual Support

The CQC recommended that we strengthen our spiritual support in our inpatient Wards in Southampton and we have been in discussions with Southern Health FT who have confirmed that they will support us with the provision of spiritual support across all our wards. We are in final discussions to bring this issue to a conclusion.

4.1 - Financial Performance April 2018/19

Performance

£137k **Deficit in Month**
£107k Favourable to plan

£137k **Surplus YTD**
£107k Favourable to plan

£1,000k **Deficit Year End Forecast**
£0k Achieving control target

Purchase Orders and Debts

Eligible invoices raised in month 831

790 Purchase orders raised in month

Purchase orders raised in month against eligible invoices 95%

£5,272,120 Total debt month end

£1,254,136 Total debt over 90 days month end 24%

Savings

£452,000 Savings Target YTD

£409,000 Savings Delivered YTD

£155,000 QIA Savings Delivered YTD

90% Savings Achieved

Capital Finance Summary

£142,000 YTD Spend

£12,713,000 Year end plan

100%
50%
0%

1.1% Spend against year end plan

4.2 Finance Commentary

Month 1 Results

The Trust is reporting an in month adjusted deficit of £137k for month 1, £107k favourable to plan. STF income of £80k is included for achieving the month 1 control total.

CIPs

CIP delivery in month 1 was £409k, £43k adverse to plan. The main cause of the adverse variance is due to growth funding in Mental Health Services which hasn't been included as awaiting confirmation from the CCG.

The £155k of CIP that was delivered and had been through the Trust's Quality Impact Assurance (QIA) process included any saving scheme that potentially could impact service delivery and was scrutinised and signed off by the Chief Nurse before going live. The remaining £254k savings delivered were made up of schemes such as contract tariff reductions or improved estates costs and will be put through the QIA process in the coming months for oversight and good governance; the majority of these have been through the initial stages of QIA with conditions attached. The Trust expects the QIA value to close significantly to the savings delivered value over the coming months.

Capital and Cash

Month 1 capital expenditure spend is £142k. Projects totalling £4.0m have been approved and in most cases are in progress.

The cash balance at 31 March 2018 was £9.2m.

Aged debt

Debt over 90 days overdue has increased by £366k month on month, at 30 April is £1.3m and at 31 March was £0.9m. Total debt overall has decreased month on month from £7.6m to £5.3m.

Invoices processed via PO

The Trust continues to promote the use of purchase orders when ordering goods and services. In month 1 the percentage of eligible invoices processed via a PO (rather than via Non-PO) was 95%.

5.1 - Workforce Performance — April 2018/19

There were **2,912.2** FTE in post this month, which equates to 3,524 staff in post.

An increase of **12.7** since last month

Bank and Agency

27,327 Hours requested in month

18,094 Hours filled by bank in month **£412,918**

7,923 Hours filled by agency in month **£308,861**

1,310 Hours requested not filled

In month, Solent are above agency ceiling by **£33,861**

84% YTD mandatory training compliance

36% YTD information governance training completed

10% YTD appraisals completed

100% medic appraisals completed, 100% job plan completion rate

10.0%
5.0%
0.0%

4.1%

Sickness & absence in month

Last month, the rate was **4.2%**

94.4% *budgeted establishment (FTE) worked in month*

5.6% *vacancy factor*

FTE Posts **173.6**

12 month rolling turnover is **14%**

54 (45.3 FTE) new starters in month

31 (22.9 FTE) leavers in month

5.2 - Workforce Commentary

Sustainable Workforce

Our vacancy factor for April as a Trust is 5.6%, which is an increase from the previous month in line with the start of a new financial year and new workforce plans. The Bank team continue to fill a high proportion of shifts that require cover, with 70% coverage in April. The year on year comparison of agency spend is once again lower in month 1, continuing the improvement from Q4.

There is a continued decline in the monthly sickness absence rate to 4.1% in April, with a sustained focus on attendance management. We have launched two new employee wellbeing initiatives; one is an online ACT course for stress management, which has received excellent feedback to date and the second is a replacement to the previous steps challenges in which participants collect healthy living points and virtually walk the Great Wall of China.

Learning & Development

The annual statutory and mandatory training compliance rate is 84% for April. The Information Governance competency has been reset for the new financial year and therefore the compliance rate has fallen to 36%. This is also the same for performance appraisals with a 10% completion rate.

The Adult Mental Health Workforce Transformation programme continues to progress. The new staffing model has been through the QIA process and the new Band 4 Associate Practitioner role is out to advert. This role will act as a bridge between the Health Care Support workforce and Band 5 Registered Nursing. This will enable increased opportunity for career progression, improved skill mix and task allocation with an overall emphasis on reducing reliance on agency cover.

Leadership, Culture & Values

A number of intact (bespoke and delivered in situ) organisational development programmes have kicked off with teams who have specific challenges and require additional support. The OD programmes consist of a range of interventions, the aims of which are to increase morale, improve leadership capability and drive individual and team performance.

Communication & Engagement

Communication activities have been focussed around our revised strategic narrative and how our people make a difference, as well as encouraging employees to share their stories. We have developed a suite of tools to help individuals and teams connect their own individual ambitions and team local plans to our priorities and 'Vision'.

There has been positive media and social media activity as part of our NHS 70 celebrations. Long serving employees, Ann Vestagaard and Sue Long, have recently been featured in The Portsmouth News, and Ann's NHS story saw significant engagement on social media (over 6k views). Meanwhile, Rose Bennett, a domestic assistant at St James' Hospital, was nominated by MP Stephen Morgan for an NHS70 Parliamentary Lifetime Achievement Award.

6.1 NHS Improvement Single Oversight Framework

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

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

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

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

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

Current Month Performance

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 continues to be the only concern across the whole framework. The liquidity in month Finance score continues as a 2 for the fourth month in a row which is positive.

April saw a decrease in the position for the Mental Health metric that measures the first episode of psychosis begins treatment within 2 weeks of referral. However a position above target was maintained. Friends and Family Test remains under the target for Mental Health, but Community scores remain consistently above the target.

Quality of Care Indicators

Organisational Health

Internal aspirational thresholds are highlighted in grey

Indicator Description	Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Staff sickness (in month)	4%	4.1%	4.1%	4.3%	4.8%	4.6%	4.9%	5.2%	5.1%	5.2%	4.3%	4.2%	4.2%
Staff turnover (rolling 12 months)	12%	15.3%	15.1%	14.8%	14.8%	14.5%	14.2%	14.3%	14.4%	14.1%	14.4%	14.2%	14.2%
NHS Staff FFT	40%	-	64.4%	-	-	64.1%	-	-	-	-	-	-	-
Proportion of Temporary Staff (in month)	6%	5.9%	6.1%	6.1%	6.4%	5.8%	5.7%	6.0%	6.1%	6.0%	5.9%	6.0%	5.6%

Caring

Indicator Description	Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Written Complaints		21	22	14	16	17	11	19	16	18	22	20	18
Staff Friends and Family Test Percentage Recommended - Care	80%	-	83.0%	-	-	82.3%	-	-	-	-	-	-	-
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Scores from Friends and Family Test - % positive	95%	95.7%	95.1%	97.8%	95.2%	95.0%	96.0%	97.0%	96.6%	96.2%	96.2%	95.9%	95.4%
Mental Health Scores from Friends and Family Test - % positive	95%	88.1%	87.1%	100.0%	90.5%	83.3%	85.4%	91.3%	83.3%	95.6%	84.3%	80.5%	74.7%

Effective

Indicator Description	Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	100%	100%	100%	92%	100%	98%	100%	100%	100%	100%
% clients in settled accommodation		69%	68%	69%	70%	72%	72%	71%	71%	71%	70%	71%	74%
% clients in employment	5.0%	6.6%	6.0%	6.0%	5.0%	5.0%	6.0%	6.0%	5.0%	5.0%	5.0%	5.2%	4.4%

Safe

Indicator Description	Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-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	1	0	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95%	100.0%	97.0%	99.0%	98.0%	97.0%	100.0%	97.0%	97.0%	96.0%	95.0%	92.0%	91.0%
Clostridium Difficile - variance from plan	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile - infection rate	0	0	0	0	0	0	1	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	-	-	-	-	-	0	0	0	0	0	0	0
Escherichia coli (E.coli) bacteraemia bloodstream infection	0	-	-	-	-	-	0	0	0	0	0	0	0
MRSA bacteraemias	0	0	0	0	0	0	0	1	0	0	0	0	0
Admissions to adult facilities of patients who are under 16 yrs old	0	0	0	0	0	0	0	1	0	0	0	0	0

Operational Performance Indicators

Indicator Description	Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	100.0%	100.0%	99.9%	99.8%	99.5%	99.7%	99.6%	99.7%	99.4%	99.4%	99.7%	99.5%
Maximum 6-week wait for diagnostic procedures	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Inappropriate out-of-area placements for adult mental health services -	0	-	-	-	-	-	0	0	0	0	0	0	0
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	71.0%	50.0%	86.0%	67.0%	83.0%	80.0%	88.0%	50.0%	40.0%	83.0%	100.0%	75.0%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%	-	-	-	-	-	97.7%	-	-	98%	97.4%	-	-
Improving Access to Psychological Therapies (IAPT) / Talking Therapies		-	-	-	-	-	-	-	-	-	-	-	-
- Proportion of people completing treatment who move to recovery	50%	60.2%	57.4%	57.3%	56.5%	61.1%	60.4%	57.8%	53.4%	57.8%	57.6%	58.2%	51.1%
- Waiting time to begin treatment - within 6 weeks	75%	99.8%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%
- Waiting time to begin treatment - within 18 weeks	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Finance Score

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

Indicator Description		May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Capital service capacity	Financial Sustainability	1	2	1	2	2	2	2	2	2	2	2	2
Score		*4*	*3*	*3*	*3*	*3*	*3*	*3*	*2*	*3*	*2*	*2*	*2*
Liquidity (days)	Financial Sustainability	-12.9	-12.5	-13.0	-12.9	-13.3	-12.7	-14.4	-15.4	-14.7	-10.7	-6.7	-6.2
Score		*3*	*3*	*3*	*3*	*3*	*3*	*4*	*4*	*4*	*3*	*2*	*2*
I&E Margin	Financial Efficiency	-1.9%	1.3%	1.4%	1.1%	0.9%	1.0%	-1.0%	-1.0%	-0.9%	-0.7%	0.4%	-0.9%
Score		*4*	*2*	*2*	*2*	*2*	*2*	*4*	*3*	*3*	*3*	*2*	*3*
Distance from financial plan	Financial Efficiency	-0.5%	0.0%	0.1%	0.2%	0.3%	0.1%	0.0%	0.1%	0.1%	0.2%	1.3%	0.3%
Score		*2*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Agency spend	Financial Controls	25%	24%	25%	47%	40%	38%	38%	42%	42%	43%	38%	24%
Score		*3*	*2*	*2*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*2*

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

6.2 NHS Provider Licence - Self Certification 2018/19

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

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Regarding the financial position: For 2017/18 – The Trust achieved a £0.7m surplus (subject to audit) against an agreed deficit control total of £1.5m. Our External Auditor conclusion is awaited. For 2018/19 our agreed control total is £971k deficit Internal control processes has been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls. The Board is not aware of any other departures from the requirements of this condition.	Concerning CQC compliance: We continue to address actions and monitor compliance with requirements made following our 2016 comprehensive inspection and subsequent inspections.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. Concerning Board level capability – All positions are substantively filled and qualifications, skills and experience are taken into consideration together with behavioural competencies as part of recruitment exercises for any vacancy. The Executive team will be undertaking a 360 degree team appraisal during Q1 2018/19. Established escalation processes allow staff to raise concerns as appropriate.	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Integrated Care Partnership
Portsmouth and SE Hampshire
Urgent and Emergency Care Programme
Update to Solent NHST Board May 2018

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

'The What'

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

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

In order to deliver these objectives we committed to:

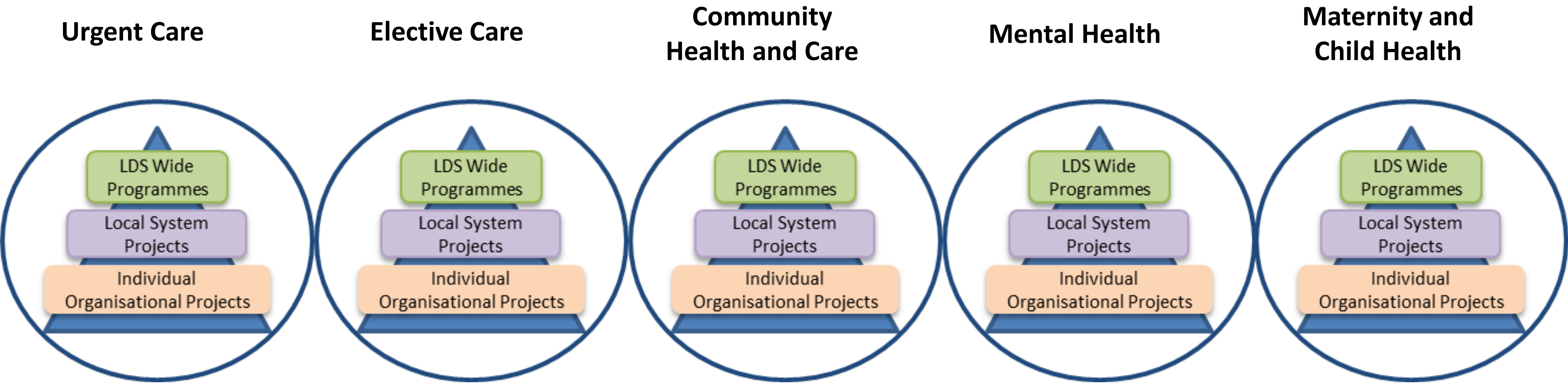
❶ **Agree and deliver a single system improvement plan** to restore and improve service quality, performance and financial health, with clear and agreed priorities. The immediate priority is to deliver significant improvements in urgent and emergency care performance.
❷ **Establish a new way of working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

'The How'

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

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

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



The PSEH Operating Plan:

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

PSEH LDS Operating Plan | Community Health and Care

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

Community Health and Care Programme

PSEH LDS

Local System projects

Individual organisational projects

Detailed in individual Organisational Operating Plans (See Annex A)

1819 Project Focus:

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

Deliverables:

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

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

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

Programme Quality and Performance Outcomes and Benefits

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

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

To improve flow, reduce LOS, reduce conveyance and admissions and reduce harm, enabling the system to meet A&E and Delayed Transfers of Care targets and optimise outcomes for patients.

Urgent & Emergency Care Programme

PSEH LDS

Local System projects

Individual organisational projects

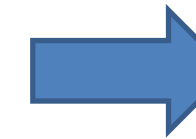
1819 Project Focus:

High impact change discharge actions

GP streaming in the Emergency Department (Urgent Care Centre)

Deliver new 111 integrated urgent care model

Detailed in individual Organisational Operating Plans



Deliverables:

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

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

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

Programme Quality and Performance Outcomes and Benefits

- Achieve ED access target by September 2018 and 95% occupancy on reduced bed base
- Improved patient experience with care being given in the right place at the right time – Home first wherever possible
- Delayed transfers of care – Reduced to 3.5% national target
- Reduction in excess beds days
- Inpatient admissions growth reduced by 2%
- Stranded and super-stranded reduced to 40% of inpatient population

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

High Impact Change Discharge Actions

Priority Actions

PRIORITY:- Embed SAFER and Red to Green across all wards

PRIORITY:- Embed single leadership and single team approach for IDS

PRIORITY – Embed Why not home? Why not today? - start by piloting new approach in one ward from May 2018

PRIORITY – Implement 5Qs to ensure delivery of new CHC guidance from October 2018

System

Complete Newton and PWC demand and capacity diagnostics

Streamline IDS processes

Implement proportionate assessment to support trusted assessor model

Embed choice and expectation policy as BAU by June 2018.

Portsmouth specific actions

- Establish in-house re-ablement team
- Pilot new way of neighbourhood team way of working
- Ensure sustainability of intermediate care model and investment to deliver D2A, alongside new way of working

Hampshire Specific Actions

Review role of ERS/CRT in line with Hampshire wide intermediate care strategy

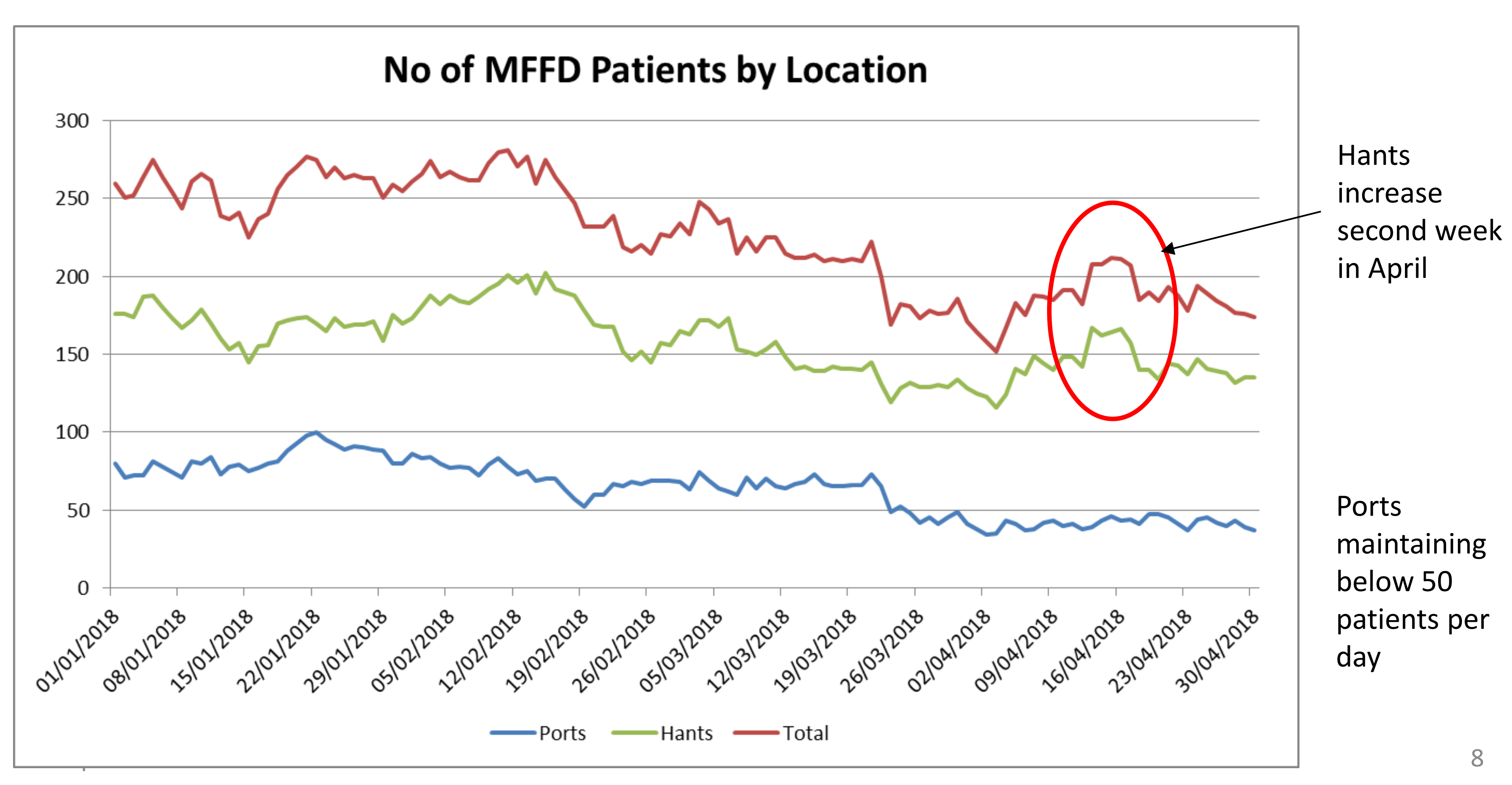
Address any home and care home capacity issues to better support D2A

Review community bed pathways to better support D2A

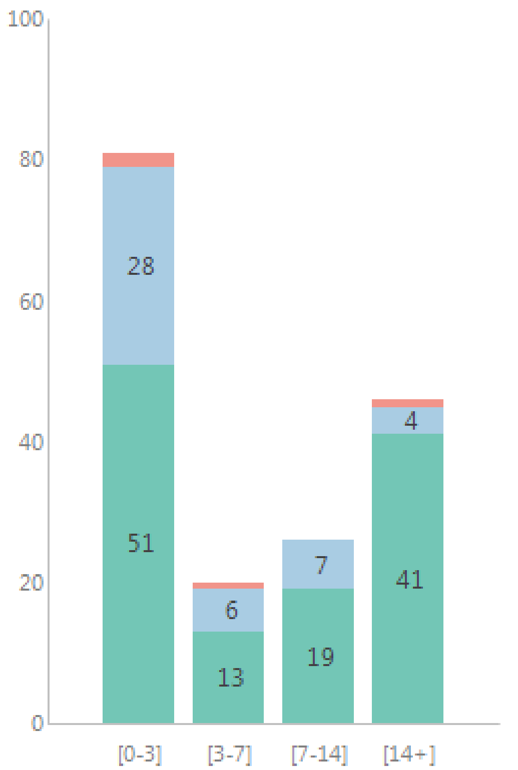
D2A- why not home why not today

High Impact Change Outcome
High Impact Change 1: - Early discharge planning. In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.
High Impact change 2 - Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.
High Impact Change 3 - Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.
High Impact Change 4 - Home first/discharge to assess. Providing short term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.
High Impact Change 5 Seven-day service. Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.
High Impact Change 6 - Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.
High Impact Change 7 - Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.
Change 8 Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

There is a reduction in the number of patients on the MFFD list



MFFD distribution numbers by days Fit to Leave



Comments

- A combination of improved complex and simple discharge processes is needed for acute care flow.
- The reduction in MFFD for Portsmouth and also in Hampshire has produced a reduction in PHT bed base but we are currently not able to quantify the ROI.
- We have experienced the best couple of months of sustained ED performance that most people can remember with only occasional poor days
- We need to make further progress to sustain the Portsmouth position and improve the Hampshire position this side of summer- options being considered for further outcomes based risk sharing agreements
- The concept of D2A is not yet business as usual
- Community health and social care integration is critical for delivery
- The development of the neighbourhood model is key to the future urgent care pathway with characteristics including proactive planned care, improved community emergency response, real alternatives to conveyance, the right capacity with a home first approach
- The 111 redesign is at an early stage but will be fundamental, and needs to firmly be embedded in the local community model.
- We need a planned patchwork of urgent care and urgent treatment centres across the system to ensure population coverage and clarity of provision.

Portsmouth and South East Hampshire Healthcare System

Portsmouth & South East Hampshire
Clinical Commissioning Groups

A&E Delivery Board

Performance Report

May 2018

Key Messages

- The following areas have improved over the April period:
    - PHT performance against the A&E 4 hour target
    - Reduced level of ambulance handover delays
    - NO 12 hour trolley breaches
    - Closure of escalation beds
    - Average number of patients on the Medically Fit For Discharge list (MFFD) remained below 200
    - Reduction in DToCs (2 weeks below the national target of 3.5%)

The trust were are OPEL 2 & 1 for the majority of April.

The chart below includes the OPEL rating of the trust per day.
OPEL 4 – 1 day
OPEL 3 – 3 days
OPEL 2 – 15 days
OPEL 1 – 11 days
The increase in OPEL status was the week following the Easter Bank Holiday which is where it had been anticipated there would be pressure on the system

April 2018

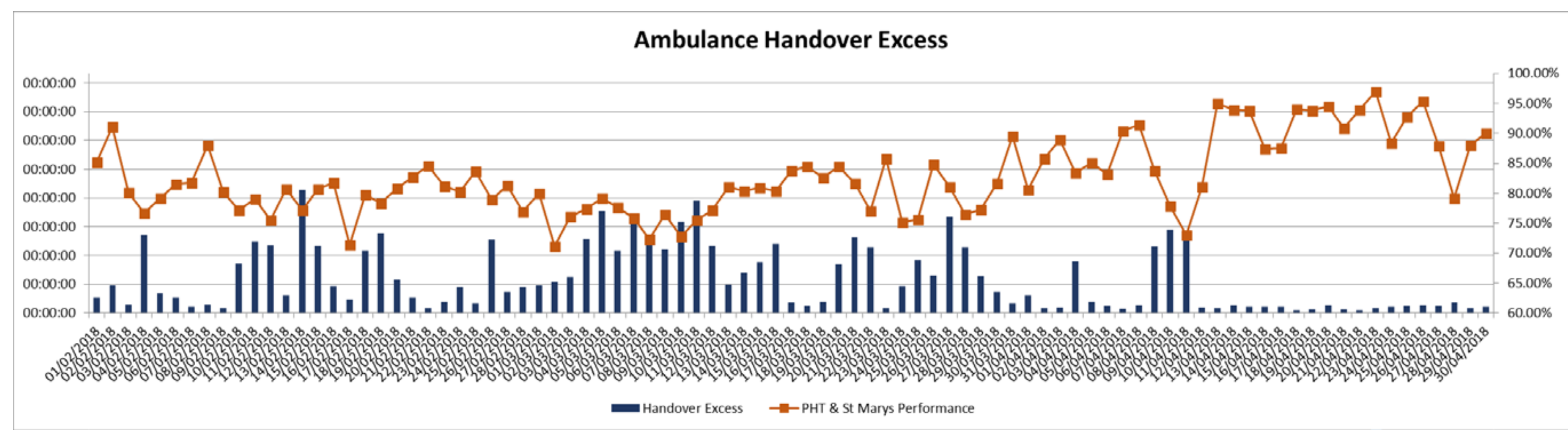
500
450
400
350
300
250
200
150
100
50
0

100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%

01/04/2018 02/04/2018 03/04/2018 04/04/2018 05/04/2018 06/04/2018 07/04/2018 08/04/2018 09/04/2018 10/04/2018 11/04/2018 12/04/2018 13/04/2018 14/04/2018 15/04/2018 16/04/2018 17/04/2018 18/04/2018 19/04/2018 20/04/2018 21/04/2018 22/04/2018 23/04/2018 24/04/2018 25/04/2018 26/04/2018 27/04/2018 28/04/2018 29/04/2018 30/04/2018

PHT attendances
Breaches
Admissions
Total Discharge
PHT & St Marys Performance

Ambulance handover excess was lower for the majority of the month of April compared to previous months



Ambulance Handover Excess April 2018

84:00:00
72:00:00
60:00:00
48:00:00
36:00:00
24:00:00
12:00:00
0:00:00

01/04/2018 02/04/2018 03/04/2018 04/04/2018 05/04/2018 06/04/2018 07/04/2018 08/04/2018 09/04/2018 10/04/2018 11/04/2018 12/04/2018 13/04/2018 14/04/2018 15/04/2018 16/04/2018 17/04/2018 18/04/2018 19/04/2018 20/04/2018 21/04/2018 22/04/2018 23/04/2018 24/04/2018 25/04/2018 26/04/2018 27/04/2018 28/04/2018 29/04/2018 30/04/2018

How can the number of patients medically fit for discharge (MFFD) be reduced?

Since the initial decrease in the number of patients on the Medically Fit For Discharge list reduced to <200 in March this has been maintained and further work needs to be undertaken for the reduction to continue.

MFFD

250
200
150
100
50
0

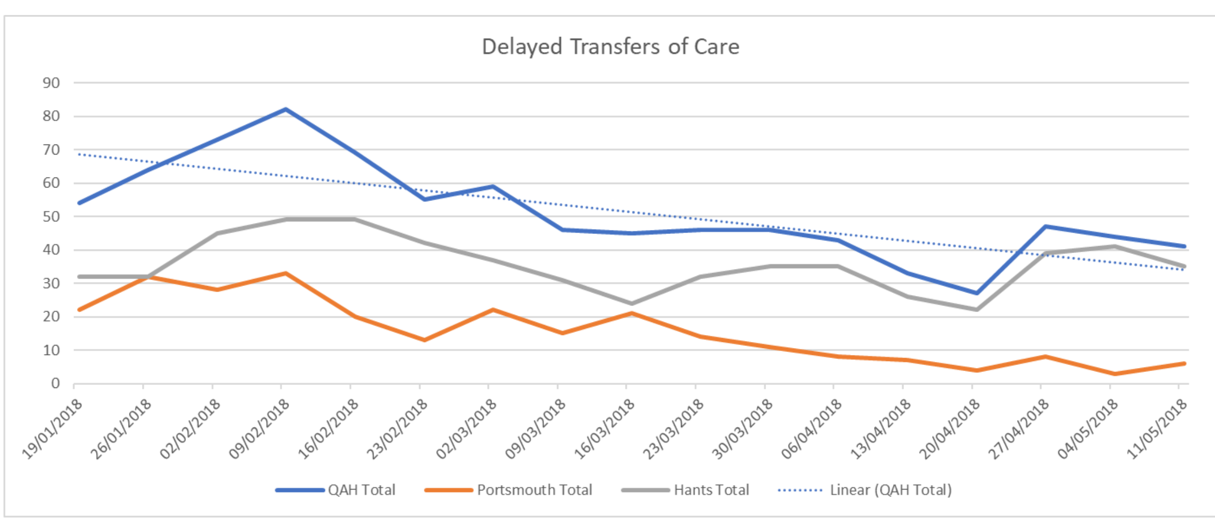
3500
3000
2500
2000
1500
1000
500
0

04/03/18
11/03/18
18/03/18
25/03/18
01/04/18
08/04/18
15/04/18
22/04/18
29/04/18
06/05/18

Portsmouth MFFD
Hampshire MFFD
IDS Led Discharges
Average Bed Days Lost MFFD

Portsmouth and South East Hampshire Healthcare System

Delayed Transfers of Care (DToCs)



- DToCs were below the national target of 3.5% for a two week period which has not been sustainable
- Newton Europe have been commissioned to undertake a piece of work to analyse DToCs within the Portsmouth & South East Hampshire system

	06/04/18		13/04/18		20/04/18		27/04/18		04/05/18		11/05/18	
	No	%										
Portsmouth	**8** Health – 5 Social - 2 Joint – 1	**0.84%**	**7** Health – 2 Social – 5 Joint - 0	**0.72%**	**4** Health – 2 Social – 2 Joint - 0	**0.44%**	**8** Health – 3 Social – 5 Joint - 0	**0.85%**	**3** Health –3 Social – 0 Joint - 0	**0.32%**	**6** Health – 3 Social – 3 Joint - 0	**0.64%**
Hampshire	**35** Health – 21 Social – 9 Joint - 5	**3.65%**	**26** Health – 14 Social – 9 Joint - 3	**2.41%**	**22** Health – 15 Social – 4 Joint - 3	**2.40%**	**39** Health – 23 Social – 10 Joint - 6	**4.13%**	**41** Health – 23 Social – 15 Joint -3	**3.55%**	**35** Health – 16 Social – 16 Joint - 3	**3.72%**
OOA					**Social - 1**							
Total	43	4.49%	33	3.38%	27	2.94%	46	4.61%	44	4.64%	41	4.36%

Quality Exceptions

PATIENT SAFETY

- PHT: improved position resulting in reduced overcrowding in ED and ambulance handover delays
- PHT: improved position on utilisation of escalation capacity, patient moves and patients outlied outside of admitting specialty
- **0** 12 hour DTA breaches reported for April and May to date.
- **0** serious incidents have been reported relating to the UEC pathway in May to date.
- **Solent:** no concerns identified in relation to patient safety that require escalation/reporting to the ED board.
- The system managed and where required recovered promptly from the Easter Bank Holiday and May Bank Holiday weekend; no adverese quality impact has been reported.

PATIENT EXPERIENCE

- ED FFT (March 2018): 95.3% would recommend compared to **93.3%** in February, **94% in January and 95.5%** in December. **1.3%** would not recommend compared to **2.2%** in February, **1.2%** in January and **2%** in December.
- The Emergency Departments' response rate compliance has not been sustained and further decreased to 10% in March compared to **13.6%** in February (target 15%)
- NHS Choices April: two items of feedback were submitted to the NHS Choices website in relation to emergency care:
  - *My son had a head wound which needed stitches. The staff were fantastic one nurse stitched his head . The staff are absolutely amazing.*
  - *From the moment I saw the navigator and they bleeped stroke team due to symptoms I felt safe. Receptionist was lovely and I was seen by stroke nurse specialist (lovely kind lady) A sincere and heartfelt thank you to all*

CLINICAL OUTCOMES

- No exceptions to report

STAFF

- All providers: continued high work pressures (potentially) resulting in potentially increased stress and staff resilience.
- PHT continue to report significant temporary staffing resource requirements to fill existing vacancies across all areas.

CQC UPDATE

- **PHT: 5** CQC requirement/enforcement notices remain in place.
- **PHT:** CQC report published 4th May 2018, following unannounced inspection February) outlining continued concerns and issues with the safe delivery of care in the urgent and emergency care pathway. The CQC undertook a further inspection in May and the trust received verbal feedback on 10th May.

  PHT to provide a verbal update at the May ED-DB.

OTHER

- No other exceptions to report.

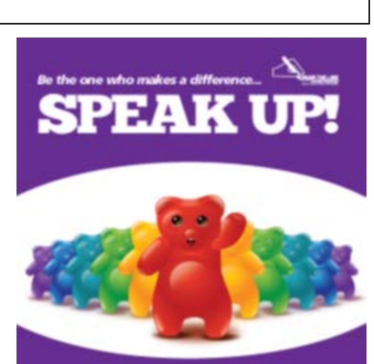
Portsmouth and South East Hampshire Healthcare System

Weekly Dashboard

		Target	04/03/18	11/03/18	18/03/18	25/03/18	01/04/18	08/04/18	15/04/18	22/04/18	29/04/18	06/05/18
ED 4hr Wait												
PHT 4 Hour Performance		95%	68.4%	65.7%	72.9%	73.3%	74.0%	81.5%	79.7%	88.2%	86.2%	86.6%
St Marys Performance		95%	100.0%	99.7%	100.0%	98.8%	99.9%	99.9%	99.1%	100.0%	99.5%	99.9%
PHT & St Marys Performance		95%	77.7%	75.7%	81.2%	80.3%	81.8%	87.0%	85.3%	91.8%	90.3%	90.3%
PHT No of attendances (daily average)			373	404	401	406	497	390	377	365	359	403
PHT No. 12 hour Breaches		0	1	1	4	3	2	0	0	0	0	0
PHT Type 1 Admissions			700	735	703	701	828	740	786	800	809	768
PHT Type 1 Conversion Rate		TBC	34.10%	33.50%	32.50%	31.80%	36.70%	34.0%	38.4%	36.60%	36.90%	35.10%
Average Daily Ambulance Handover Delays		<6h 30m	240h 43m	499h 04m	227h 00m	237h 47m	236h 49m	75h 45m	205h 02m	2h 12m	38h 40m	
No med pts waiting for bed in ED at 08:00		0	78	95	96	65	102	58	77	29	38	46
New Medical Model												
% of first Consultant Review <14 hrs	Med SSU	95%	81.9%	77.9%	83.9%	80.7%	85.8%	74.3%	74.7%	86.1%	76.7%	79.3%
	Med AMU	95%	70.4%	71.3%	67.6%	57.3%	71.6%	67.1%	82.9%	75.0%	75.1%	76.9%
Reduce LOS	Med	TBC	8	8	10	11	9	10	8	9	8	8
	MOPRS	13	14	19	10	17	12	12	14	16	18	13
AMU speciality triaged patients		<45	39	47	42	43	46	42	42	42	42	38
SAFER												
Escalation Beds		<15	29	37	42	34	22	12	17	1	2	2
Medical Outliers		<20	38	53	58	54	46	51	42	35	26	32
Discharges per day	Simple	>90		92	84	92	87	88	97	99	94	105
	Complex	25	14	18	18	19	19	14	19	20	17	18
No of Discharges before 09:00		TBC	24	28	26	18	25	21	23	29	30	21
% Patient Discharged before midday		33%	15.7%	19.1%	16.8%	18.2%	16.8%	16.2%	17.7%	16.6%	16.3%	15.6%
Stranded Patients (>7 days)		<400	513	506	507	512	492	498	477	454	458	459
Super Stranded Patients (>21 days)		<199	233	229	225	216	217	221	220	201	191	192
MFFD												
Average no of MFFD - All		108	237	230	212	196	175	181	202	196	186	178
Average no of MFFD - Portsmouth		36	70	67	68	58	43	40	42	45	43	32
Average no of MFFD -Hampshire		72	165	160	140	135	129	140	158	148	140	134
Average Bed Days Lost MFFD			3006	2645	2532	2217	1917	1981	1926	1743	1811	1879
IDS												
No IDS Led Discharges		176	99	123	124	134	130	97	138	148	128	134
DTOC												
PHT	Number	33	61	45	45	46	46	43	33	27	47	44
	%	3.50%	6%	5%	5%	5%	4.67%	4.49%	3.38%	2.94%	4.98%	4.64%

Item 16

You Presentation to	X In Public Board Meeting		Confidential Board Meeting				NHS Solent NHS Trust
Title of Paper	Freedom to Speak Up Board Report – May 2018						
Author(s)	Mandy Sambrook, Lead Guardian		Executive Sponsor		Jackie Ardley, Chief Nurse		
Date of Paper	16th May 2018		Committees presented		---		
Well Led KLoEs	W1 Leadership Capacity & Capability	x	W2 Vision & Strategy		W3 Culture	x	W4 Roles & Responsibilities	x
	W5 Risks and Performance		W6 Information	x	W7 Engagement	x	W8 Learning, Improvt & innovation	x
Action requested of the Board	X To receive		For decision				



The role of the Freedom to Speak Up Guardian is to provide independent and confidential support to staff that want to raise concerns and promote a culture in which staff feel safe to raise concerns. Over the past 12 months 46 staff contacted the Guardians with concerns and all cases were supported. All concerns were resolved locally. In addition, other activities have been undertaken to raise awareness of Freedom to Speak Up and to imbed Freedom to Speak Up within the Trust. The Lead Guardian has also contributed to the national and regional development networks in this area.

National Guardianship

<u>Board guidance now available</u>

This guidance has been produced jointly by the National Guardians' Office and NHS Improvement. It sets out expectations of boards and board members in relation to Freedom to Speak Up.

It also includes important guidance for Freedom to Speak Up Guardians on their relationship with Board members, and reporting to their Boards.

A self-assessment is currently underway.

- Assurance currently indicates the line of accountability and escalation is from the Lead F2SU Guardian to the Board which meets the national standard with ¼ reports to Board.
- National reports and guidance available on Intranet Page with all national Guardian guidance
- ¼ Updates reported through assurance committee.
- F2SU Steering Group None Executive Director and CEO Lead Guardian meet on a monthly basis to discuss exceptions and steer developments.
- Monthly meetings held with Chief Nurse and Lead Guardian supporting and reviewing any cases by exception and patient safety issues.

<u>National Guardians' Office publishes Q4 data</u>

96 percent of Trusts provided data this quarter.

The Q4 data headlines include:-

- 2,114 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions.
- 642 of these cases included an element of patient safety / quality of care.
- 1,027 included elements of bullying and harassment.
- 93 related to incidents where the person speaking up may have suffered some form of detriment.
- 366 anonymous cases were received.
- 16 Trusts did not receive any cases through their Freedom to Speak Up Guardian.
- 222 of the 232 NHS Trusts listed in our directory sent returns.

Case Reviews: National Office

As part of its work the National Guardians' Office reviews how a NHS Trust or foundation Trust has supported its workers to speak up, where it receives evidence that this support has not met with good practice.

The standards of good practice against which the NGO assesses the actions of Trusts are found in the Francis Freedom to Speak Up review and the standard, integrated Freedom to Speak Up policy published by NHS Improvement.

The National Guardians' Office is currently undertaking a 12 month pilot of its case review programme, which began in June 2017. At the end of the pilot it will review the process to see how it can be improved. It will use all the feedback it receives during the pilot, including from individuals who have referred cases, to ensure that the case review process meets the needs of all workers who wish to speak up.

The primary focus of a case review is on extracting as much learning as possible relating to how 'speaking up' processes and cultures can be improved and the likelihood of obtaining such learning is one of the principal selection criteria the National Guardians' Office applies when deciding which cases to review.

In August and September 2017 the National Guardians' Office conducted a review of the 'speaking up' processes, policies and culture at Southport and Ormskirk NHS Trust. This was because it had received information that the Trust's response to its workers 'speaking up' was not in accordance with good practice.

The National Guardians' Office publishes its case review reports on its webpages and ensures that they are shared with individuals and bodies with a direct interest in the review process. These include Trust workers who have contacted us about their 'speaking up' experiences, the Trust itself and regulatory bodies with responsibility for ensuring the Trust delivers care and treatment according to accepted standards.

Solent NHS Trust Guardians are currently reviewing the recommendations and findings from the Southport and Ormskirk NHS Trust, reviewing the good practice and any lessons that can be learnt.

Within three months the Trust should take appropriate steps to ensure that minority and vulnerable workers, including BME workers are free to 'speak up'.

When the recommendations from Southport and Ormskirk have been reviewed the Solent Guardianship will use them to help guide future developments for the next 6 months. The Guardians will also be undertaking an annual review and future scoping and planning for the next year.

The Freedom to Speak Up reviews could be undertaken within any Trust through the National Guardians' Office and will also be central to the CQC well-led inspection.

Solent Local Delivery

The role of the Freedom to Speak up Guardian is:-

1. To commence facilitation of discussion between staff and management, not to solve concern raised.
2. Promotion of the Role
3. Further develop a culture of openness and freedom for staff to raise concerns to their managers that will be explored and resolved and lessons shared.
4. Escalate and support

The current staffing framework has developed with the support from the board.

1 x Lead Guardian (Mandy Sambrook)

1 Appointed Guardian 2 days a week (Ian Scrase)

3 x Assigned Care Group Guardians

We will look to appoint more guardians when the new model is defined.

There is evidence at both local and national level that the role of the Guardian needs full commitment from the Guardian and the organisation. There is a current review underway regards the model of delivery now we have employed a guardian 2 days a week.

There is a plan in place being led by the newly Appointed Guardian which will enhance and promote the current structure and ensure that all staff are aware and have access to Freedom to Speak Up.

A current review of our service's knowledge of Freedom to Speak Up has demonstrated further work in marketing and promoting this area is required. A plan is being developed to ensure this is cascaded throughout the organisation and senior managers and executives are given the information required to help support the promotion of the role.

Guardians meet monthly; this includes supervision of cases from the Lead Guardian.

The F2SU is now part of corporate Induction and will be enhanced through the Appointed Guardian.

The Lead Guardian and Guardians represents the Thames Valley and Wessex Regional Network.

Service Areas

There is a clear line of escalation to the NED and Chief Nurse should the Lead Guardian feel that patient safety concerns require immediate attention.

The CEO and NED are briefed monthly by the Lead Guardian any concerns and themes being raised, highlighting any further support required to address the concerns.

All F2SU cases are in confidence and only cases relating to safeguarding will be shared outside of this framework. Staff will be encouraged to discuss with managers in the first instance if the case allows.

Where matters are not being taken forward internally the Lead Guardian can take the matter externally to the National Guardian.

Service managers will be advised of any concerns being raised, the Guardian will always ensure that the person 'speaking up' is supported to understand the concerns and guide them to the appropriate area for further escalation should they not be satisfied with the manager's response, either through the Guardian relationship or relevant support.

There is further work to be undertaken on raising concerns within the organisation in relation to evidence reported through surveys, SIRIS, complaints and quality reports. There needs to be further guidance within the organisation on how this will be managed going forward.

There will be a survey going out to staff that have used Freedom to Speak Up Guardians.

Annual Reporting

Quarterly Reports are submitted to the National Guardians:

Q1 10
Q2 9
Q3 14
Q4 13
Total Cases Raised 46

All cases were raised anonymously/confidentially from a manager

2 Patient Safety Concerns

75 % Element Harassment/Bullying/ Conflict

There have been two concerns raised regarding patient safety which were responded to within service, and any risks mitigated.

It is important to note there have been themes within concerns raised in all care groups. It is often noted that concerns raised are not in isolation and a theme of conflict during organisational change and management structures can often be the catalyst.

Within these themes was a view on the developing HR consultancy and mechanisms of support from HR, a report has been shared with the relevant manager and actions taken to address the gap. The Freedom to Speak Up Guardians have supported and directed staff with concerns regards process and wrap around support.

The Guardians are starting to go into teams where challenges have been noted and offering support, Jubilee House being an example, where staff had undergone an internal CQC mock inspection and

had highlighted they did not know how to ‘speak up’. Further support was offered to staff and visibility of the Guardian was central to promoting the culture of ‘speaking up’.

Feedback from Staff

Successes

Responsiveness of guardianship being able to support each member of staff that has accessed F2SU, with positive results:-

To date each case raised has been responded to therefore ensuring staff voices are heard.

Increasing visibility amongst services with pride and introducing F2SU Guardians at every opportunity is part of the role, this needs to continue to develop within the organisation at all levels.

Further communications and promotion of the role is required to ensure that there is equity across all areas of the organisation is challenging, however the commitment and appointed guardian are committed.

Item 17.1

Exception and recommendation report

Committee /Subgroup name	**Assurance committee**	**Dates of meeting**	17th April & 15th May 2018
Chair	**Mick Tutt**	**Report to**	Trust Board

Key issues to be escalated
The most significant risk issue discussed in this reporting period concerned the **temporary closure of Maples ward, our Psychiatric Intensive Care facility in Portsmouth** in early May, after an incident which culminated in significant damage. The May meeting received notification that partial re-opening would be possible from c.16th May and, following my visit to the Orchards Unit, shortly after the incident, I was assured that not only did the staff on-duty at the time respond in a thoroughly professional & confident manner – which ensured that, despite extensive environmental damage, no-one was harmed – but that approach has continued subsequently; in a calm, measured & proportionate manner; which means the needs of people on the ward at the time have been appropriately planned for Of significant note is that this ability to arrive at as-near-as a state of 'Business-as-Usual' was achieved in no small measure because of the co-operative and collective will of system-partners Further verbal up-dates will be available at the Board We received **drafts** of both the **Annual Governance Statement** & **annual Quality Priorities** at our April meeting and a **draft** of the **annual Quality Account** at our May meeting; all prior to their finalisation and presentation, together with the Annual Report and Accounts, at the May '18 Board meeting We considered **System-wide quality governance** requirements, at our April meeting; in the context of:- a) both Chief Operating Officers (COOs) regularly providing up-dates of – essentially – system-wide, as opposed to Solent-specific, risks and concerns within their exception reports b) a presentation, from the STP and Portsmouth & South East Hampshire system Quality lead at a recent Lay Member & Non Executive Governance group meeting We were assisted in this consideration by the presence of Quality leads for the CCGs in both cities. We have had regular attendance from Portsmouth for c.6 months, and this has now been enhanced by the attendance of a representative from Southampton at the April meeting We concluded that there still appeared work to do; to embed quality governance and have confidence in its maturity and robustness, at a system-level – and asked that the relevant Executives take responsibility for following this through We also concluded that, rather than ad-hoc reports from our COOs, we should have a standing agenda item; which would enable positive consideration of quality governance risks, beyond those of a purely Solent perspective The first system-wide agenda item was received at the May meeting and, largely, provided a more positive perspective from the Portsmouth & South East Hampshire system than that we have received over recent months

We were also informed, at the May meeting, that the STP and Portsmouth & South East Hampshire system Quality lead had 're-launched' the quality governance oversight, in Portsmouth & South East Hampshire system and we received confirmation of Solent representation at this forum
We will look, over coming months, to see how the processes in Portsmouth & South East Hampshire, and across the STP footprint generally, embed and mature

The May meeting welcomed our (previous) interim **Chief Nurse** (CN) as the **substantive appointment**; she and COOs provided escalation of a range of risks at both meetings, with:-

- some **emerging concerns regarding ligature risk and other associated work** undertaken and planned
- **on-going IT issues** which continued to impact on the quality of experience for people accessing services, and also creating concerns regarding the efficiency of the e-mail system

being the predominant concerns, and:-

- the **positive impact of the introduction of Associate Nurse Practitioners** within the mental health service and other approaches to considering a workforce which does not solely focus on 'professions-traditional-to-the-NHS'
- the evidence of a **culture of positive risk-analysis and reporting**, again within the mental health service
- changes in the way inwhich **Health Visiting and other parts of the Integrated Early Help & prevention services** have responded, positively, to alterations in commissioning intentions – in a manner which demonstrates a strong change-management culture within the service

being causes for celebration

The April meeting noted receipt of the **draft** of the **Internal Audit review** of the effectiveness of our assurance processes – and, consequently, the confidence the Board could have that this was robust
We noted that amendments to working arrangements which might flow from the findings, would follow for the May meetings of both the Quality Improvement & Risk group and the committee and I note below the May committee's endorsement of **revised Terms of Reference**, appended for Board consideration and endorsement

The May meeting also noted that the report on the **wheelchair review** would be considered by system-partners later in the week and would appear, as a substantive agenda item, at the June meeting

Decisions made at the meeting

The Committee approved the following policies at the May meeting (there were no policies presented at the April meeting) :

- **Secondment Policy**
- **Relocation Assistance Policy**

And Chairs action was taken to approve the following policies, following subsequent request for amendments at the May meeting;

- **Safeguarding Supervision Policy**
- **End of Life Policy**

The Committee approved the attached Terms of Reference and request the Board endorse these.

Recommendations to the Trust Board
➢ **the Board are asked to note the issues set out above; specifically the revised Terms of Reference**

Other risks to highlight (not previously mentioned)
None of note

Item 17.2

Solent NHS Trust
Assurance Committee - Terms of Reference

The Assurance Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. The role of the Audit & Risk Committee is to take a view as to whether the arrangements for gaining assurance are effective.

1 Constitution

1.1 Solent NHS Trust Board resolves to establish a Committee of the Board to be known as the Assurance Committee (the Committee). The Committee 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 Board to ensure they are still appropriate.

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

1.3 The Committee will work closely with the Audit & Risk Committee for those aspects of governance associated with assurance and internal control and will report to the Audit & Risk Committee on matters as requested by that Committee.

2 Purpose

2.1 The Committee is responsible for providing the Trust Board with assurance on all aspects of quality of care; governance systems, risk issues for clinical, corporate, workforce, information and research & development and regulatory standards of quality and safety. In particular providing assurance to the Board regarding :

- Regulatory compliance (including Safeguarding) and the provision of services in accordance with statute, best practice and guidance
- High standards of healthcare governance and high quality service provision.
- Risk – ensuring that risks are identified, prioritised and appropriately managed as highlighted via the Chief Nurse and Chief Operating Officers report to the Committee.
- a culture of continuous improvement across the Trust exists and learning is shared and embedded

3 Duties

3.1 Objectives:

- To seek assurances on behalf of the Board.
- To scrutinise assurances that processes are in place to assess and monitor clinical governance performance concerning all aspects of service quality
- To be assured that effective processes are in place to achieve all areas of regulatory compliance including registration and recommendations of the CQC
- To seek assurance that the development of all clinical governance activities within the service lines improve the quality of care throughout the Trust

3.2 The Committee will seek assurance on all aspects of quality via:

- Exception report from
  - The Chief Nurse and Chief Operating Officers' Report which will highlight items to escalate to the Committee from the Quality Improvement and Risk Group including key risks
- A scheduled programme of 'deep dives' which will scrutinise information such as complaints, incidents, risks, staffing and other quality matters.
- Scheduled reports from the various annual programmes including
  - CQC oversight
  - Research & Improvement , including Clinical Audit & Effectiveness and Quality Improvement
  - Serious Incident Panel
  - Learning from Deaths Reviews
  - Safeguarding Group
  - Commissioning for Quality Improvement (CQUINs)
  - Thematic Clinical Leads
  - Freedom to Speak Up
- Via the QIR Group, the Committee also seeks assurance regarding Medicines Management, Emergency Planning and Resilience, Infection Prevention & Control and Health and Safety. The annual reports for these agendas are also noted at the Committee prior to presentation to Board.

3.5 The Committee will approve Terms of Reference for its reporting groups.

3.6 The Committee will scrutinise and approve each groups Annual Report detailing how assurance is provided according to its terms of reference and individual objectives. The Committee will then onwardly assure the Board appropriately within its Annual Report.

3.7 The Committee is responsible for approving policies and procedures on behalf of the Trust Board, following agreement at the Policy Steering Group.

3.9 The Committee will also seek assurance from other functions concerning Trust business where there are regulatory compliance issues and will require the relevant management lead to provide regular assurance reports.

3.10 The Committee will receive quarterly reports on achievement against the Trust's Quality Priorities.

4 Membership

4.1 The Committee is appointed by the Trust Board and comprises:

- Non Executive Director (Chair) or nominated deputy
- Two Non- Executive Directors
- Executive Directors
  - Chief Executive (or Deputy)
  - Chief Operating Officers (accompanied by CDs as invited)
  - Chief Nurse
  - Chief Medical Officer
- Associate Director of Corporate Affairs and Company Secretary

- Patient / service user representative – tbc
- Observer: Governors

5 Attendees

5.1 If Executive Directors are unable to attend a meeting they should agree a deputy who is authorised to act on their behalf, with the CEO in consultation with the committee chairman.

5.2 Other attendees will be expected to support the membership on any 'deep dive' or annual programme reports.

5.3 Agreed representatives from CQC and Clinical Commissioning Groups have a standing invite to attend meetings and papers will be shared in advance of meetings.

5.4 The Head of Compliance will also be an attendee.

6 Quorum

6.1 To ensure appropriate balance, no business shall be transacted at the meeting unless the following are present;

- The Chair or a nominated deputy being a Non-Executive Director
- a minimum of one other Non-Executive Director
- a minimum of two Executive Directors

7 Frequency

7.1 Meetings will be held ten times a year, scheduled to support the business cycle of the Trust and additional meetings can be called by the Chair of the Committee if it is deemed necessary. Frequency may be reviewed, as the other amendments in working arrangements prompted by the Internal Audit Review of spring 2018 'bed-in'.

8 Secretary

8.1 The Assistant Company Secretary and Corporate Support Manager or their nominee shall act as the secretary of the committee.

8.2 The administration of the meeting shall be supported by the Assistant Company Secretary and Corporate Support Manager who will arrange to take minutes of the meeting and provide appropriate support to the Chairman and committee members.

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

It is accepted that Committee members will scrutinise papers and attend the meeting prepared to seek any further assurances necessary. Authors of papers are, therefore, not required to re-state information already provided; but to provide material up-dates and be prepared to address issues requiring further assurance.

9 Notice of meetings

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

10 Minutes of meetings

10.1 Minutes of the meeting will be shared with the members following agreement by the Chair.

11 Authority

11.1 The committee has no powers, other than those specifically delegated in these Terms of Reference.

11.2 The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties

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

11.3 To hold Executive Directors, through their service managers, senior managers and clinicians, accountable for the quality and regulatory compliance of services.

12 Reporting

12.1 The Committee Chair will submit an exception report to the Board and will highlight any issues the Board should be informed of or areas where assurance is insufficient/of concern.

12.2 The Committee will present an Annual Report to the Board against its duties as outlined in the Terms of Reference.

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

12.4 Members attendance at Committee meetings will be disclosed in the Trust’s Annual Report

Version	12
Agreed Assurance Committee	Date: 15th May 2018
Date of Next Review	Date: May 2019

Item 17.3

Assurance Committee Annual Report 2017-18

Introduction

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

Meetings

During 2017-18 the following meetings were held:

- 18th April 2017
- 16th May 2017
- 20th June 2017
- 18th July 2017
- 19th September 2017
- 17th October 2017
- 21st November 2017
- 16th January 2018
- 20th February 2018
- 20th March 2018

Membership & Attendance

Attendance by members is outlined as follows:

	Meeting										
NAME	18th April	16th May	20th June	18th July	19th September	17th October	21st November	16th January	20th February	20th March	**% attendance**
Mick Tutt – Chair Non Executive Director	P	P	P	P	P	P	P	P	P	P	100%
***Mike Watts** Non Executive Director	P	A	P	P	P	P	P	A	P	P	80%
***Francis Davis** Non Executive Director	P	P	P	A	P	P	A	P	P	P	80%
Jon Pittam Non Executive Director	P	A	P	P	A	P	P	P	P	P	80%
Sue Harriman Chief Executive Officer	A	P	P	A	P	P	P	P	A	P	70%
Mandy Rayani Chief Nurse	P	P	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100%
Jackie Ardley Chief Nurse	n/a	n/a	n/a	n/a	n/a	n/a	n/a	A	P	P	66%
Sarah Austin Chief Operating Officer	P	P	P	P	A	A	P	A	P	P	70%
Dan Meron Chief Medical Officer	P	P	P	A	P	A	P	P	P	P	80%
Lesley Munro Interim Chief Operating Officer followed by Chief Nurse	P	P	P	P	P	P	A	n/a	n/a	n/a	85%
David Noyes Chief Operating Officer	n/a	n/a	n/a	P	P	P	P	P	P	P	100%
Rachel Cheal Associate Director of Corporate Affairs and Company Secretary	A	P	P	A	P	A	A	A	P	P	50%

P= Present A= Apologies

*Mandy Rayani left the Trust in June 2017

*Lesley Munro left the role of Interim Chief Operating Officer in May 2018 and took the role of Chief Nurse in

June 2018 until November 2017

*Jackie Ardley took on the role of Interim Chief Nurse in December 2017

*David Noyes joined the Trust in July 2017 as Chief Operating Officer, Southampton and Countywide Services

ToR

The ToR were amended in June 2016, to reflect that the Audit & Risk Committee Chair could be a member of the Assurance Committee. Revised ToR were presented to the November 2016 meeting, following reflection on governance reviews undertaken by Internal Auditors KPMG, External Consultant Julie Jones and the CQC. It was agreed to commence the revised arrangements in January 2017. It was further agreed to ask Internal Auditors PwC to conduct a wider review – of the effectiveness of the overall assurance process, which was completed at the end of March 2018. Revised ToR, for both the Quality Improvement & Risk group and Assurance committee will be submitted in due course, in response to this review

Status against the achievement of the Committee's Objectives

Objectives	Year end
Any urgent matters of safety will be reported to the Committee, at the commencement of each meeting.	*Agenda planned accordingly for every meeting and now amended to include matters arising from Freedom-to-Speak-Up Guardians*
An Internal Audit review of the changes made, as a consequence of the revised ToR, will be sought during 2017/18 to provide assurance that the changes have not diluted the effectiveness of the work of the Committee.	*Internal auditors undertook a review and attended the February 2018 meeting as part of the review work.*
Exception reports from the COOs and the Chair of QIR will be received at each meeting, the precise format of these may change throughout the year as the changes in arrangement become embedded.	*The reporting format has been reviewed and the committee has received a number of iterations, responding to comment received*
A series of 'deep dives' into specific areas of Governance and Regulatory Compliance will be received at each meeting.	*Agenda planned accordingly*
Safe Staffing will be monitored through the receipt of regular reports from the Chief Nurse and where necessary, by exceptions.	*Agenda planned accordingly*
Other reports will be received following agreement by the Chair, CMO and CN	*On-going*

Summary of business conducted in year

Highlights of the main business conducted by the Committee for the period April 2017 to and including March 2018 are summarised as follows;

- A monthly update on urgent matters associated with Freedom to Speak Up, as noted above, was received and a full report was noted in April and October 2017 and February 2018.

- The draft Quality Accounts were presented for comment at the April 2017 meeting for onward endorsement of the Board.
- Regular Mortality updates were provided and a full report was presented at the June 2017 meeting, and subsequently. The February 2018 meeting endorsed the change of title to 'Learning from Deaths...'
- The Committee was briefed on risk management effectiveness for sub-contracting arrangements and it was agreed to provide a report to the Audit and Risk Committee in order to note the robust system in place. Subsequent reporting through the Finance committee was agreed – with exceptions coming to the Assurance committee via the COOs report
- A training matrix update was provided at the April 2017 meeting, following a Safeguarding deep dive undertaken in January 2017 on training expectations.
- The May 2017 Committee received an amalgamated report of Southampton and Hampshire and Portsmouth Care Groups to identify major risks to services and continued compliance with regulatory requirements.
- Service line Annual Governance Statements were presented to the February 2018 committee for inclusion in the main Trust Annual Report.
- The format of the Committee was reviewed at the May 2017 meeting and it was agreed to continue with the format set out in the January 2017 meeting, pending end of calendar year review being undertaken by Internal Audit to seek process assurances. The IA review subsequently took place in early 2018 and changes in format will be discussed at the May 2018 meeting of the committee
- Quality Improvement and Risk Group exception reports were noted at each meeting with the exception of meeting quick turnarounds when a verbal update was provided. The COO Care Group reports were amalgamated with the QIR report in October 2017 and it was agreed to review in the New Year. This continues to be a 'work-in-progress' and further iterations can be expected
- The Committee received a report on a review of physical health assessment and management, at the May 2017 meeting.
- A CQC deep dive was provided at the June 2017 meeting. An oversight on CQC Quality Review Visits was presented to the January 2018 meeting where key issues for escalation and progression on actions were provided.
- An overview was provided on Quality Impact Assessment (QIA) schemes.
- The Committee was provided with an overview on Thematic Clinical Leads and of the proposed alignment of Advance Clinical Practice and how to link with the Advanced Clinical Practice Framework.

The Committee received the following annual reports:

Wessex Trust SAS Development	April 2017
Information Governance	May 2017
Assurance Committee	May 2017
Complaints	June 2017
Infection Prevention and Control	June 2017
Risk Management Strategy	June 2017
Safer Management of Controlled Drugs	July 2017
Health and Safety	July 2017

Safeguarding	July 2017

- Each meeting agreed items for escalation to the Board and items for cascading to services.

A committee exception report was presented to the Board following each meeting.

Objectives for 2018-19

1. **The outcome of the Internal Audit review of the effectiveness of the overall assurance process will be actioned during Q1 2018/9**
2. **Any urgent matters of safety, or Freedom-to-Speak-Up concerns, will be reported to the committee, at the commencement of each meeting**
3. **Exception reports from the COOs and the Chair of QIR will be received at each meeting**
4. **A series of 'deep dives' into specific areas of Governance and Regulatory Compliance will be received at each meeting**
5. **Other reports will be received following agreement by the Chair, CMO and CN**

Conclusion

The Committee has complied with its Terms of Reference during the period under review.

Report Author(s)	Mick Tutt, Non Executive Director and Assurance Committee Chair Jayne Edwards, Corporate Support Manager and Assistant Company Secretary

Appendix 1 – List of Policies agreed by Assurance Committee 2016-17

APRIL 2017	MAY 2017
• CJD Policy • Registration Authority Smart Card • Fire Safety Policy • Medicine Policy ***Approved via Chair's action:*** • Policy for Surveillance Camera System (CCTV) • Physical Security Management Policy	• Serious Incidents Requiring Investigation (SI) Policy • Investigation Policy • Waiting Times and Patients Access Policy ***Approved via Chair's action:*** • Slips, Trips and Falls Policy (Patients) • Anti-Fraud, Corruption and Bribery Policy • Fire Safety Policy
JUNE 2017 • Harmful Substances and Alcohol Use Policy • Controlled Drugs Policy • Psedonymisation Policy • Advanced Decision to Refuse Treatment Policy ***Approved via Chair's action*** • CPA and Standard Care Policy	**JULY 2017** ***Approved via Chair's action:*** • Managing Concerns and Complaints Policy and Procedure • Uniform Policy
SEPTEMBER 2017 • NICE Policy (formally Implementation of National Guidance Policy) • Freedom to Speak Up (formally Whistleblowing Policy) • Policy on Policies ***Approved via Chair's action*** • Mortality Policy • Social Media Policy	**OCTOBER 2017** • Data Assurance Policy • Audio-Visual Policy ***Approved via Chair's action:*** • MRSA Policy
NOVEMBER 2017 • Volunteers Policy • Psychiatric Observations and Engagement Policy • Medical Appraisal and Revalidation Policy ***Approved via Chair's action*** • Information Governance and Risk Policy • Registration of Professional Staff Policy • Retirement Policy	**JANUARY 2018** • Commercial Income Distribution Policy
FEBRUARY 2018 • Clinical Supervision Policy ***Approved via Chair's action:*** • Creating a Smoke Free Work Environment Policy	**MARCH 2018** • Medicines Management and Safety Policy • Data Encryption Policy • Data Protection, Caldicott and Confidentiality Policy • Adult Bowel Care Policy ***Approved via Chair's action:*** • Deprivation of Liberty Safeguards and Mental Capacity Act Policy • Ligature Risk Assessment and Management Policy

REPORT

Item 18

Presentation to	In-Public Board						
Title of Paper	Chairman's report on meetings with Governors						
Author(s)	Jayne Edwards, Corporate Support Manager and Assistant Company Secretary			Executive Sponsor		Dr Alistair Stokes, Chairman	
Date of Paper	4th May 2018			Committees presented		n/a	
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities
	W5 Risks and Performance		**W6** Information		**W7** Engagement	X	**W8** Learning, Improvt & innovation

Executive Summary

Community Engagement Strategy Meeting – 19th March 2018

Engagement Consultant Philip Krinks provided a presentation and summarised the outcomes of phase 1 of the development of the Community Engagement Strategy. Each Governor in attendance was given the opportunity to share their opinions on past engagement and of the proposed strategy.

Governors endorsed the direction of travel in respect of the merging framework and it was agreed to present to the March Board and the decision reached, to be reported to the Members Council in April.

Member's Council – 20th April 2018

The CEO briefed the Council on the STP national agenda and on a system reform phase of work in progress within Hampshire and Isle of Wight. A year-end update was provided and the Council noted the good progress made to address actions raised by the CQC during 2016 inspections.

Philip Krinks updated the Council on progress made with the Community Engagement Framework development. The Council agreed to consider future engagement implications to the Trust's existing members and it was agreed to hold a further Members Council meeting in early July following discussions with executives, for a final proposal to be submitted to the July Board for final approval.

Mick Tutt, Deputy Chairman informed the Council of his attendance at the Portsmouth Hospital NHS Trust (PHT) Council of Governor where a parallel discussion took place. It was noted at the meeting that the PHT Board would also receive a report at their July meeting, proposing a future direction for engagement with members, governors and others.

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

n/a

Key Decisions/ Action(s) requested

The Board is asked to note the update.

Item 20

Presentation to	X In Public Board Meeting ☐ Confidential Board Meeting							NHS Solent NHS Trust
Title of Paper	**Briefing Note to Board Following Charitable Funds Committee 15th May 2018**							
Author(s)	Francis Davis, NED and Chair of the Charitable Funds Committee Sue Harriman, CEO							
Date of Paper	18th May 2018			**Committees presented**		Discussed at Charitable Funds meeting 15th May 2018		
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	x
	W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	
Action requested of the Board	☐ **To receive**		X **For decision**					

1. Background and Recap:

As briefed to the board during 2017 the Charitable Funds Committee set out to review its direction in the light of extraordinarily high administrative costs in proportion to activity, a very low number of applications (many of a low quality) and the vast majority requesting one off grants for resources the committee felt were more appropriately the responsibility of crown/ NHS funding. More pressing still was the realisation that the charity resources had to a large degree been 'restricted' with no clear mandate or requirement to do so.

As briefed previously to board meetings and board workshops we:

(i) Unrestricted all funds that were not the subject of restrictions to create an unrestricted reserve of circa £230k. (As of 17th April the only restricted charitable funds relate to a donation for spiritual care and, being determined, and a recent gift from the HIV charity Groundswell of a few thousand pounds (circa £4k)–

(ii) Identified areas for savings not least by significantly reducing insurance premia and also by benchmarking historic charitable audit fees with those now available in the marketplace. A process for the appointment of a new charitable auditor is underway and looks set to save several thousand pounds.

(iii) Have undertaken a programme of external scoping meetings (without prejudice or commitment) with potential donors, in kind contributors and supporters of a putative charity relaunch to determine their perceptions of our asks, our charitable offer, test some potential principles and how we might fare in their priorities relation to other causes locally.

(iv) Recognised the need to have some identified staff resources and so have similarly started to explore the concept of attracting a possible part time pro bono Director of the charity who might take on running high profile launch or support gathering events such as a dinner onboard HMS Victory or service at Portsmouth Cathedral and/or support new staff fundraising .

At the outset we flagged with the board a 'nuclear' option were it judged impossible to make progress in proportion likely effort required by of considering making the whole charitable fund

available to the Hants and IOW Community Foundation or equivalent to 'spend down' more cheaply and efficiently than we might manage.

2. Outcome :

(i) After wide ranging outreach it is clear that while charitable fundraising from external parties will be possible it will require very significant effort for the level of returns and will be increasingly confusing for external allies given the profile of especially the two hospital charities and the hospices in our patch. The effort needed could not be funded adequately from our existing resources nor merits investment from exec and senior exec teams at a time of wider pressures.

(ii) Consequently the committee in April reviewed the situation again and identified three options:

(a) To spend the reserves down using existing applications. *The argument against this was that the existing quality of applications are weak and tend towards funding what appear to be NHS mainstream items*.

(b) To identify new criteria and invite applications and spend the reserves down. *The argument against this is that such an approach would not model best practice in charitable grant making by seeking to enhance the value of the grant by co-resourcing or maximising social and economic returns on investment.*

(c) To seek to use the existing reserves as a means to lever in additional in cash and kind resources in order to maximise the social impact and outcomes secured by the resources , model best grant investment practice and demonstrate innovative action after a frustrating hiatus. ***A number of external allies and internal resources have been identified and among them the Social Investment Business (a lottery endowed specialist social impact investor with an endowment of £15 million chaired by the Rt Hon Hazel Blears MP https://www.sibgroup.org.uk/) have expressed strong in principle enthusiasm to co-fund in the region of £50,000 to £100,000 and to develop a joint plan drawing seeking synergies from their skills, networks, and expertise and our skills, networks and expertise.***

Resources identified thus far:

- ***£230,000 Charitable funds***
- ***£230,000 matching (if necessary over three years) from Solent NHS Trust innovation funds***
- ***£50-£100,000 from Social Investment Business (tbc) plus time, knowledge networks***
- ***With possible additional resources flagged by Sarah Williams as being salient as further 'matching' for a development and evaluation dimension from commercial research, AHSN and a number of research funders***
- ***Additionally the chair of charitable funds is in dialogue with the Wellcome Trust and a number of other national funders.***

The aim would be to create a combined innovation challenge fund able to make investments of a larger scale than previously and to put in place support to prepare those drawing up bids to the

challenge fund and support delivery. The 'awards panel' would combine internal, external impact and innovation expertise.

3. Board Decision 1

Following discussion with non- exec and exec directors the board **agreed** the step change /innovation challenge model was its preferred option and mandated the charitable funds committee at its meeting in May 2018 to work up the approach, principles and methods to **implement such a challenge. In doing so the board asked the charitable funds committee might explore how part of the fund could be allocated in the process for a fresh approach to micro-grants for staff proposals.**

4. Proposed Approach, Principles And Methods:

Our planned approach benchmarks us not against traditional NHS charities or 'benevolent' grant making practice but seeks to align us with best practice in the NHS charity sector and beyond. As such we propose to combine charitable funds, the Trust's innovation funds and external gifts and grants of cash and in kind resources.

A number of external partners have been identified and initial strong enthusiasm to assist with such resources has been expressed. If the Board are in agreement these conversations will be pursued in the coming weeks with a mind to developing a joint approach with co-funders and co-investors.

4.1 Principles:

The design of the major challenge as a whole and the final scoring criteria for bids system will be designed by the programme board with four key themes and six key principles. Thematically, the Charitable Funds committee recommends that the challenge be focused on:

(i) Children and families
(ii) Mental Wealth
(iii) Learning Disabilities
(iv) Enhancing healthy behaviours

And guided by the followed *principles*:

(i) Recyclability of the investment – in other words will the £ be useable more than once because invested as loan/social equity or against 'investing to save' or another method

(ii) Depth and breadth of co-llaboration with external civil society organisation(s), carers, users of services. The call will be 'inside-out' inviting staff to collaborate and co-invent and 'outside –in' inviting challenge and co-creation from external partners.

(iii) Likely social impact measured by numbers benefitted, vulnerability +/or diversity of beneficiaries, additional resources in cash and kind levered in .

(iv) Preference for step change/innovation over 'improvement' impact

(v) Quality of proposal timeline, finance, resource reinvention and health impacts.

(vi) Replicability, sustainability +/or scaleability within and beyond Solent NHS Trust (eg into ICS)

The micro grants programme will comprise 10% of the charitable funds (including the two restricted budgets) . It will be focused thematically in the following areas:

(i) Staff welfare
(ii) Patients and carers needs

Specific criteria will be drawn up and agreed by the charitable funds committee in time for its planned June meeting.

4.2 Governance and Process:

For the major challenge should the Board be in agreement, we will move to

- Agree and formalise internal resources. To note 10% of charitable funds (circa £43000) will be ring fenced for the micro grants programme focused with 80% allocated to the challenge fund.
- Agree and formalise external partners + resources
- Assuming joint collaboration establish joint programme board chaired by DN.
- Agree final prize design and scoring matrices
- Launch prize call with highly relational low key communications through Solent manager networks, voluntary sector suppliers, MPs, and Council for Voluntary Service CEOs.
- Those working on bids will receive assistance from internal and external partners to support with outline finance and innovation cases. A number of innovation workshops will be held across the Trust. The first 'bid' phase will be an outline concept with a final shortlist invited to work up something more detailed.
- Judging panel comprising (draft) Chair of charitable funds, COO , Head of Research, Chair of assurance, two representatives of partner organisations, two from civil society bodies uninvolved in bids or the work. There will be an awards ceremony/event at the appropriate time.

5: Timing, Staffing And Resources

Our hope would be in a position to launch during the Autumn/late Autumn.

Operational capacity demands will not be high but could be significantly secured from partner organisations in addition to some staff capacity pledged from the Solent finance department. There will need to be 'one off' assistance with internal comms when the 'call' goes out and again at the awards phase.

With the Boards agreement, and with professional assistance from HR colleagues, we wish to advertise and appoint a part time Honorary Director of the Charitable Trust. Initial soundings have identified some enthusiasm from skilled individuals who would be open to applying for such a role.

The Honorary Director would:

(i) Report to the lead Exec for charitable funds.
(ii) Assist/Support/lead operationally with the challenge fund/prize process
(iii) Assist/support/lead operationally with identifying bets requests with the allocation of the ring fenced fund for staff priorities
(iv) Start to develop a series of fundraising events and initiatives for the central charity the proceeds of which would help to resource further innovative activity around the themes outlined above.
(v) Support staff fundraising events and efforts based around a new policy that resources raised by frontline staff 'sticks' to their unit or expressed priorities.

The Honorary Director would have a job description, be subject to DBS and fit and proper persons assessment , be recruited by advert and would be for a specific term in the first place with clauses in their volunteering agreement that allow mutual rights to termination of the role.

5. Decisions Requested:

1. That the board **agree** this approach and authorises the charitable funds committee to action the above plan.
2. That the board **authorises** the recruitment of a part time Honorary Director for the Charitable Trust

Charitable Funds May 2018

Item 22.1

Exception and recommendation report

Committee /Subgroup name	**Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee**	**Date of meeting**	17th May 2018
Chair	**Mick Tutt**	**Report to**	Trust Board

Key issues to be escalated
We were joined, again, by colleagues from Solent MIND who act as both Independent Mental Capacity Act (IMCA) and Independent Mental Health Act (IMHA) advocates for people detained in both Solent and Portsmouth Hospitals Trust. They provide a much-valued 'proxy' for the views and wishes of people we detain and we asked that further thought was given to strengthening and deepening that offer We noted the meeting held between Solent Chief Executive Officer (CEO), myself and Samantha Allen, CEO for Sussex Partnerships –which followed-up on the positive feedback from the Clinical Director for Children & Families services at the previous meeting, regarding progress made, since he had first raised concerns regarding Hampshire-wide on-call cover from Children & Adolescent Mental Health services (C&AMHs) last summer It was noted that Sustainability Transformation Partnerships (STP) and local system developments would, probably, offer the most appropriate route for addressing the shortage of provision for young people – which was, again, demonstrated through receipt of a report of a young person aged under 18 admitted to our adult mental health wards. We were assured that all necessary actions had been undertaken and we understood that a more appropriate placement for the young person was available within a few days. More local provision would mitigate this unsatisfactory scenario We received a brief up-date on the situation with regard to Maples ward, following the incident which led to its recent temporary closure. This was to ensure Associate Hospital Managers (AHM) and our IMCA/IMHA colleagues were aware of any reasons for alterations to their usual patterns of activity. The committee were informed that substantive scrutiny had taken place through the Assurance committee, but we noted the reported extemporary action of the practitioners – and partners across the system – at the time and subsequently and the fact that reduced capacity was available again on Maples ward at the time of the meeting We noted that the increase in – local – use of the Mental Health Act 1983 (MHA), over the recent years, appeared to mirror national trends but that recourse, by people detained, to intervention from AHM or MHA Tribunals was less than that experienced nationally. We asked our management colleagues for any explanation for this, apparently positive, position. The 'positive risk-taking' approach to pursuing least-restrictive alternatives was cited, along with the average length-of-stay; which continues to appear on national benchmarking data as an extreme (low duration) outlyer. Together with our IMCA/IMHA colleagues we explored some of the consequences of this – such as re-admission rates somewhat less-clearly an outlyer to national expectation. We also heard clinical rational for why this continued to demonstrate good practice It was noted that this position would be explored, more extensively, with colleagues from the national mental health network on Tuesday 22nd may and a further up-date will be available as a verbal up-date at the meeting

We received reports of management scrutiny into the use of the restrictive practices of restraint and seclusion. We noted that, with regard to the former, reports of restraint within the Kite unit appeared for the first time. However, description of the incidents leading to this restrictive practice confirmed that appropriateness of the action taken
We continue to receive assurances that the restrictive practice of seclusion was not used in any location other than Maples ward – but we noted the, continued, increased use of the intervention. We were assured, through the management scrutiny, that all incidents met the expectations of the MHA Code of Practice and by our IMCA/IMHA colleagues that they felt they were, now, being involved appropriately

We received a proposal, from our management colleagues for adequate data to confirm provision of appropriate MCA and MHA training, and consequent practitioner competence – as required by our Terms of Reference – and supported urgent action being taken to ensure this delivered the information we sought

Part B of the committee was our usual training session for AMH, and focussed on the annual mental health law update, provided to both the trust and system-partners from Portsmouth & South East Hampshire on 10th may
We noted how case law continued to refine the expectations placed on practitioners, with regard to the application of both the MCA and the MHA, and the necessity for AHM to reflect these expectations when considering the legitimacy of detention
The slides from this session are attached, for information.

Decisions made at the meeting

We considered the draft Annual Report (available as a seperate agenda item) and, with some minor amendments, endorse its receipt by the Board

Recommendations to the Trust Board

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

Other risks to highlight (not previously mentioned)
None of note

Item 22.2

Mental Health Act Scrutiny Committee Annual Report 2017-18

Introduction

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

Meetings

During 2017-18 the following meetings were held:

- 18th May 2017
- 17th August 2017
- 16th November 2017
- 22nd February 2018

Membership & Attendance

Attendance by members is outlined as follows:

NAME	18th May 2017	18 7h August 2017	17 6h November 2017	22nd February 2018	% attendance
Mick Tutt – Chair Non Executive Director	P	P	P	P	100%
Jon Pittam Non Executive Director	A	P	P	P	75%
Alistair Stokes Trust Chairman	P	A	A	A	25%
***Mandy Rayani** Chief Nurse	A	n/a	n/a	n/a	0%
***Lesley Munro** Chief Nurse	n/a	P	P	n/a	100%
***Jackie Ardley** Chief Nurse	n/a	n/a	n/a	A	0%
***Lesley Munro** Interim COO- Southampton & County Wide Services	A	n/a	n/a	n/a	0%
***David Noyes** COO – Southampton & County Wide Services	n/a	P	A	P	66%
Dr Dan Meron Chief Medical Officer	P	A	P	P	75%
Sarah Austin Chief Operating Officer, Portsmouth	A	A	A	A	75%
Matthew Hall ***On behalf of the Chief Operating Officer, Portsmouth***	P	P	A	P	
***Francis Davis** Non Executive Director	A	A	A	P	25%

P= Present A= Apologies

*Mandy Rayani left the Trust in June 2017
* Lesley Munro was appointed as Interim Chief Operating Officer, Southampton between February 2017 and May 2017. From June to November 2017 Lesley took on the role of Interim Chief Nurse

draft

*David Noyes joined the Trust as Chief Operating Officer, Southampton in July 2017
*Jackie Ardley was appointed as interim Chief Nurse in December 2018

Terms of Reference

The ToR were reviewed at the November 2017 meeting. Changes made to ensure alignment to the CQC Well Led Key Lines of Enquiry, regarding Mental Health Act administration, were noted at the February 2018 meeting.

Status against the achievement of the Committee's Objectives

Objectives for 2017-18	Year end position
To continue to utilise the Mental Health Act lead Report as a main vehicle for scrutinising compliance with the expectations of the Act. This will continue to seek assurance in the light of internal and external inspections, audits, reporting and national changes in policy, research and law.	*Agenda planned accordingly for every meeting*
To continue scrutiny of the use of seclusion and restraint, seeking assurance from management reviews that the expectations of the Act and Code of Practice are adhered with.	*Agenda planned accordingly for every meeting*
To refine the scrutiny of the application of DoLs, across the Trust and the outcomes of training provided for practitioners on the MCA and MHA	*Definition of DoLS scrutiny achieved but still work to conclude with regard to appropriate oversight of the outcomes from MCA & MHA training*
With regard to Associate Hospital Managers: To continue the process of reflective training sessions at part B of the meeting, including at annual up-date from our solicitors	*Agenda planned accordingly for every meeting*
To formally conduct a third round of reviews/appraisals for AHM based on previous recommendations to the Governance and Nominations Committee.	*Appraisals (for Pam Coen and Jon Pittam) undertaken and recommendation to be made to G&N committee for an extension for 3 years*
To continue to advocate for a choice of venues for community hearings	*Community venues offered – but rarely taken up*
To continue to review reasons for non-attendance (by those detained) at hearings	*Should be subject to greater scrutiny this coming year – along with ensuring that the committee seek to understand the views of people detained, generally.*

Summary of business conducted in year

The majority of business conducted at the meetings was through the Mental Health Act Scrutiny Report; co-ordinated by the MCA&MHA Lead, with contributions from relevant clinical and service leads and seclusion reviews.

The report included an executive summary which highlighted key issues and guided committee members to more detail within the body of the document, as well as appendixes where necessary.

Each meeting received a Restraint and Seclusion Assurance report for noting.

The May 2017 Committee was briefed on the locked door status on Hawthorns ward and it was noted that decisions taken were based on a balance of staff and service users' best interests.

Updates were provided with regards to ongoing resolutions to address CQC issues raised following visits to the Kite Unit, Maples Ward and Hawthorne's Ward.

The Committee was briefed on the latest position on national issues with CAMHS providers and outcomes of a quality summit held by NHS England with in-patient care providers to discuss challenges and consider potential solutions.

The Committee received an update on the MCA and MHA training compliance and noted the creation of a competency framework that will receive ongoing monitoring to ensure staff are following competency framework requirements.

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

Training sessions were provided during Part B of the meeting and psychiatrists as well as Executive Directors and other management colleagues were invited to attend, if the training was considered to be of value.
The following training sessions were provided:

18th May 2017	Review of Psychiatric Conditions
17th August 2017	Information Governance
16th November 2017	AHM Responsibility Refresh
22nd February 2018	Mental Health Medication

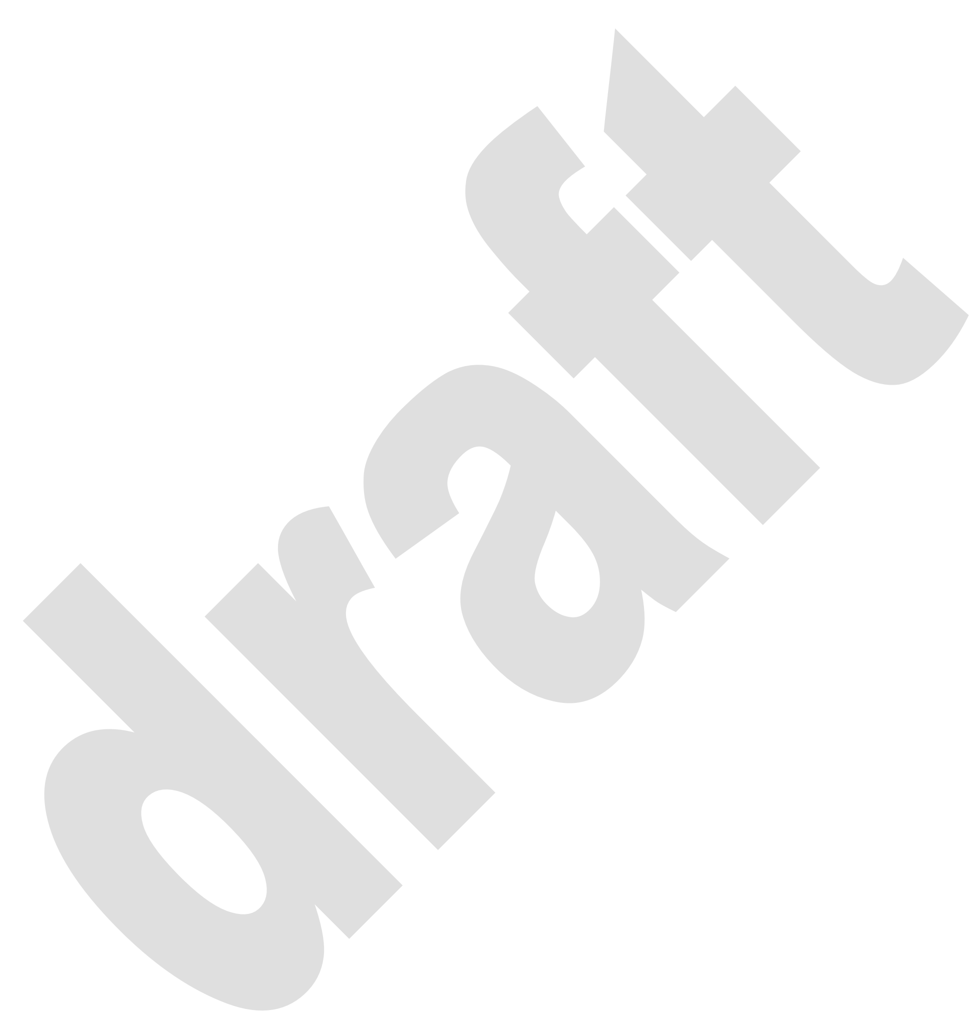
Objectives for 2018-19

- To continue to utilise the Mental Health Act lead Report as a main vehicle for scrutinising compliance with the expectations of the Act
- To continue the scrutiny of the use of seclusion and restraint
- To continue the scrutiny of the application of DoLs, across the Trust
- To receive further advice on the provision of appropriate oversight of the outcomes from MCA & MHA training
- To continue the process of reflective training sessions for Associate Hospital Managers
- To continue formal reviews/appraisals for AHM
- To continue to advocate for a choice of venues for community hearings
- To consider further scrutiny of the reasons for non-attendance (by those detained) at hearings

To seek further options to understand the views of people detained, generally

draft

Conclusion	
The Committee has complied with its Terms of Reference.	
Report Author(s)	Mick Tutt, Non Executive Director and Assurance Committee Chair Jayne Edwards, Corporate Support Manager, Assistant Company Secretary



Item 22.3

Mental Health Act and Mental Capacity Act

Some Current Issues

Paul Barber

Former Partner and Solicitor (non-practising)

May 2018

Independent Review of the Mental Health Act

- Rising rates of detention under the act
- Disproportionate number of people from black and minority ethnicities detained under the act
- Stakeholder concerns that some processes relating to the act are out of step with a modern mental health system
- The balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent
- The ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one
- Detention may in some cases be used to detain rather than treat
- Questions about the effectiveness of community treatment orders, and the difficulties in getting discharged
- The time required to take decisions and arrange transfers for patients subject to criminal proceedings

Some Capacity Assessment Issues

The Capacity Assessment Process

- MCA Code of Practice Guidance on the assessment process states that stage 1 is the "diagnostic" test (S2) and stage 2 is the "functional" test (S3)
- The Court of Appeal in *PC and NC v City of York Council (2013 EWCA Civ 478)* suggests the reverse –ie assessors should first evaluate the (in)ability to decide (S3) and then consider whether this is because of an impairment (S2). Case since followed in *An NHS Trust v CS (2016)EWCOP 10;* and *Kings College Trust v C & E (2015) EWCOP 80* (see below)
- Unless the inability to make a decision is *because of* an impairment etc it will not be covered by the MCA and the matter may need to be referred to High Court (not Court of Protection) for how to proceed and protect the person concerned under its inherent jurisdiction (*DL v A LA (2012) EWCA Civ 253).* It is insufficient for the impairment to be "referable to" or to "significantly relate to" (see *WBC v Z (2016) EWCOP 4* and *Re SB (2013) EWHC 1417 (COP))*

CC v KK and STCC (2012) EWHC 2136 (COP)

- Professionals must avoid conflating a capacity assessment with a best interests analysis by attaching excessive weight to their own views of how physical safety may be best protected and insufficient weight to P's own views of how her emotional needs may best be met. Need to avoid the "protection imperative" (para 25)
- Imperative to have regard to MCA S1(3) ie whether all practical steps have been taken to help P make the decision. This involves presenting her with detailed options so that her capacity to weigh up those options can be fairly assessed
- P need only comprehend and weigh the salient details relevant to the decision and not all the peripheral detail. *(See A PCT v LDV et al (2013) EWHC 272 (Fam))*
- Different individuals may give different weight to different factors, eg as to the importance of avoiding or accepting varying degrees of risk
- See also *Re CD (2015) EWCOP 74 :* wishes and feelings of P should be confined to the best interests analysis and not undermine a capacity assessment (P wanted op. but lacked capacity to consent to it (para 28))

The Salient Details

- P need only comprehend and weigh the salient details relevant to the decision and not all the peripheral detail
- What are the salient details? *(A PCT v LDV et al (2013) EWHC 272 (Fam))*

  Case not setting a precedent but relevant factors here included:

  - she is in hospital to receive care and treatment for a mental disorder;
  - the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;
  - staff at the hospital will be entitled to carry out property and personal searches;
  - she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
  - if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.
- See also *Derbyshire CC v AC et al (2014) EWCOP 38* and *LBX v K,L,M (2013) EWHC 3230 (Fam):* Courts increasingly prepared to give guidance as to relevant and irrelevant factors in making a wide range of decisions

The Introduction of Informed Consent?

Montgomery v Lanarkshire Health Board (2015) UKSC 11

- The concept of informed consent to medical procedures whereby (a) what information is given to the patient and (b) whether this is sufficient is judged objectively rather than subjectively has not been part of UK law. The House of Lords in *Sidaway (1985) AC 871* decided that both were to be subjectively determined by the doctor with the protection of a *Bolam* defence
- In *Montgomery* the Supreme Court held that *Sidaway* was wrong. As far as (a) was concerned it remained for the doctor to determine the risks etc of a procedure, but as to (b) what material risks were to be discussed with the patient was to be determined by the reasonable man test, not by reference to a *Bolam* competent body
- The doctor could as a limited therapeutic exception withhold information from the patient if he reasonably considers disclosure would be seriously detrimental but this was not to be abused
- The application of this judgement to those with impaired capacity is not entirely clear. All practicable steps will need to be taken to give the patient a broad general understanding of the "salient points"

MHA Code Guidance re Recording of Capacity Assessments

As well as the capacity assessment outcome should be recorded (13.22):

- the specific decision for which capacity was assessed
- the salient points that the individual needs to understand and comprehend and the information that was presented to the individual in relation to the decision
- the steps taken to promote the individual's ability to decide themselves. How the information was given in the most effective way to communicate with the individual
- how the diagnostic test was assessed, and how the assessor reached their conclusions, and
- how the functional test was undertaken, and how the assessor reached their conclusions

See also 13.21: "Capacity should be reassessed as appropriate over time and in respect of specific treatment decisions"; also CQC requirement of baseline capacity assessments on admission

A Good Capacity Assessment?

- Be clear about the decision being assessed.
  - Ensure P (and you) have the concrete details of the choices available.
  - What are the salient details to understand/comprehend (ignoring the peripheral and minor details)?
  - Avoid the protection imperative.
- Demonstrate the efforts taken to promote P's ability to decide.
- Evidence each element of the capacity assessment:
  - What is the impairment/disturbance? Is it temporary or permanent?
  - Why could P not understand, or retain, or use/weigh, or communicate in spite of the assistance given?
  - How is the inability because of the impairment/disturbance (as opposed to something else)?
  - Why is this an incapacitated decision as opposed to an unwise one?
- NB Ulysses pact and Advance Consent proposed developments

Some Best Interests Issues

Best Interests (1)

The person making the determination *(5.8-5.12)* ***must*** consider all relevant circumstances (S4(11))*(5.18-5.20)* and take the following steps (S4(2)) *(5.13 – the S4 checklist)(NB exception for Advance Decisions (5.4; 5.45))*

- Consider whether P will regain capacity in future? If so when? *(Take steps to support P or develop capacity (5.25-5.28))*
- Involving P to maximum extent possible (*use "all practical means" (5.23) and see "Practical steps to support" S1)*
- Consider (so far as reasonably ascertainable)*(eg emergency may rule out (5.39))* past and present wishes and feelings of P, esp.written; his relevant beliefs and values; other factors he would be likely to consider if able *(eg altruistic motives (5.47-5.48)); if depart from P's preferences record in writing (5.43)).* **Note Law Commission's proposals for placing this consideration at head of the list.**

Best Interests (2)

- If practicable and appropriate to consult them *(see 5.49-5.55)*, take into account views of anyone named by P; carer or person interested; donee of LPA*;* deputy; as to what would be in P's best interests and as to P's wishes etc. *(Need to respect confidentiality (5.56-5.57)*
- If issue concerns life sustaining treatment (S4(10)) determination re best interests must not be motivated by desire to bring about death. *It is for Doctor to assess if treatment is life sustaining (5.30)*
- NB decision in ***Re Y (Mental Incapacity: Bone marrow transplant)*** preserved by checklist (5.48): "best interests goes beyond the person's best medical interests"
- To prevent discrimination the person deciding best interests must not do so merely on basis of:-

  the person's age or appearance, or a condition of his, or an aspect of his behaviour which might lead others to make unjustified assumptions about what might be in his best interests

  (principle of equal consideration(5.16-5.17))

Aintree Trust v James (2013) UKSC 67 (1)

- First consideration of MCA by Supreme Court
- Context: request for declaration that it was lawful and in P’s best interests to withhold invasive treatment and CPR from seriously ill man in ICU for 7 months and lacking capacity to decide
- P’s wishes, feelings etc are not determinative but of central importance in best interests decision making
- Best interests test not what reasonable person would think, but to view matter from P’s viewpoint in a holistic way with his own values, likes and dislikes
- May not always be possible to establish P’s wishes, views etc but so far as it is possible it is those which should be taken into account, with the decision made through the prism of P’s likely or actual wishes

Aintree Trust v James (2013) UKSC 67 (2)

- "The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be"
- The protection imperative again

M v Mrs N (2015) EWCOP 76

- First case in which ANH withdrawal sanctioned where P in MCS rather than a persistent vegetative state
- Essential to enquire into and if possible establish P's views, not only through what he has said. Where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interest's'. See *An NHS Trust v CS (2016)EWCOP 10 para 21:* views of P will carry less weight if inconsistent or contradictory
- To superimpose what the Court thinks best, may result in indirect discrimination. The central objective is to avoid a paternalistic approach and to ensure that the incapacitous achieve equality with the capacitous
- The importance of the wishes and feelings of an incapacitated adult, communicated to the court via family or friends but with similar cogency and authenticity, are to be afforded no less significance than those of the capacitous (eg through an Advance Decision)

Briggs v Briggs (2016) EWCOP 53

- Tension between sanctity of life and autonomous wishes of now incapacitated P. Should ANH be discontinued in P’s best interests?
- Test is not “what would P have done?” but P is at the heart of decision
- If P’s wishes can be ascertained with sufficient certainty (“a compelling and cogent case”) this prevails over strong presumption in favour of preserving life. Court did not state to what standard it had to be satisfied as to P’s wishes. P might not know what he would want for himself. Decision as if for a different person? Court will consider evidence showing P had not considered certain aspects of his present situation when expressing wishes
- Court should not set a low threshold for setting aside an ADRT. If ADRT or LPA clear no space for court to intervene on best interests.
- Court (para 60) gave examples of where it would not give effect to what P would have wanted. See eg *DM v Y City Council (2017) EWCOP 13*
- Court decided P would not have consented to further ANH
- See also *Abertawe Bro Morgannwg University LHB v RY and CP (2017) EWCOP 2* – similar approach to sanctity of life issue but where it was impossible to ascertain P’s wishes

A Good Best Interests Assessment?

- Document what you have seen and to whom you have spoken (and, crucially, what they have said!).
- In particular, record P’s past and present wishes, feelings, values, beliefs. Put yourself in the position of P.
- Do you have good reason to depart from P’s preferences?
- Evidence how you have engaged P and improved their ability to participate in the assessment.
- Evidence how you have engaged consultees, their views, and what they know about P.
- Demonstrate application of the Code and the best interests checklist.
- Be clear about the concrete options (eg between living in a care home and living at home <u>with a realistic package of care</u>).
- Evidence your balance sheet of those options (with indication of the factors’ weight and likelihood).
- Remember there is no “least restrictive” principle
- Avoid the protection imperative!

Developments Post Cheshire West

What is Deprivation of Liberty?

- ECtHR case law has established that dol within the meaning of Article 5 has three constituents: the *objective* component of confinement in a particular restricted place for a not negligible length of time; the *subjective* component of lack of valid consent and; the *attribution of responsibility to the state* (Storck v Germany (2005) 43 EHRR 6). All three must be present.

Cheshire West and P&Q in the Supreme Court (2014) UKSC 19

- The “acid test” of the objective element of dol was whether P was under continuous supervision and control **AND** was not free to leave
- The “subjective” element is confined to whether there has been a valid and effective consent to dol. “Tacit compliance” is not sufficient. Lack of capacity to object cannot prevent dol
- What exactly does “continuous supervision and control” mean? Does this imply having P under direct line of sight observation at all times, or could this be intermittent but with staff under an obligation to be ready and willing to intervene/control if needed? When does support with everyday living become control? See (*Stanev v Bulgaria (App’n No 36760/06)* and *Atudorei v Romania (2014) ECHR 947*

Cheshire West and P&Q in the Supreme Court (cont)

- What does not being “free to leave” mean? Lady Hale quoted Munby J’s decision in JE v DE: ...“in the sense of removing himself permanently in order to live where and with whom he chooses”. See also *D (A Child) (2017) EWCA Civ 1695*
- This comment should relate to P’s specific **context** – ie where is it that P wishes to leave? General Hospital (*NHS Trust v FG (2014) EWCOP 30)*? Hospice? Psychiatric Hospital? Police Car? Care Home? Ambulance? ICU *(Ferreira v Coroner for S London (2017) EWCA Civ 31)*?
- The question does not turn on whether P is actively seeking to leave or passively remaining, but on whether if he purposefully attempts to leave he will be prevented from so doing

Life After Cheshire West!

Ramifications of this decision still being played out re:

- Community Treatment Orders
- Conditional Discharge Orders
- Outpatients, A&E S136 suites etc
- Dol in P’s own home
- Respite Care
- General Hospitals inc ICU, coma and brain injury
- Hospices and terminal care
- Children and Young People
- Guardianship
- State involvement

DOL on In-patient Wards: Discussion

- What does P need to be able to understand (about coming into and remaining in hospital) to be able to consent with capacity? See *CC v KK and STCC*; and *LDV* and the "Salient Details"
- Is P unable on balance of probabilities to understand this? (MCA S3)
- Does P consent on the basis of this understanding and is he/will he be truly compliant? See *AM v SLAM*, and *GJ*
- Will P objectively be deprived of his liberty? See Cheshire West etc in the Supreme Court
- MHA Code of Practice (13.53) " …..a person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not.)"

DoL in Acute Hospitals Post Cheshire West (1)

- In *Ferreira v Coroner for Inner S London ((2017) EWCA Civ 31)* the Court of Appeal held that P in an ICU receiving life-saving treatment was distinguishable(“a long way”) from the situation in Cheshire West, so that the “acid test” did not apply
- Such treatment falls outside Article 5(1) so long as it is rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert real risk of serious injury or damage and kept to minimum required for that purpose
- Article 5 (1)(e) is to protect persons of unsound mind and does not apply if receiving materially the same treatment as person of sound mind
- Even if acid test did apply P was not “not free to leave” because the true cause of her lack of freedom to leave was the underlying illness not (as in Cheshire West) her mental disorder. The root cause was her physical condition not restrictions imposed by the hospital

DoL in Acute Hospitals Post Cheshire West (2)

- There may be circumstances in acute hospitals where deprivation of liberty occurs with the need for an authorisation (eg *An NHS Trust v FG (2014) EWCOP 30)* but this is likely to be in extreme circumstances and where the treatment might be materially different from that given to a patient of sound mind
- The demands upon resources were not relevant to the CA decision, but the Court was clearly pleased at the implications of its decision for saving fruitless detraction from the purpose of ICUs
- How would this decision be relevant to P in a hospice where it could not really be argued that the treatment was “life-saving”? A DOLS authorisation implies death in state custody requiring an inquest (but this is soon to change when the Policing and Crime Bill 2017 comes into force)
- Are “context” and even “purpose” becoming relevant again to the existence of deprivation of liberty? *(Austin v UK (2012) ECHR 459)*

CTOs and dol (1) - (PJ v A LHB (2015) UKUT 480 (AAC))

- The lowering of the threshold for dol as the result of Cheshire West is relevant to the conditions attached to a CTO
- The CTO regime does not take precedence over issues of breach of Article 5. Can S64D for incapacitated P prevent such breach?
- If the conditions do or may amount to dol the Tribunal should adjourn to see whether the treatment can be provided without breach of Article 5 and if not P should be discharged
- Relevant to the Tribunal's considerations would be whether P consents with capacity to the conditions, so negating dol. Here what matters is the reality on the ground – ie the fact that breach of the conditions is not directly enforceable does not necessarily mean there is not dol; likewise whether P's consent is valid or negated by coercion. The fact that P objects is not conclusive of lack of consent or capacity to consent. (See also *MM v WL Clinic (2015) UKUT 0644 (AAC):* Constrained choice can be real)

CTOs and dol (2) – (Welsh Ministers v PJ (2017) EWCA Civ 194)

- The Court of Appeal has firmly rejected the Judge's approach in *PJ*
- The Tribunal has no "umbrella" power to regulate, revise, change or consider the CTO conditions (including whether they are lawful or interfere with P's Convention rights). P's remedy is Judicial Review. The Tribunal can only affirm or discharge the CTO
- The RC has the ultimate power of detention. The power to make conditions is the RC's. These can amount to a dol if they fall short of the level of restrictions in hospital and are used for the specific purposes of the scheme. **(Note this conflicts with Code at 29.31)**
- The CTO framework with its safeguards (and limitations) is a procedure prescribed by law which provides practical protection of P's Convention rights
- Whether P consents to the conditions is therefore not directly relevant

DOL and Conditional Discharge (1)

- In *SSJ v RB (2011) EWCA Civ 1608* the CA significantly restricted the operation of the conditional regime by affirming that a Tribunal could not order conditional discharge into the community on conditions amounting to a deprivation of liberty (a tribunal could not substitute one form of dol for another). This was so even if P was in agreement with the conditions (as such agreement would be coercive) – so P would have to remain in hospital in order to protect his Article 5 rights!
- In *SSJ v KC (2015) UKUT 376* the effect of this decision was considerably mitigated. The court held that if P is to be accommodated in a hospital or care home and lacks the relevant capacity he may be given a conditional discharge with a DOLS authorisation alongside without breaching Article 5 so long as he is not ineligible
- Judge also suggested P with capacity could consent to such conditions (thereby negating dol) even if they took place in an environment of coercion. This the same judge confirmed in *MM v WL (2015) UKUT 644.*

DOL and Conditional Discharge (2)

- In *SSJ v MM (2017) EWCA Civ 194* The Court of Appeal affirmed its earlier decision in *RB* and stated that the subsequent attempts to permit a Tribunal to impose conditions amounting to dol had no legal basis. A Tribunal had no such “umbrella” power which would have needed to be specifically provided in the MHA and to have required a process; such a power could not be implied.
- Consent by P to the conditions, even if not coercive, could not prevent a compulsory confinement from amounting to dol nor create in the Tribunal a jurisdiction it does not possess. Moreover such consent could not be irrevocable and if withdrawn would mean the dol would become unlawful.
- If satisfied capacitated P consented to conditions which would keep him and the public safe in the community the Tribunal could grant an absolute discharge or impose conditions falling short of dol (failing which he remains in hospital!)
- The Act did not authorise detention outside hospital when P is conditionally discharged. Parliament would have to change the law if that presented practical difficulties.
- If P not ineligible, DOLS could run alongside to legitimise dol

Guardianship Post Cheshire West

- Guardianship does not authorise dol *(C v Blackburn with Darwen BC (2011) EWHC 3321 (COP); NL v Hampshire CC (2014) UKUT 475 (AAC); (and see also Code 30.5 and 30.31);* and can be used alongside DOLS *(NM v Kent CC (2015) UKUT 125 (AAC);* The power to require P to live somewhere might not amount to dol, but it could if the care plan in operation there constituted dol
- Does the "acid test" lower the threshold, or will there not be continuous supervision and control?
- If the regime constitutes dol DOLS may be applied if P lacks capacity and is not ineligible. Since *AM v SLAM (2013) UKUT 0365 AAC* tribunals would have to consider the availability of DOLS – see *KD* above. P might consent to the conditions, thereby negating dol.
- If P has capacity and does not consent to the arrangements how can they be authorised?

PR and DoI post Cheshire West (1)

D (A Child) Deprivation of Liberty) (2015) EWHC 922 (Fam)

- 15year old with ADHD, Asperger's and Tourette's admitted to 6 bed psychiatric unit with school room attached. Not allowed to leave without staff or family member. Child not Gillick competent.
- In determining whether objectively there was dol, Cheshire West "acid test" applied irrespective of disabilities
- PR could authorise (and thus negate) dol. *RK v BCC et al (2011) EWCA Civ 1305* was wrongly decided and arguably inconsistent with Cheshire West
- What fell within the scope of PR might differ according to the disabilities and needs of the child. For an autistic child with erratic challenging and potentially harmful behaviours the scope of PR might include more than for a child without disabilities. Introduction of such a comparator in this way is arguably inconsistent with Cheshire West.
- Note: Same judge said in *A LA V D (2015) EWHC 3125 (Fam)* that these conclusions did not apply if child was in care
- Note: *A LA v D, E, C (2016) EWHC 3473 (Fam):* Gillick competent 15 year old can consent to dol and thus negate it.

PR and DoI post Cheshire West (2)

What of16 and 17 year olds? *(Birmingham CC v D (2016) EWCOP 8)*

- "…….however close the parents are to their child and however cooperative they are with treating clinicians, the parent of a 16 or 17 year old young person **may not** consent to their confinement which, absent a valid consent, would amount to a deprivation of that young person's liberty...This falls outside the scope of PR"
- Judge affirmed his decision in *D (A Child)* (see previous slide) re under 16 year old
- Judge did not accept that the accommodation of a young person pursuant to s20 CA 1989 could never amount to a deprivation of liberty
- The local authority was intimately involved in D's placement at and confinement within the residential unit. Accordingly judge held that D's confinement was imputable to the state, so was within Article 5.

  In any event a public body, as an organ of the state, is under a positive obligation to protect the rights accorded by Article 5(1)

PR and Dol post Cheshire West (3)

- This case has now been considered by the Court of Appeal (D (A Child) (2017) EWCA Civ 1695) which held that a person with PR (but not a LA) can consent to confinement of a 16/17 year old lacking capacity which without consent would amount to dol provided this falls within the scope of Parental Responsibility (which is nuanced according to the young person's disabilities)
- The more coercive the confinement the less likely it is to fall within the scope of PR. The MHA Code of Practice guidance at 19.41 may be helpful
- Young children are probably not confined so as to engage Article 5

Deprivation of Liberty at Home

(W City Council v Mrs L (2015) EWCOP 20)

- Arrangements made to "contain" Mrs L (a 93 year old woman with Alzheimer's) safely in her own home by means of fencing, gates, locks, sensors and alarm calls, monitored by family members, held not to constitute deprivation of liberty. The fact that it was her own home was a "relevant factor"; it was not a "placement", distinguishing it from institutional accommodation. That Mrs L was content to be there was also relevant. Court's reasoning arguably more consistent with minority judgements in Cheshire West.
- LA's involvement consisted of several visits each day by specialist carers. However Court held if there had been deprivation of liberty this would not have been imputable to the State as required for breach of Article 5. "The responsibility of the State is… diluted by the strong role which the family has and continues to play". Contrast this with *Birmingham CC v D* (ante) and *Staffordshire CC v SRK (2016) EWCOP 27.* Imputability to the state is a very complex issue

Some Consent to Treatment Issues

When Capacity is not Decisive

Patients detained under the MHA (Part 4)

- Under S58 (administration of medicine by any means during detention after 3 months) SOAD certifies that P is capable, has not consented but that it is appropriate that the treatment should be given
- S58A covers ECT for detained patients (see later slides)
- Under S63 consent of P not required for medical treatment for mental disorder (outside SS57/58) if given by or under direction of the Approved Clinician in charge
- Medical treatment for mental disorder broadly interpreted by the courts (B v Croydon Health Authority)
- CTO patients governed by Part 4A MHA whether capacitated or not. No treatment in absence of consent if capacitated without recall

X v Finland - Is MHA S63 under Threat?

- In *X v Finland (Appn No.34806/04)* ECtHR held there was a breach of Article 8 because Finnish law permitted the forced administration of medication by doctors despite refusal by patient, without immediate judicial scrutiny of its lawfulness and proportionality and without the court being able to order its discontinuance
- It could be argued that MHA S63 creates a similar power. However:-
- The combined effect of the procedural requirements of the MHA, the power of Tribunals to discharge and in particular the cases of *Wilkinson v UK (2006) MHLR 142), R(JB) v Dr Haddock (2006) EWCA Civ 961, R(N) v Dr M (2002) EWCA Civ 1789), R(PS) v Dr G and Dr W (2003) EWHC 2335 (Admin),* and *R(B) v Dr SS(2006) EWCA Civ 28* and recently *Nottinghamshire Healthcare NHS Trust v RC (2014) EWHC 1317 (COP)* may mean that sufficient safeguards have been built into the scheme for compulsory treatment for **UK** law to be compliant with Article 8. Convincingly demonstrating the therapeutic need to proceed is akin to importing a best interests test into MHA

Advance Decisions Statements of Wishes and MHA

- If Advance Decision is valid and applicable, it is binding
- If Advance Decision is either not valid or not applicable, while it is not binding it cannot be ignored. See *Newcastle Foundation Trust v LM (2014) EWHC 454 (COP) - Advance Decision to refuse blood products valid and applicable but even if not P's expressed wishes should be respected as being in her best interests*
- Advance Decision displaces the S4 MCA best interests checklist
- Best interests checklist requires statements of wishes to be considered "so far as is reasonably ascertainable"
- Statement of wishes and an Advance Decision would have to be considered even where MHA 1983 Part IV allows treatment to be imposed on P in deciding whether this was "convincingly shown to be a therapeutic necessity" (See *Nottinghamshire Healthcare NHS Trust v RC (2014)EWHC 1317 (COP).*

Anorexia Cases – Paradigm or Exception?(1)

- A LA v E (2012) EWHC 1639 (COP). Lacks capacity. Advance Decisions invalid. Multiple MHA admissions. 20% chance of recovery with specialist intervention. Best interests and proportionate to impose treatment (under MHA)
- An NHS Trust v L (2012) EWHC 2741 (COP). Similar scenario but gloomier prognosis. “This is one of those few cases where the only possible treatment, namely force feeding under sedation, is not to be countenanced in Ms L’s best interests: to do so would be futile, carrying with it a near certainty that it would cause her death in any event”
- An NHS Trust v X (2014) EWCOP 35. Similar scenario. Court endorsed view of doctors that it was “clinically inappropriate, counter-productive and increasingly unethical to cause her to be admitted for further compulsory feeding”. Took into account X’s wishes and feelings

Anorexia Cases – Paradigm or Exception?(2)

- Betsi Cadwaladr v W (2016) EWCOP 13. Similar scenario. Court agreed with unanimous professional view that using coercion to get W to eat was no longer appropriate. It was beyond the power of doctors, family members and court to improve her circumstances or to extend her life.
- Cheshire & Wirral v Z (2016) EWCOP 56. Similar scenario. Court had three options. First, naso-gastric feeding under MHA under physical restraint. Rejected as dangerous and unjustifiably distressing. Second, as first option but treatment under chemical sedation. Rejected because of high risk of respiratory or cardiac arrest. Third, discharge from MHA and treated if at all only on a voluntary basis. Adopted without any realistic hope that Z would in fact engage meaningfully. “Choosing between 3 palliative care options”
- In all but the first of these cases Court is effectively handing back control to P despite findings of incapacity in relation to the anorexia. Balancing of Article 2 and 8 rights of P

MHA Code Guidance

- All treatment provided should be appropriate to the patient's mental health condition and take account of any advance decisions made by the person and any wishes or feelings they have expressed in advance of treatment (24.6).
- (Even when given during first 3 months under S63) the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment (24.41)
- Code confirms what appear to be inexorable incremental moves in the direction of ascertaining and respecting P's wishes, whether informal or detained, wise or unwise, capacitated or not, and having less regard for the wishes or views or powers of those providing treatment
- Note also moves to introduce Ulysses Pacts and Advance Consent

S2 or S3?

Issues for Discussion

Context: suggestions from Tribunals and DH that there are too many S2s and resultant expensive hearings

- Who decides S2 or S3 – the doctors or the AMHP?
- To what extent should AMHP examine the doctors' conclusions?
- What is the purpose of each?
- Is there a hard line between S2 and S3 or is there overlap?
- Is S2 less restrictive than S3? If so how?
- Are the criteria (and are the safeguards) higher for S3 than S2?
- Might it be unlawful to admit under S2 rather than S3?
- What of S3(2)(c): treatment cannot be provided unless under S3?
- What happens if P is treated immediately admitted under S2?
- Is assessment in the community different from in hospital (legally)?

Section 2 or Section 3? (Code Para 14.27-14.28) (1)

S2 if:

- The full extent of the nature and degree of a patient's condition is unclear;
- There is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission; or
- There is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis

Section 2 or Section 3 (Code Para 14.27-14.28) (2)

S3 if:

- The patient is already detained under section 2 (detention under section 2 cannot be renewed by a new section 2 application); or
- The nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as an informal patient are already **sufficiently established to make it unnecessary to undertake a new assessment under section 2**

Senior President of Tribunals’ Annual Report 2017 (1)

- “Reference has been made in a previous report to the possible overuse of s.2 given that s.2 is primarily for assessment purposes and yet a high proportion of patients detained under s.2 are well-known to mental health services.”
- “Anecdotally these reasons include pressure on beds in some areas and use of s.2 to “ jump the queue” and some are highlighting …out of hours “sectioning” when professionals who know the patient are unavailable. Stand alone admission teams are likely to be unfamiliar with the patients’ case”
- “Changes to the MHA Code… “have not produced a significant reduction in s.2 admissions”

Senior President of Tribunals' Annual Report 2017 (2)

- "s2 cases "present the tribunal with a serious challenge of urgent listing". Rule 37(1) requires that the hearing of any application by a s.2 patient must start within 7 days after the date on which the tribunal received the application notice. However, Rule 37(4)(a) also provides that the tribunal must give all parties at least 3 working days' notice of the hearing."
- "Even if the tribunal lists the case immediately upon receipt, most s.2s will- by the time a full panel convenes- only have (on average) around 14 days left to run before they expire. However for those who are then further detained on s3 a further right of application to the tribunal then arises."

S2 or s3 and Jones' on-going view:

- 'A patient whose current mental health and circumstances require him to be subject to the very significant procedure of compulsory detention surely needs to be assessed however well known he might be to mental health services. Something has happened in that patient's life to justify intervention under the Act and it is the factors that precipitated the detention and their impact on the patient that need to be assessed. The extent of any prior knowledge that might exist about the patient does not deflect from the need to assess the patient's *current* situation (MHA Manual 18th ed, pg 34)

Some legal debates & views- s2 & s3

Section 2(2)(a) states that:

He is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period.

- Assessment and treatment surely have different meanings here (assessment is not defined in the MHA) even taking account of the broad definition of treatment?
- Assessment in s2 should precede any medical treatment for the mental disorder in s2
- Assessment may or may not be followed by treatment

Some legal debates & views- s2 & s3

- S2 and s3 are for different purposes.
- Section 3 is for the purpose of treatment of a mental disorder when assessment has been completed.

"The Act requires that appropriate treatment is available…If the distinction between assessment and treatment is real, section 2 may not be an option if the clinician is already clear in his or her mind what treatment ought to be given. If that were the case, what would be the assessment required?"

(Mental Health Law & Policy –Gostin 2010)

“Least restrictive”?

- Nothing in the MHA to support a view that every s3 admission must be preceded by a s2

- There is no case law to support a proposition that s2 is “less restrictive” than s3…both comply with Article 5 ECHR

- It should not be assumed that s2 is less restrictive than s3 as this argument can be applied either way and both have adequate safeguards.

- The question and arguments are irrelevant because s2 and s3 are for different purposes.

Finally on the issue of s2 v s3, the Welsh Code (para 14.21) is interesting in that it states:

Decisions should not be influenced by the possibility that:

- a proposed treatment plan has been formulated but the treatment to be administered under the Act will last less than 28 days
- access to the Mental Health Review Tribunal for Wales may be quicker for a patient detained under section 2, than a patient detained under section 3
- a community treatment order will only be available if the patient has been admitted under section 3
- a patient's nearest relative objects to admission under section 3.

What is the purpose of the admission?

- To assess a condition which at the time of admission is not understood well enough for doctors to know what treatment is needed or to treat a condition which is sufficiently well understood for doctors to know what treatment is needed

- What still needs (re)-assessed? assessing the nature of the disorder and likely response to treatment…?

- Is treatment for mental disorder likely to start immediately on admission?

- How does the MHA Code guide us?

Item 24.1

Presentation to	X In Public Board Meeting		☐ Confidential Board Meeting		NHS Solent NHS Trust			
Title of Paper	Governance Updates – including: - Board Code of Conduct - Declarations of Interest - NHSI Provider Licence Compliance Annual Declaration							
Author(s)	Rachel Cheal – AD Corporate Affairs and Co Sec.		Executive Sponsor		Sue Harriman, CEO			
Date of Paper	17th May 2018		Committees presented		---			
Well Led KLoEs	W1 Leadership Capacity & Capability		W2 Vision & Strategy		W3 Culture		W4 Roles & Responsibilities	x
	W5 Risks and Performance		W6 Information		W7 Engagement		W8 Learning, Improvt & innovation	
Action requested of the Board	☐ To receive		X For decision					

The following governance documentation has been reviewed and updated (changes tracked in red font):

1. **Board Code of Conduct (Item 24.2) –** the Code of Conduct has been reviewed; there are no material changes to note and minor changes are highlighted. Appendix 2 Fit and Proper Person Self Declaration has been amended following approval of the Fit and Proper Person Standard Operating Procedure at the Feb 2018 Governance and Nominations Committee, removing reference to Monitor/Foundation Trusts.
2. **Declarations of Interest** - it is good governance to formally annually note the declarations declared by Board members. These can be found within pg 47 of the Annual Report. Board members regularly update these; the register is held by the Company Secretary's office and contemporary updates are available via our public website.
3. **Board Terms of Reference (Item 24.3)** - the terms of reference have been reviewed; there are no material updates. Reference the People and OD Committee has been included. Minor amendments have been tracked/highlighted.
4. **NHS Provider Licence Compliance Annual Declaration - (Item 24.4)**

The requirement

In April 2017, NHS Improvement introduced a new requirement on all NHS Trusts whereby each Trust is asked to **self-certify in accordance with the NHS Provider Licence** on an annual basis.

Although NHS Trusts are exempt from needing the provider licence, directions from the Secretary of State require NHSI to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF), bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

Solent NHS Trust, is therefore required to self-certify annually that we meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that we have complied with governance requirements.

The process

The Board last formally 'self-certified' against the requirements at the May 2017 In Public Board meeting. At this point it was also agreed that on-going compliance be incorporated within the wider SOF requirements, captured within the Performance Report, rather than solely considering the requirements on an annual basis.

Changes to process in 2018/19

There is no requirement during the year ahead to return the completed self-assessment to NHSI, as previously – Trusts must, however, **publish their self-certifications via their websites**. From **July 2018 NHSI will conduct spot audits on a select number of NHS Trusts** (and FTs).

NHS Providers are asked to self-certify the following after the financial year-end:

Condition	Requirement
Condition G6 (3)	• Providers must certify that their Board has taken all precautions neccessary to comply with the licence, NHS Acts and NHS Constitution (by 31 May 2018)
Condition FT4 (8)	• Providers must certify compliance with required governance standards and objectives (by 30 June 2018)

A template has been provided by NHSI to capture Trust responses on a 'comply or explain' basis, which has been adapted for internal use to capture assurance.

There is no set process for assurance or how conditions are met, which is reflective of autonomy - each Trust is therefore required to determine how compliance is met (or otherwise). NHSI requires each **Board to formally 'sign'** in agreement of compliance against the conditions.

Providers are required to have effective systems and processes in place to ensure compliance; to identify risks to compliance and take reasonable mitigating actions to prevent those risks/or compliance failures.
A copy of Solent NHS Trust's compliance with these conditions are found in Item 24.4 (a copy of the full Licence Conditions for G6 and FT4 are found in Appendix 1)

Recommendations:

The Board is asked to:

1. Approve the **Code of Conduct** (and individual Board members will then be asked to make individual declarations)
2. Note the **Declarations of Interest** as included within the Annual Report and note that contemporary updates are published on our public website
3. Approve the **Board Terms of Reference**
4. Confirm its agreement with the responses outlined against each of the **Provider Licence requirements; or provide alternative responses as agreed**. Representatives of the Board (the Chairman and the CEO) are asked for formally sign in agreement.

Item 24.2

Board of Directors: Code of Conduct

Purpose of Agreement	To outline the behaviours and requirements expected of the Board
Reference Number	Solent/Corporate / BoDCoC/01
Version	Version 5
Name of Approving Committees/Groups	Board of Directors
Operational Date	May 2018
Document Review Date	May 2019
Document Sponsor (Name & Job Title)	Dr. Alistair Stokes, Chairman
Document Manager (Name & Job Title)	Rachel Cheal, Associate Director of Corporate Affairs and Company Secretary

Version	Summary of amendments
2	Overall document review and incorporation of Regulation 5 Fit and Proper Person requirements – amended Appendix 2.
3	Annual Review- updated section 3.1 to reflect new organisational values, changes made to reference 'Members Council' throughout, no other material amendments required
4	Annual Review
5	Overall document review- updates made to: • Referencing General Data Protection Regulation (section 5.5, pg4) • Referencing new policy title 'Managing Conflicts of Interest' (section 8.4, pg5) • Appendix 2 Self-declaration updated following approval of the Fit and Proper Person SOP at the Feb 2018 Governance and Nominations Committee (removing reference to Monitor /FT) • Appendix 3 – referencing SolNET (the Trust's intranet) and updated Board report template to be used

Foreword – this Code of Conduct applies specifically to the Board of Directors (as defined below); however the principles described equally apply to all members of staff.

1. Introduction

1.1 High standards of corporate and personal conduct are an essential component of public services. Solent NHS Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant Code of practice.

1.2 The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of the [1]Board of Directors.

1.3 This Code forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust.

1.4 The Code is intended to operate in conjunction with the Standing Orders. The Code applies at all times when the Board are carrying out the business of the Trust or representing the Trust.

1.5 The Board must also comply with the statutory and general duties requirements conferred by legislation as set out in the NHS Act 2006 ("NHS Act"), as amended by the Health & Social Care Act 2012 ("HSCA").

1.6 The Board must also comply with the following;

- Standards for NHS Board Members 2012
- Code of Conduct - Code of Accountability in the NHS 2004

2. Principles of public life

All Directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

2.1 Selflessness**:** Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

2.2 Integrity**:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

2.3 Objectivity**:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

[1] *For the purpose of this document the Board of Directors/ Directors means, Board members (voting) and non-voting (i.e. other executive directors and lay members)*

2.4 Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

2.5 Openness: Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

2.6 Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

2.7 Leadership: Holders of public office should promote and support these principles by leadership and example.

3. Corporate vision & values

3.1 Solent NHS Trust Board of Directors will also adhere to the following organisational values developed with staff and the Board:

Our values are:

4. General Principles

4.1 The Board of Directors has a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

4.2 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for service users and for the public.

4.3 The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Standing Orders, Financial Standing Orders and an accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct.

4.4 The Board of Directors expects that this Code will inform and govern the decisions and conduct of all Directors.

5. Confidentiality and Access to Information

5.1 Directors must comply with the Trust's confidentiality policies and procedures.

5.2 Directors must not disclose any confidential information, except in specified lawful circumstances.

5.3 Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable.

5.4 Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

5.5 The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the General Data Protection Regulation[2], the Freedom of Information Act and other relevant legislation which will be followed at all times by Board of Directors and all staff.

5.6 As part of this Code of Conduct, the Board are asked to confirm their agreement with the Non-Disclosure Agreement, located in Appendix 1.

6. Register of Interests

6.1 Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the Standing Orders.

6.2 It is the responsibility of each Director to update the register entry if their interests change.

6.3 A pro forma is available from the Company Secretary - failure to register a relevant interest in a timely manner may constitute a breach of this Code.

7. Conflicts of Interest

7.1 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

7.2 Directors have a further statutory duty not to accept a benefit from a third party by reason of being a Director or for doing (or not doing) anything in that capacity.

7.3 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the Director must declare the nature and extent of that interest to the other Directors. It is equally important to register any potential conflicts.

7.4 If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

[2] The GDPR replaces the Data Protection Act

7.5 The Chair will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the Director should withdraw from the meeting for the period of the discussion.

7.6 In the event of disagreement it is for the Board of Directors to decide whether a Director must withdraw from the meeting. The Company Secretary will provide advice on any conflicts that arise between meetings.

7.7 Further information can be found within the Standing Orders.

8. Gifts and Hospitality

8.1 The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure.

8.2 The use of the Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered.

8.3 All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust in the eyes of the community.

8.4 The Board of Directors has adopted a *'Managing Conflicts of Interest Policy'* which will be followed at all times by Directors and all employees. Directors and employees must not accept gifts or hospitality other than in compliance with this policy.

9. Freedom to Speak Up /Whistle – Blowing

9.1 The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature.

9.2 The Board of Directors has adopted a Freedom to Speak Up Policy (whistle-blowing policy) on raising matters of concern which will be followed at all times by Directors and all staff. The policy sets out the arrangements and procedures to be followed in situations where staff wish to raise a concern, the document also outlines the scrutiny and oversight by the Audit & Risk Committee.

10. Personal Conduct

10.1 Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute.

10.2 Specifically Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code of Conduct
- Respect others and treat them with dignity and fairness

- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion
- Be honest and act with integrity and probity
- Contribute to the workings of the Board of Directors as a Board member in order for it to fulfil its role and functions
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the Trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate
- Recognise the differing roles of the Chair, Deputy Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors
- Make every effort to attend meetings where practicable
- Adhere to good practice in respect of the conduct of meetings and respect the views of others
- Take and consider advice on issues where appropriate
- Acknowledge the responsibility of the Members Council to represent the interests of the Trust's members and partner organisations in the governance and performance of the Trust, and to have regard to the views of the Members Council
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person
- Accept responsibility for their performance, learning and development.

11. Fit and Proper Person Requirements

11.1 In accordance with Monitor's NHS Provider Licence Condition G4 and Regulation 5 of the Regulated Activities Regulations, Health & Social Care Act 2008, Directors are asked to confirm their compliance with the Fit and Proper Persons Test as outlined in Appendix 2. Although the Fit and Proper Person requirements of Regulation 5 do not apply to the Members Council, the Trust has implemented its own governance procedures, including reference to Fit and Proper Person requirements, the introduction of standard DBS checks, and Companies House checks.

12. Fraud, Corruption and Bribery

12.1 In accordance with the Bribery Act 2010 and the Trust's 'Fraud, Corruption & Anti –Bribery Policy', Solent NHS Trust is committed to supporting anti-bribery and corruption initiatives and recognises the importance of ensuring that there are appropriate policies and procedures in place to ensure that all staff are aware of their responsibilities. Solent NHS

Trust is absolutely committed to maintaining an honest, open and well-intentioned atmosphere. It is also committed to the elimination of any fraud within the Trust and to the rigorous investigation of any such cases. The Board of Directors will comply with the Trust's policy.

13. Board Principles regarding meeting etiquette and administration

14.1 Principles of meeting etiquette and administration are summarised in Appendix 3.

14. Compliance

14.1 The members of the Board of Directors will satisfy themselves that the actions of the Board of Directors in conducting Board business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon.

14.2 All directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code of conduct.

Appendix 1 - Non Disclosure Agreement

Dear Director

As a member of the Board of Directors, you will hold a valued and trusted position within our organisation. In the course of discharging your role, you will receive Confidential Information (please see further below). To protect the interests of the Trust and its service users, the Code of Conduct expects you to agree to respect the confidentiality of such information.

Please confirm your agreement to do so by signing and returning to the Trust the enclosed compliance form. Please direct any questions you may have to the Trust Secretary.

For the purposes of this commitment, "Confidential Information" means:

(a) all information (whether communicated orally or in writing) relating to the business, financial, staff or other affairs of the Trust disclosed to you in your capacity as a Director of the Trust (including, without limitation, agendas and minutes relating to meetings); but excluding any information already in the public domain (for example, Part 1 In Public Board agendas and associated papers) and

(b) all notes, memoranda or other documents prepared by you which contain, reflect or are generated from the information referred to in (a) above.

If you are in any doubt as to whether particular information is Confidential Information, please check with the Trust Secretary.

It is worth emphasising that the Trust is committed to transparency and openness, as well as to meeting its statutory obligations. To be clear, nothing in this letter or the commitment which it seeks from you shall prejudice any rights that you may have under the Public Interest Disclosure Act 1998 and/or any obligations that you have or may have to raise concerns about patient safety and care with regulatory or other appropriate statutory bodies pursuant to applicable professional and ethical obligations (including those obligations set out in guidance issued by regulatory or other appropriate statutory bodies from time to time).

Yours sincerely

Rachel Cheal, Associate Director of Corporate Affairs & Company Secretary, on behalf of Solent NHS Trust.

Appendix 2 - Fit and Proper Person Declaration

Pre-employment and annual declaration for Director and Director-equivalent posts

Solent NHS Trust ("the Trust")

1. It is a condition of employment that those holding director and director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the NHS Provider Licence Condition G4, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulated Activities Regulations"), and the Trust's Standing Orders.

2. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

NHS Provider Licence Condition G4,

3. Condition G4 provides that the Licensee shall not appoint as a director any person who is an unfit person, except with the approval in writing of the Regulator.

4. Directors contracts contain a provision permitting summary termination in the event of a director being or becoming an unfit person. The Trust shall also ensure that it enforces that provision promptly upon discovering any director to be an unfit person, except with the approval in writing of the Regulator.

   (Regarding governors, no person who is unfit may become or continue as a governor, except with the approval in writing from the Regulator).

   If the Regulator has given approval in relation to any person in accordance with the above the Trust shall notify the Regulator promptly in writing of any material change in the role required or performance by that person.

5. An "unfit person" is defined at condition G4 as:

   (a) an individual:

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) 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; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and 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; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

Trust's Standing Orders

9. The Trust's Standing Orders (section 2.10) places a number of restrictions on an individual's ability to become or continue as a director. A person may not become or continue as a director of the Trust if:

- 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);
- 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.

Declaration

I acknowledge the extracts from the Provider Licence, Regulated Activities Regulations and the Trust's Standing Orders above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post.

I declare that I have not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying out of a regulated activity in any former roles. If the Trust discovers information, after appointment, that suggests an individual is not of good character, or if concerns or findings regarding misconduct or mismanagement under the Fit and Proper Person requirements are made, these will be shared with Regulators as appropriate and may lead to action in accordance with the Trust's disciplinary policy.

Name	
Signed	
Date	
Position	

Appendix 3 - Solent NHS Trust Board Principles

The members of Board of Directors hereby agree to follow the below principles:

1. Apologies sent to the Associate Director of Corporate Affairs and Company Secretary ASAP

2. Agenda items to be agreed by Chair and Chief Executive Officer at least 2 weeks prior to meeting

3. In accordance with the Intelligent Board Recommendations, every member of the Board needs sufficient information at a high enough level to be confident that the organisation is well run. Papers must be presented in accordance with the Board Report template and guidance[3] available on SolNET. The submitted board paper while succinct must contain sufficient information to act as a stand-alone paper without reference to any additional papers which may be made available outside the formal board papers. Executive sponsors must not rely upon board members reading additional papers as a means of communicating critical information.

4. Papers received after the deadline stipulated will not be accepted and will be deferred, unless with express permission from the Chair.

5. Authors of papers to ensure that they are sponsored by the relevant Executive Lead, prior to being submitted for circulation to the Board with the agenda

6. Agendas and papers to be circulated 5 working days prior to meeting

7. All papers to be read prior to meeting

8. A.O.B to be agreed at the start of the meeting

9. A Register of Interests will be maintained and all members will separately declare any interests in agenda items at the start of the meeting, which will then be recorded in the minutes.

10. Throughout the meeting Members will address the Chairperson as 'Chair'.

11. Attendance at the meeting should take priority over other meetings, however it is recognised that on occasions there will be competing priorities. In these circumstances the Board Member shall negotiate with the Chair/Chief Executive Officer regarding attendance

12. Mobile phones and blackberries will be switched off during the meeting and not used (except in the case where the attendee is on-call. The Chair should be notified at the start of the meeting in such cases). Use of laptops/ ipads is only permitted for the sole purpose of supporting the meeting.

13. These principles are extended to Board Committees.

14. An annual agenda cycle will be maintained by the Secretary to the Board and will include the standing items that are required to be presented each month.

[3] http://intranet.solent.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc=/DocumentCentre/ManagedTemplates/Board%20Report%20template.doc&action=default

Annual Declaration of Compliance with Code of Conduct

1. I confirm that I have received and read the **Code of Conduct** for the Board of Directors. I confirm that I have complied with the Code to date and I agree to comply with it in the future in carrying out my role as a Director of Solent NHS Trust.

In doing so, I also;

2. confirm my agreement to preserve the confidentiality of confidential information, as outlined in the **Non Disclosure Agreement**, Appendix 1

3. acknowledge the extracts from the Provider Licence, Regulated Activities Regulations concerning **Fit and Proper Persons requirements** as outlined in Appendix 2. I confirm that I do not fit within the definition of an "unfit person" as listed and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post.

4. confirm I understand and respect the details outlined in **Solent NHS Trust Board principles**, Appendix 3.

Name (please print)	
Signature	
Date	

Please return this completed signed form to: **- Associate Director of Corporate Affairs & Company Secretary, Solent NHS Trust, Solent NHS Trust Headquarters, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR**

Item 24.3

Solent NHS Trust
Trust Board Terms of Reference

Reference to "the Board" shall mean the Trust Board

1 Constitution

1.1 The Board is accountable to the Secretary of State for the effective direction of the affairs of Solent NHS Trust, setting the strategic direction and appetite for risk of the Trust, establishing arrangements for effective governance and management and holding management to account for delivery, with particular emphasis on the safety and quality of the Trust's services and achievement of the required financial performance

1.2 The Board has established the following Committees:

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

2. Purpose

2.1 The purpose of the Trust Board is to govern the organisation effectively and ensure that the Trust is providing safe, high quality, patient-centred care.

2.2 The Board leads the Trust by undertaking the following key roles:

- Ensure the management of staff welfare and patient safety
- Formulating Strategy, defining the organisations purpose and identifying priorities
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
- Seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- Shaping a positive culture for the board and the organisation.

3 Duties

3.1 <u>Clinical Standards and Patient Safety</u>

3.1.1 To receive reports which provide assurance of the quality and safety of healthcare services, education, training and research delivered by Solent NHS Trust, by applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies and assure the Board that areas of concern are being monitored.

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

3.1.3 To oversee the risk management ~~strategy~~ framework implementation of Solent NHS Trust, and ensure appropriate action in relation to adverse events that occur.

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

3.1.5 To be responsible for overseeing the development and implementation of a workforce ~~strategy~~ plan, ensuring the workforce meets the needs of the organisation and is fit for purpose.

3.2 Formulate Strategy

3.2.1 To set the strategic direction to be pursued by the Trust being cognisant of the Sustainability and Transformation ~~Plan~~ Partnership for Hampshire and the Isle of Wight

3.2.3 To develop and approve a long term clinically informed Trust Strategy which is designed to bring healthcare benefit to the population, build reputation and ensure the sustained success of Solent NHS Trust enabling the organisation to compete effectively in the healthcare market.

3.2.4 To oversee the implementation of the long term financial model (LTFM) to deliver the long term success of Solent NHS Trust as well as oversight of the achievement of the Trust's Control Total.

3.2.5 To ensure the necessary financial and human resources are in place to meet strategic objectives and review management performance.

3.2.6 To approve business cases and new business opportunities as recommended by the Chief Executive, Trust Management Team Meeting (TMT) and Finance Committee and in accordance with the Trust's SFI's and Scheme of Delegation

3.2.7 To approve the development of innovative models of service delivery and redesign proposed by the Chief Executive and TMT

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

3.3 Shape Culture & Partnership Working

3.3.1 To foster positive and productive external relationships with partners and stakeholders in the local health economy, in particular with patient/user groups and forums; Local Authority, Health and Wellbeing Board, Sustainability & Transformation ~~Plan~~ Partnership partners, Healthwatch and Primary Care.

3.3.2 To maintain public and staff confidence and engagement with Solent NHS Trust and facilitate the effective involvement of the public

3.3.3 To ensure that the culture of the organisation reflects NHS values as reflected in the NHS Constitution, namely: respect and dignity; commitment to quality of care; compassion; improving lives; working together for patients and everyone counts.

3.4 Performance Management

3.4.1 To continuously monitor and respond to performance of all Solent NHS Trust services ensuring close links to operational plan objectives and vital signs.

3.4.2 To agree and approve SLAs with NHS providers.

3.4.3 To consider directives, comments and recommendations from the Board's committees and take the appropriate action.

3.5 Governance

3.5.1 To be assured that an appropriate governance framework of prudent and effective controls is in operation which enables resources and risk to be assessed and managed allowing transparency, probity, integrity and the efficient use of resources.

3.5.2 To deliver financial balance/surplus and continuously monitor the organisations viability as a going concern

3.5.3 To approve the Annual Report, Quality Account and Annual Accounts

3.5.4 To be responsible for ensuring the effective stewardship of assets

3.5.5 To provide advice concerning action against litigation.

3.5.6 To receive and review the Board Assurance Framework and request the presentation of reports where additional assurance is required.

3.5.7 To embed the Learning Organisation and Quality Improvement ethos into all activities.

4 Membership

4.1 The Trust Board will comprise the following:

Voting members:

- Independent Chair (Chairperson)
- Five Non-Executive Members
- Chief Executive
- Chief Nurse
- Director of Finance & Performance
- Chief Medical Officer
- Chief People Officer

Non voting members:

- Chief Operating Officer Portsmouth and Commercial Director
- Chief Operating Officer Southampton and County

4.2 In the case of the number of votes for and against a motion being equal, the Chair of the Board will have a second, casting vote.

4.3 A manager who has been appointed formally to act up for an officer member during a period of incapacity or temporarily to fill an officer member vacancy, shall be entitled to exercise the voting rights of the officer member.

4.4 Members will be expected to attend at least 75% of meetings.

4.5 When an executive director member is unable to attend a meeting, a nominated deputy must be identified. The nominated deputy must be a direct report to the Board member.

5 Attendees

5.1 The following will be attendees at the meeting;

- Associate Director of Corporate Affairs and Company Secretary

5.2 In addition, lead officers representing other services/departments may attend when required or at the invitation of the Chair.

6 Secretary

6.1 The Corporate Support Manager and Assistant Company Secretary or their nominee shall act as the secretary of the committee**.**

6.2 The administration of the meeting shall be supported by the Corporate Support Manager and Assistant Company Secretary who will arrange to take minutes of the meeting and provide appropriate support to the Chairman and committee members.

The agenda and any working papers shall be circulated to members five working days before the date of the meeting.

7 Quorum

7.1 No business shall be transacted at meetings of the Board unless the following are present;

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

8 Frequency

8.1 Meetings will be held every other month or more frequently if required, under the Chairmanship of the Solent NHS Trust Chair.

8.2 The following meetings will be held:

- Seminar (to brief the Board on current issues)
- In Public Meeting
- Confidential Meeting

8.3 Additional Board Development Workshops will be scheduled throughout the year as appropriate to support Board development and strategic planning.

9 Notice of meetings

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

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 and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

10 Minutes of meetings

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

10.2 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of

interest and minute them accordingly**.**

10.3 Minutes of meetings shall be circulated promptly to all members once agreed.

10.4 Minutes will be available under the Freedom of Information Act 2000.

11 Authority

11.1 The Board may :

- seek any information it requires from any employee of the Trust in order to perform its duties
- obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- call any employee to be questioned at a meeting of the Board as and when required.

12 Reporting

12.1 The Board will develop an Annual Cycle of Business where scheduled items throughout the year will be presented.

12.2 The Board will receive copies of minutes / updates (including exception reporting) from its reporting Committees via the relevant Committee Chairs

12.3 The Chairs of Committees will also be responsible for ensuring relevant information and decisions are reported and cascaded back through the appropriate communication channels.

12.4 The Board will receive project reports on an ad-hoc basis.

12.5 Member's attendance at meetings will be disclosed in the Trust's Annual Report.

Version	8
Agreed at Trust Board	May 2018
Date of Next Review	May 2019

Item 24.4

Solent
NHS Trust

Self-Certification 2018/19 – NHS Provider Licence – May 2018

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
Condition G6 – Systems for compliance with licence conditions				
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	The Board is not aware of any departures or deviations with Licence conditions requirements. The effectiveness of internal control systems and processes are reviewed on an annual basis and documented within the Annual Governance Statement as presented to the Audit & Risk Committee and incorporated within the Annual Report. In addition, assurance to the Board is supported by opinions from Internal Auditors and External Auditors. Annually the Trust declares compliance against the requirements of the NHS Constitution	
Condition FT4 – Governance Arrangements				
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate.	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSI.	

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
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation	Confirmed	The Board is not aware of any departures from the requirements of this condition. On an annual basis the Trust has implemented a process of governance reviews (via the Governance and Nominations Committee) including; - Reviewing composition, skill and balance of the Board and its Committees - Reviewing Terms of Reference - The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business conducted in year. A mid-year review of each Committee is also conducted. The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quoracy as well as any recommendations made following Internal Auditor (or other external review) – including the outputs of the Audit concerning the effectiveness of the Assurance Committee and Quality Improvement and Risk Group. The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.	

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	*Confirmed	Regarding the financial position: For 2017/18 – The Trust achieved a £0.7m surplus (subject to audit) against an agreed deficit control total of £1.5m. Our External Auditor conclusion is awaited. For 2018/19 our agreed control total is £971k deficit Internal control processes has been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls. The Board is not aware of any other departures from the requirements of this condition.	Concerning CQC compliance: We continue to address actions and monitor compliance with requirements made following our 2016 comprehensive inspection and subsequent inspections.

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
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. Concerning Board level capability – All positions are substantively filled and qualifications, skills and experience are taken into consideration together with behavioural competencies as part of recruitment exercises for any vacancy. The Executive team will be undertaking a 360 degree team appraisal during Q1 2018/19. Established escalation processes allow staff to raise concerns as appropriate.	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Signed on behalf of the Board of Directors;

Signature

Title

Date

Signature

Title

Date

Appendix 1 – details of full relevant Licence conditions:

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   (a) the Conditions of this Licence,
   (b) any requirements imposed on it under the NHS Acts, and
   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement (Monitor) a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHS Improvement (Monitor) in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply 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.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
(a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement (Monitor) from time to time; and
(b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
(a) effective board and committee structures;
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:
(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.
8. The Licensee shall submit to NHS Improvement (Monitor) within three months of the end of each financial year:
(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and
(b) if required in writing by NHS Improvement (Monitor), a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.