Solent **NHS**

NHS Trust

Annual Report and Accounts 2015/16

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

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Statement from the Chairman and Chief Executive Officer

We are pleased to present you Solent's 2015/16 Annual Report, incorporating our Quality Account for the same financial period.

This has been an exciting, but challenging, year for Solent NHS Trust. We have all worked hard to become as financially efficient as possible, whilst ensuring our services are safe and of the right quality standards. There have been clear signals for change from NHS England and The Five year Forward View (5YFV) has described a new environment for health and social care, working within communities and not constrained by organisational boundaries.

Recognising that we need our staff or 'Team Solent, as we refer to them, alongside us as we prepare ourselves for the future, we have taken time this year to reconsider our Values and how we work within them. Team Solent told us that they wanted, Honesty, to work in a trust where Everyone counts, where people should be Accountable and Respected, and where a sense of Teamwork was essential, HEART. We are working hard to understand what these values mean to us and our communities. We will continue to ensure we live our values and support those around us to do the same.

The year has also been rewarding in a number of areas, and the coming year promises to deliver even more successes. Our staff, our biggest and best asset, have taken on the challenges thrown their way with grace, magnanimity and determination. You will read in this annual report that, amongst other achievements about

- staff that have been nominated for local and national awards
- case studies that demonstrate the real difference made to real people who come into contact with our services
- initiatives and campaigns that have helped improve mental and physical health of some people within the communities we serve
- innovative services that are benefitting staff and service users alike

We recognise that, nationally, public sector funding is limited, leading to reducing investment. In the meantime, the demand for our services continues to grow year-on-year. In addition, we have made a number of essential investments in our Information Technology (IT) infrastructure and our Clinical Records System (CRS); this alongside a need to ensure we significantly reduced accumulated cost pressures has meant that we have had to focus on delivering our Business Plans safely and effectively, whilst not compromising quality.

Team Solent has responded admirably to the financial challenges we have faced, even when some of the decisions we have made meant direct change for them personally. We have focused on reducing our overhead costs so all available money can go to support our front line services. We have concentrated on reducing the number of buildings we use, and where appropriate, we have moved staff to work alongside our partners in health and social care. This has helped us to reduce overheads and sell property so we can invest back into our teams. Although we still have much more to do, we have invested in our IT systems so we can support staff to work remotely with real time data and we are embracing a new 'Digital age' as we all try to work as efficiently as we can. We have encouraged staff to share ideas about working more efficiently and supported them where we can to realise their idea.

We recognise that some of the decisions we have made will have increased our risk and so we have put significant effort into our risk management processes. We have not always got it right, and where mistakes have been made we have ensured we understand and learn for the future. As an example, when we have seen increasing numbers of vacancies in a team following a service change, and we have had to resort to increasing agency use to ensure safe staffing levels; this is not optimal from a quality perspective or indeed cost efficient.

Our Cost Improvement Programme (CIP) had greater traction this year, and although some of our savings were generated non-recurrently, we delivered a better position than our planned deficit of £5.2m, with a year-end outturn of a £5.1m deficit. For 16/17 we have an agreed deficit plan of £4.5m. We have taken time to learn from this year's planning round to enhance our 16/17 planning processes. We are confident our major transformation schemes for the coming financial year will help us break even from 1 April 2017.

We are, however, cognisant of the on going financial challenges in the system around us and the impact they may have on our services. Reductions in Public Health funding this year, and next year, have had, and will continue to have, a direct impact on our health visiting and public health nursing services in the two cities, our sexual health service and a range of health promotion services across Hampshire. We will work with partners to transform these services to ensure they continue to provide quality and safe care with reducing investment, but this will be a challenge for all involved.

As Chairman and Chief Executive Officer (CEO) of Solent NHS Trust, we extend our thanks to our dedicated staff, in every part of the organisation, who have helped grow and establish our role as a health provider at the heart of our communities. We know their continued dedication to duty will see us cement and realise our vision as an NHS Trust that takes pride in delivering *great care at the heart of our community*.

With this attitude from our staff, it really is not a surprise that we were named, by the Health Service Journal (HSJ), Nursing Times and supported by NHS employers, as one of the top 120 places to work in the NHS. The list is drawn up using data from the NHS Staff Survey and analysed by the HSJ and Best Companies Group, an independent workplace research firm. Well done Team Solent and thank you!

Alistair Stokes
Chairman

Sue Harriman
Chief Executive Officer

As a Board, we decided to defer progression of our Foundation Trust application in November 2015. We did this because we felt it was important to refocus on the services we provide and the staff who provide them, and the part that Solent plays in our local health economies. This focus on people and services rather than organisation form was, we believe, the right thing to do for us and our communities. We have had a good year, we know at times it has been hard, but thanks to all the staff in Team Solent our services have a strong and exciting future.

Section 1: Performance Report

Statement from the Chief Executive

It has been an amazing year, sometimes exciting, sometimes frustrating and sometimes incredibly stressful for us all, but as I reflect on what we have achieved I am immensely proud of the Trust, its staff and our partners. Even in a financially constrained environment, so much has been achieved and with such amazing good grace. We have not always got it right, but when this happens we learn from the opportunities this creates. We have also had to make some difficult decisions along the way, but the way in which Team Solent has behaved is testament to the individuals within it.

For 2016/17 we will focus on:

Our communities - Providing great care

Our staff – making Solent NHS Trust a great place to work

Our partners – delivering great value for money together

We will do this by having a strong set of Values that defines each of us and how we conduct our business and deliver our services. With staff involvement we have changed our Values based on what we believe is right for Solent NHS Trust and our communities:

- **H**onesty
- **E**veryone Counts
- **A**ccountable
- **R**espectful
- **T**eamwork

They spell **HEART**, our staff told us they wanted to be at the heart of their communities and be empowered to care from the heart. We will work hard in 2016/17 to use our Values in everything we do.

We started the year with a financial mountain to climb and an ambitious plan to deliver services within a £5.2m deficit budget, we have surpassed this by ending the year in a £5.1m deficit position. At the same time, we have significantly invested in a new clinical record system and are close to moving our IT infrastructure to a new stable and modern platform. We have, at times, not communicated well enough with our staff, our plans and the changes they describe have caused distress to some. We are always learning. For 2016/17 I commit to making sure we involve all staff in our decisions and, indeed, we aim to support our staff to co-produce the changes that they feel are right for their services.

These efforts, across the Trust, have put us in a strong position for the future. We are now an organisation in financial control, not blind to the on-going financial challenges we face, but prepared for them.

We know already that models of health and care are changing and we need to keep up pace. For instance, we are living longer and there are a growing number of people with complex, multiple mental and physical long term conditions. As a community provider of specialist services, it is imperative that we continuously adapt – and that includes making some difficult decisions along

the way – to ensure our offering continues to be relevant for our communities.

Our investment in our IT is part of that new offer. There has been a significant amount of effort invested into making sure we not only adopt the new IT systems but that we get the best from them, that could and should be a game changer for us. I must acknowledge that after a slow start this year we have seen real pace of change but we have so much more to do. We have in the past over promised and under delivered when it came to what IT could do for us, and we lost the faith of some of our staff along the way. We will learn from this and be better moving forward. 2016/17 will be a year for delivery and change and we hope our staff will lead us through that change to a new Digital Age.

In some of our service areas we have seen some performance challenges. When this has happened we have tried to work actively with those who receive our services, and our commissioners. I believe we are an organisation that works hard to learn from our successes and our failures. Part of that learning will be reflected through our new Operational Plans, or our Quality Priorities, that you will see described in this report.

I want to finish by giving my personal thanks for the commitment and hard work of our staff. I am always deeply moved when I spend time out in service seeing the difference that is made to people's lives on a daily basis.

Regards,

SJHarriman

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 after operating for one year as a merged organisation formed from Southampton and Portsmouth City Primary Care Trust's provider arms.

We are one of the largest specialist community and mental health providers in the NHS with an annual revenue of £179m for 2015/16, a workforce in excess of 3,400 staff (equating to nearly 3,100 whole time equivalent posts) and delivering over 1.25 million service user contacts per annum.

What do we do?

Our role is to provide high quality, best value community and mental health services to local people. Our services are provided from a range of locations, including community hospitals and day hospitals, as well as numerous outpatient and other settings within the community such as health centres, children's centres and within people's homes.

We work with families to help children have the best start in life and provide community support when children are unwell and need extra help. We work with adults and older people with physical or mental health problems and provide care in the community.

By working with GPs and social services, we bring services together to help people manage their condition better, to stop it getting worse and to help keep people at home.

We also promote health and wellbeing. Our screening and health promotion services support people to lead a healthy lifestyle. As part of the NHS family, we work closely with other trusts to make sure that service users get the best possible care.

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 400,000 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.

> "As part of the NHS family, we work closely with other trusts to make sure that service users get the best possible care"

Our services

We are fully supportive of the need to join up health and social care services so that they work together seamlessly for local people. More support in the community will mean that people will stay healthier and maintain their independence in their own homes - avoiding hospital stays.

We are working more closely than ever with primary care and adult social care. Part of the plan includes moves to sit side by side as part of the same team, which will help avoid duplication and co-ordinate care around the needs of individuals and their carers. We are working closely with all of our partners to develop the plans. Residents should experience a service that is more focused on preventing their needs escalating.

We have organised our clinical services into care groups aligned, or coterminous, with geographical boundaries of our cities and the county.

Workforce in excess of 3,400 staff

The following diagram illustrates our Care Group structure:

County Care Group	Portsmouth Care Group	Southampton Care Group
Sexual Health Services	Adult Mental Health inc. Substance Misuse	Primary Care, MSK, Podiatry and Pain
Special Dental Services	Adult Services	Adult Services

Children's Services
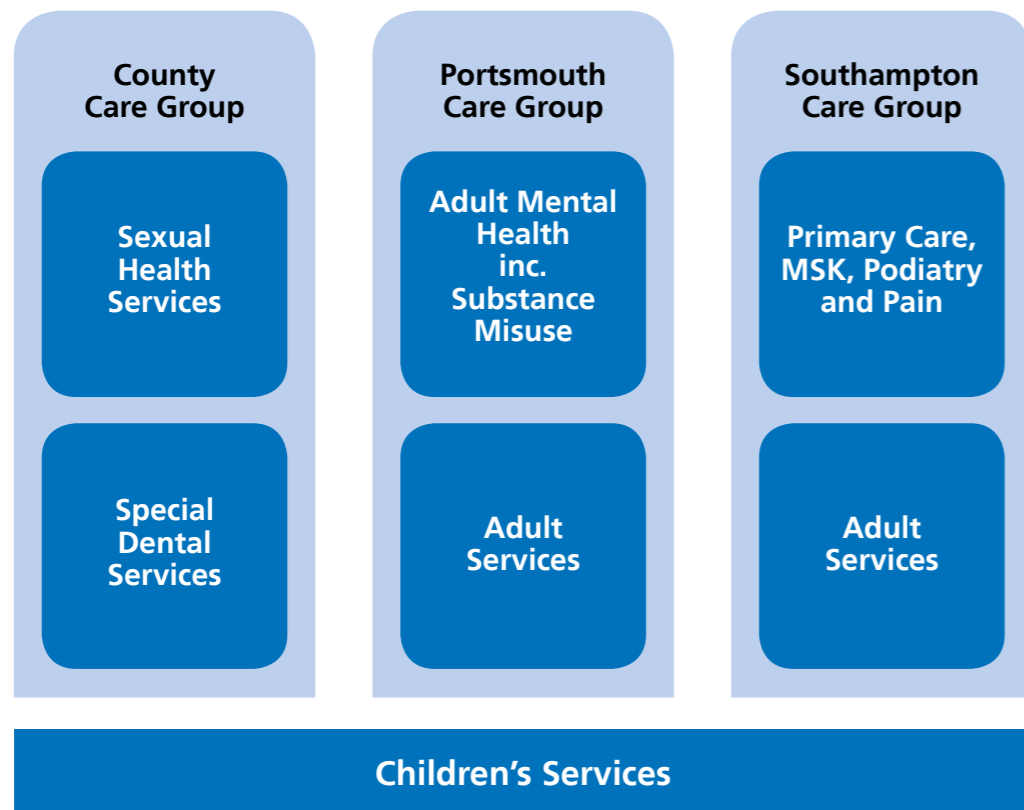
Our values

Our 'INSPIRE' values have stood us in good stead for the first few years of this organisation but at the end of the financial year, we were presented with an opportunity to refresh and strengthen the values of Solent for the future. Over 450 of our staff said a change was needed and that we needed a new set of values that feel right for us.

Consequently, we refreshed our values and have now adopted a set of values that reflect even better our role at the heart of the community we serve.

The values are deliberately written in plain English and should mean something to us all, staff, patients, carers, partners and so on.

Our new values spell **HEART** and those involved in the creation of them said they liked HEART and what it meant to them. Some of the comments were *'we are at the heart of the community'*, *'we want to be recognised as caring'* and *'heart is symbolic of being at the centre, whether that's our staff or our patients or their families, they are at the centre of what we do'*.

Of course the important part is what each value means to us and how we live by them.

Our values are illustrated below:

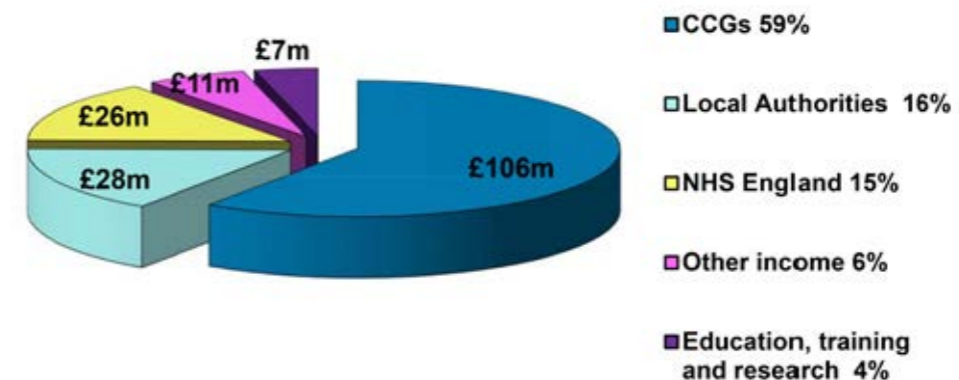Honesty Everyone counts Accountable Respectful Teamwork

As part of the appraisal process during 2016/17 staff will be asked to consider what the values mean to them, which will help us develop a behavioral framework by which we will be able help ourselves and support our colleagues to live by our values every day.

Our vision

Our refreshed vision is to provide great care, be a great place to work and deliver great value for money.

Our finances

During 2015/16 we had an income of over £179 million. Our income by commissioner is illustrated below:

- CCGs 59%
- Local Authorities 16%
- NHS England 15%
- Other income 6%
- Education, training and research 4%

Our Objectives

Our Trust plan was organised under six headings which reflected our most important priorities for 2015/16. These priorities were widely communicated in the Trust and reflected in service plans and individual staff objectives.

1. Our service users

- Ensuring our service users continue to receive safe care, and can achieve the best outcomes
- Involving service users and their carers in decisions, listening to their feedback and improving services to meet their needs
- Providing services that are easy to access
- Ensuring services are well-led, maintaining strong quality governance.

2. Our staff

- Making sure that our staff have the right skills and support to do their job well, are prepared for future roles and that our recruitment is values based
- Developing our leaders

- Ensuring our staff are valued members of the team, who can actively contribute to service improvements and be recognised for their loyalty and commitment
- Making sure our staff know how to raise concerns with the confidence that they will be supported
- Having strong clinical management teams with effective business support, allowing more decisions to be made closer to front-line service delivery
- Embedding performance excellence, appraisal and revalidation.

3. Our services

- Working with our partners to deliver joined-up care for service users by integrating health and social care services and working closer with GPs
- Working with our partners to reduce the number of people admitted to hospital.

4. Our business

- Successfully delivering our ambitious change programmes and showing the benefits they bring to service users and staff

- Working positively with other providers and commissioners in order to deliver improvements in patient care.

5. Our infrastructure

- Upgrading our IT infrastructure and establishing a new clinical records system that increases service resilience, establishes a mobile working culture that delivers greater productivity within clinical teams
- Working with partner organisations to streamline working practices through shared facilities, functions and resources
- Running our estate more efficiently by operating from fewer sites and collocating services where it makes sense to do so.

6. Our future

Working with staff and partners to refresh our five year strategy to provide a clear direction for the future of our organisation.

The year in review

Our journey to becoming a Foundation Trust

In November 2015 we took a decision to pause our plans to become an NHS Foundation Trust (FT). We had been on a journey to become an FT for a few years and in 2014 were referred to Monitor, England's health sector regulator, for the final assessment. The decision to disembark on the FT journey by the Board has largely been taken in response to the radical and rapid change being experienced in the health and social care sector, nationally and locally. We have decided to be dynamic and responsive to these developments so as to deliver new models of care with partners.

We are now considering other models of care, particularly those outlined by NHS Chief Executive, Simon Stevens in his Five Year Forward View plan launched in October 2014.

Although we decided to step off the FT pipeline, it has not ruled out us revisiting the application at a later date and we remain confident the effort and commitment invested in the process so far will be recognised and stands us in good stead should we decide to progress this avenue in the future.

Working with our partners and alliances (who they are, their importance)

We continue to enjoy very effective working relationships with our commissioners and partners in care. Our plans for Better Care, in both cities, act as the foundations for partner relationships, and our whole system working has ensured we deliver our obligations in urgent care performance for Portsmouth and Southampton.

We have been looking at closer working with the two city councils for front line service integration and have also examined opportunities for back office collaboration. We also continue to provide extensive support to both acute trusts, Portsmouth Hospitals NHS Trust (PHT) and University Hospitals Southampton NHS Foundation Trust (UHS), to relieve pressure on beds in both hospitals.

Working with the community

Senior managers have continued to regularly attend Health and Overview Scrutiny Panel/ Committee meetings in Portsmouth, Southampton and Hampshire.

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

- Baytrees Detoxification and Rehabilitation Unit
- St James and St Mary's Community Health Campus
- Dentistry.

We have also engaged with the public on:

- changes to Child and Adolescent Mental Health Services (CAMHS) in Southampton
- relocation of Southampton Community Paediatric Services from Wordsworth House to Better Care Centre at the Western Community Hospital
- relocation of dental services provided at Yateley Medical Centre.

The Board is kept abreast of engagement activity via our marketing report. This incorporates any community engagement activity which has taken place. Patients, from various services, also attend Board seminars to give their perspective on their experience of our services and the Board formally reflects on any learning.

Whole system response and emergency preparedness

The major incident policy is reviewed annually by the Emergency Planning lead to ensure it remains compliant with current Emergency Preparedness Resilience and Response (EPRR) legislation. All Business Continuity plans are also reviewed. Co-operation between organisations is fundamental to robust emergency preparedness.

We continue to participate as a member of the Local Health Resilience Partnership (LHRP), represented by the Chief Operations Officer, Southampton.

The Emergency Planning practitioner (EPP) also regularly attends local health resilience meetings and feeds back relevant information to the emergency planning group. The EPP also works in partnership with the two local community Trusts to ensure all work undertaken is consistent across the area and that there is a greater understanding of EPRR within the organisations. Working together in this way supports the requirements of the Climate Change Agreements and allows for joint learning and the sharing of EPRR documents and workplans. We have participated in the following exercises during 2015/16.

- System wide communications test was carried out in October 2015 with a further test to be completed in May 2016.
- Participation in LIVEX exercise in November 2015 when the major incident room at the Western hospital was opened to test the response.
- New training plan for all on call staff has been developed and is in place for 2016/17.

- 'Train the trainer' for Decision Loggist is now provided in-house and in 2015/16 eight staff trained and on the register
- The EP lead has participated in the planning of a mass casualty exercise in readiness for an event which will take place in July 2016

Our volunteers

We appreciate the important and valuable contribution volunteer roles can make, helping us to achieve our objectives and enhancing patient experience. Volunteering also offers the opportunity to participate in the community health agenda.

We also recognise that there is growing evidence to support the introduction of 'volunteers by experience' in health and social care settings. Many of our patients have advised us of the life-changing connections they have made when they have had the opportunity to meet with others who have had a similar diagnosis or health experience.

We are in the process of further developing the opportunities we can offer for traditional volunteers and volunteers by experience. We will be reviewing the support we provide to volunteers during the year ahead.

> ## "We appreciate the important and valuable contribution volunteer roles can make, helping us to achieve our objectives and enhancing patient experience".

Charitable funds

In June 2015, with the help of our public members, the charity was rebranded and re-launched as 'Beacon, Solent NHS Charity' in an effort to heighten public awareness and encourage associated fundraising activities. The 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's the smallest things that can make the biggest difference.

We are immensely grateful to everyone who has donated money. The donations we received during 2015/16 amounted to £2,073. We are also extremely appreciative to our staff who have worked hard to raise funds for Beacon, including organising and holding fun days through to significant personal efforts such as running the London Marathon.

During the year, we have used our charitable funds to purchase various items to enhance the care we provide to our patients. This has included purchasing children's toys and books, as well as exercise bikes in our adult services. During the year ahead we will work with our services to raise the profile of Beacon to encourage fundraising activities and spending.

Principle risks and uncertainties facing the organisation

Our focus during 2015/16, 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.

Whilst we finished the year, slightly better than plan, with an adjusted deficit of £5.1m, our Cost Improvement Programme (CIP) did not deliver all of its recurrent savings. As a result our plan for 2016/17 is a £4.5m deficit which includes major transformation schemes; these schemes enable us to breakeven from 1 April 2017.

Impairments of £27.0m have been recognised in 2015/16, of which £10.2m has been shown in the Statement of Comprehensive Income and the remaining £16.8m being taken to the revaluation reserve. The impairments are due to a refreshed view of how services could be delivered from modern facilities.

The great majority of trade is with CCGs and NHS England, as commissioners for NHS patient care services. As CCGs and NHS England are funded by Government to buy NHS patient care 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, when the Trust works to minimise the risk to income. The Trust has access to a revolving working capital facility that it can draw down as needed.

There will, however, 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. In 2015/16, these funding reductions have

been particularly marked in public health budgets held by the Local Authorities; this has impacted on our health visiting and public health nursing services in the two cities, our sexual health service and a range of health promotion services across Hampshire. CCG budgets are under similar constraints and the risk is that we will have to reduce, or stop, the provision of some services due to insufficient funds to deliver them safely and effectively. Our partner health and social care organisations are facing similar risks.

We are actively engaged with all of our commissioners to explore options that mitigate these risks; this includes looking at different clinical and workforce models which maintain good clinical outcomes, at lower cost, and exploring partnerships with other health and care providers that deliver sustainable, integrated care. In the absence of additional funding, some services may have to be reduced in order to ensure care delivery that is both safe and affordable. This will have an impact on the availability of care.

The commercial environment also remains challenging. In response to the NHS Shared Planning Guidance 2016/17 -2020/21, which outlines a new approach to ensuring that health and care services are planned by place rather than around individual institutions, we are actively participating in the development of the system wide Sustainability and Transformation Plan (STP) with our partners. The drive towards system integration has seen a greater focus on collaborative commissioning and complex contractual arrangements that support integrated service delivery between different health and care providers and inclusive of public, private and third sector organisations. The STP will ultimately deliver the Five Year

Forward View vision, narrowing the gaps in quality of care and improving the health and wellbeing of our communities.

However, in doing so, we acknowledge that the future of Solent NHS Trust, as it currently stands, is uncertain and presents both an opportunity and a risk for us. Whilst the front line services we offer will undoubtedly remain the same, it is likely that we will be providing these via integrated models with key partners. We recognise the need to ensure financial balance within our local health economy and will be working as a system to drive efficiencies at all levels within our STP footprint. Changes in delivery models and vehicles will itself bring challenges and complexities in ensuring robust clinical governance systems, processes to ensure patient safety and ensuring we respond effectively to emerging commercial models. We will, therefore, need to ensure we take our staff on the journey, ensuring that they feel involved and well informed during the changes ahead.

There were fewer tender opportunities in 2015/16, but we have continued to respond to those that are aligned to our core business, including the defence of existing service contracts. In year, we secured £2.4m of new income and lost £7.1m (annual contract values): £5.8 million of this is attributable to the loss of the Hampshire Substance Misuse service following unsuccessful tender. Other losses were as a result of altered commissioning intentions or where we elected to stop services due to financial or quality concerns.

In May, the Trust closed the Baytrees Residential Detox Unit in Portsmouth. Inpatient activity has been reducing year-on-year as a result of changing commissioning intentions and the drive towards

community detoxification; this meant that there was insufficient income to maintain the service going forward. We have actively engaged with commissioners and providers to explore alternatives to closure but this has proved unsuccessful. We continue to work with all parties to mitigate the impact of this change on service users during the transition process.

A number of our services are to be re-procured in 2016/17 in line with commissioning plans; this includes our Hampshire-wide sexual health services, substance misuse services in Portsmouth and health promotion and smoking cessation services in Southampton. We are actively preparing to defend this business but there is a risk that either re-commissioned services models will not be financially viable, in response to reducing commissioning budgets (which will impact our decision to bid), or that we will not successfully retain the business following tender. The financial risk of both scenarios is significant, particularly for sexual health services, our largest single contract.

The loss of key services will increase the Trust's financial pressure but also potentially destabilise other service contracts where there are significant interdependencies. There is a risk that significant loss of business alongside limited opportunities for income growth, will impact our ability to deliver our financial plan. Our commercial strategy is currently under refresh and will describe how we can maintain a sustainable cost base in response to a changing market environment, including consideration of new markets and areas for potential growth.

Details of our key risks in year are included within the Annual Governance Statement, page 64.

Investing in our future

We are committed to supporting our staff to improve the way we work through the introduction of new and improved information technology (IT). A new clinical records system was introduced in 2014/15. In 2015/16 a huge effort was put in to move teams, who were using other solutions, onto the new system. Now that this work is complete, the focus for 2016/17 is on improving the use of the system, this includes supporting mobile working and customising/ streamlining the input screens to optimise the user experience. This work is expected to free up valuable clinical time to care by preventing duplication and enabling the data to be captured at or near the point of care.

We are also actively working with the other health and social care partners in Hampshire on new solutions to support the sharing of summary information on a county wide basis. Much of the design work is now complete and the project is about to enter the procurement phase.

Work continued in 2015/16 with our IT partner, CGI, to implement the replacement network, server and personal computer provision across the trust once the contract had been agreed. This work commenced in the last quarter or 2015/16 and will be on-going throughout much of 2016/17. However, several of the major foundation items have been completed successfully and the programme is now delivering to plan.

The benefits

- We will have full control of a dedicated Solent network which will improve stability and availability for our staff and partners (the current legacy shared network is overly complex and unreliable).

- The completion of the laptop roll out will provide our staff with flexible and reliable access to trust resources, either via the Solent network directly or over the remote access solution (on 4G or public/personal Wi-Fi).

- Our Solent IT team will be working with the end users to ensure that we maximise the benefits the kit can deliver by thinking of new ways of working with the technology, this will range from working in new locations via 4G/public Wi-Fi to looking at uses for technologies such as Skype for Business to support virtual meetings and potentially even remote consultations

- Working with CGI and our partners at the South, Central and West Commissioning Support Unit (CSU) to develop reporting tools and dashboards to support us and our partners maximise the benefit of information, from the management of front line patient care to automated reporting and dashboards to support the planning and provision of effective care.

> **Our focus during 2015/16, like the previous year, has been on maintaining service quality and sustaining financial recovery.**

Highlights from our clinical services

Our diabetes team, based at St Mary's Community Health Campus received national recognition at a national awards ceremony.

Southampton and county care group

We partner in new nursing service

We were delighted to be selected to run Southampton's Public Health Nursing Service for 5-19 year olds, in partnership with No Limits from April this year. The new service, Southampton Healthy Ambition, will mark the start of more joined up working with other organisations to ensure the needs of children and young children are met and they get the right care, at the right time.

Baby friendly

Our health visiting services in Southampton were awarded the Unicef baby friendly initative level 3. As a result of the team's dedication and hard work, they were able to achieve the accreditation in just three years, instead of the usual five years.

Matron shortlisted for compassionate care award

Jackie Bennett, a Community Palliative Matron for the Trust and the Marie Curie Project, was shortlisted as one of the five finalists in the Kate Granger Awards in the Compassionate Care Individual Category. Jackie was recognised for her innovative approach to enhancing end of life care, and the improvements in integrated care she has fostered.

Singing for health

Tuneful tones filled a Southampton shopping centre as Solent's COPD choir joined a number of other organisations to raise awareness for chronic obstructive pulmonary disease (COPD) on World COPD day. The choir drew in the crowds and helped raise awareness for the disease which has a high prevalence in Southampton.

Portsmouth

New mental health recovery service for Portsmouth

A new mental health recovery service in Portsmouth was officially launched in July 2015. Working in partnership with Solent Mind we provide the Portsmouth Support and Recovery Service, based at St Mary's Community Health Campus, which offers invaluable help, support and practical advice to those recovering from mental health issues.

Diabetes team are highly commended

Our diabetes team, based at St Mary's Community Health Campus, had cause to celebrate after they received national recognition at a national awards ceremony. The service which is run jointly by us, Southern Health NHS Foundation Trust and Portsmouth Hospitals NHS Trust, was highly commended in the Acute, Community and/or Primary Care Services Redesign category at the Health Service Journal's (HSJ) awards. The team was the only Diabetes team to be recognised across the country -in any of the award categories- and it now forms the template for diabetes care both in the community and in acute settings.

Diabetes foot care brings dramatic results

A diabetic patient, who faced having a toe amputated, was soon back on his feet thanks to a pioneering new treatment being trialled by us. The new TCC-EZ (total contact casting) meant the patient was back on his feet in no time. The roll-on cast works by minimising pressure and friction and redistributing the weight away from the wound to help it heal.

Our charity, Beacon funds specialist equipment

Thanks to the generous donations made to Beacon, Solent NHS Charity, we were able to purchase a wheelchair recliner for our Special Care Dental Service in Portsmouth. The recliner will make it easier and more comfortable for patients to be treated in their own chair.

Physio Team wins award for second year running

Our Musculoskeletal (MSK) Specialist Physiotherapy team won a Health Education Wessex SHINE award. The Service, which is run jointly with Portsmouth Hospitals NHS Trust, won the Chair's Highly Commended accolade, which recognises their excellence in education and training.

Toasting our success at the Best of Health Awards

A number of our services showed why we are known as an excellent provider of community and mental health services at the Best of Health Awards, run by The News in Portsmouth. We had a number of nominations. Matron Colin Beevor won the Nurse of the Year Award, with our Sexual Health Services coming runner up in their category for the innovative rapid HIV testing that they carry out in the community. Specialist Occupational Therapist, Chrissie Carden-Noad also had cause to smile as she was announced as runner up in the award's new category, the Allied Health Professional Worker of the Year.

Trust wide

Network will be focused on improving dementia care

Working in partnership with Dementia UK, we have been providing support and advice to a team of admiral nurses . As a consequence of our joint work, the Solent Dementia network was launched. The network is designed to give our dementia nurses and healthcare professionals easy access to quality information and support, which in turn will lead to better care for our dementia patients.

We are top of research league tables

Our research team had cause to celebrate after they were named one of the most active research Care Trust's in the UK for 2014/15 in the National Institute for Health Research's league tables. You can read more about our research programme within the Quality Account, page 92.

Breastfeeding in the spotlight at city picnics

A picnic in the park proved a big hit as organisations teamed up to promote World Breastfeeding Week in Southampton and Portsmouth. Scores of mums turned up to the events in the cities, with others showing their support at local libraries and children's centres. In a bid to get everyone thinking about this natural act as the norm.

We celebrate top PLACE marks in our cities

Results published by the Health Social Care Information Centre show Patient-Led Assessments of the Care Environment (PLACE) at St James' Hospital, Jubilee House and St Mary's Community Health Campus in Portsmouth were above the national average in all five of the rated areas. In Southampton, at the Royal South Hants Hospital (RSH) and Western Community Hospital (WCH) we exceeded the national average in four out of the five areas assessed.

Helping to fight flu in our city Schools

School children in Southampton and Portsmouth were given a helping hand to keep flu at bay as our flu fighters were ready for action in October 2015. For the first time in 2015/16, all children in school years 1 and 2 – aged between five and seven years old – became eligible to receive the vaccine as part of the national flu immunisation programme. After a successful tender, our school nurses visited primary and infant schools across the city to make sure little ones are protected against flu.

HIV testing is coming to you

This year's HIV Testing Week awareness campaign proved a success with more tests carried out at community venues across Hampshire than ever before, through our rapid HIV testing. Throughout the week increased numbers of people also visited our Sexual Health Services website.

> Thanks to the generous donations made to Beacon, Solent NHS Charity, we were able to purchase a wheelchair recliner for our Special Care Dental Service in Portsmouth.

> our school nurses visited primary and infant schools across the city to make sure little ones are protected against flu

Performance Analysis

Performance Governance

Performance assurance processes have been strengthened further during 2015/16. With the transition from eight service lines to a three Care Group structure, the governance process to monitor performance was refreshed also. Monthly performance review meetings take place with each Care Group or Service Line with their respective chief operating officer and key corporate leads to review and discuss any areas of performance or risks in detail. After these meetings take place, the performance exceptions raised are then discussed between Executives at monthly Performance Subcommittees. The exceptions are also raised at the monthly Trust management team meetings.

New performance dashboards have been developed and implemented for 2015/16 which detail all key performance metrics for quality, finance, workforce and operational standards for all service lines and Care Groups. Trend lines have been added also. These act as early warning indicators and enable triangulation of metrics. These dashboards are shared at Performance Review meetings, Performance Subcommittees and at Trust Board. These are also now available on the Intranet for all staff to review and be informed on Performance issues. In addition to the new dashboards, a separate interactive and detailed Quality Performance Dashboard has been created and implemented for all service lines and at Trust level. This provides performance against more Quality metrics and in greater detail, enabling higher scrutiny and assurances over particular areas of concern.

Data Quality and Assurance

One of the most significant challenges the Trust faced during 2015/16 was the transition to a new Clinical Records System (CRS) for the majority of services, commencing in June 2015. As expected, this created difficulties in data reporting and data quality. These challenges continued throughout the rest of the year. Caveats were submitted, or briefed upon, for all data submissions to commissioners or regulatory bodies, explaining the issues and expected dates of resolution. However, with inaccurate or absent data, this causes potential risks of not being able to identify or monitor performance issues. This was mitigated against by working collaboratively with the services and commissioners by conducting manual audits, service reviews or reprioritisation of reporting from the CRS transition.

Activity review

2015/16 was a busy year for us; we had over 1.25 million patient contacts - the breakdown of patient contacts and occupied bed days by service line is illustrated below:

Service line	Contacts	Inpatient occupied bed days	Total
Adult Mental Health	74,604	12,546	87,150
Adult Services, Portsmouth	171,207	23,273	194,480
Adult Services, Southampton	257,648	19,051	276,699
Child and Family Services	325,254	0	325,254
Special Care Dental Services	44,739	1,699	46,438
Primary Care and Long Term Conditions Services	283,011	0	283,011
Sexual Health Services	112,070	0	112,070
Substance Misuse Services	35,042	3,626	38,668
Solent NHS Trust TOTAL	1,303,575	60,195	1,363,770

Referral to Treatment Performance

We successfully achieved the national standards for Referral To Treatment (RTT) within 18 weeks for another year. Due to the diverse nature of services provided by us, not all services are applicable to the national RTT standards, but a breakdown of related performance for 2015/16 in entirety is illustrated in the following table.

RTT standard	Number of compliant referrals	Total number of referrals	Performance
Part 1A - Admitted	633	637	99.4%
Part 1B – Not Admitted	5851	5887	99.4%
Part 2 - Incomplete	9654	9684	99.7%

Monitor Risk Assessment Framework

Of all the Monitor Risk Assessment Framework metrics, 19 were applicable to us. Achievement is monitored monthly and performance reported through to Board. We maintained the Governance Risk Rating of zero throughout the year which is the best score attainable. However, due to the cessation of the Bitterne Minor Injuries Unit in September, Accident & Emergency performance was no longer monitored and 4 other metrics were not monitored against from October until the end of the year due to the Clinical Records System transition.

Achievement against the key national priorities for the Monitor Access and Outcomes Domains can be seen below:

Access Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Referral to Treatment Admitted	90%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%	100.0%	98.0%	100.0%	100.0%	100.0%
Referral to Treatment Non Admitted	95%	98.6%	99.1%	100.0%	99.8%	99.4%	99.6%	99.4%	98.9%	98.6%	100.0%	99.8%	99.5%
Referral to Treatment incomplete	92%	99.7%	100.0%	99.4%	99.4%	99.7%	100.0%	99.3%	99.3%	99.5%	100.0%	100.0%	99.9%
A&E All Types Monthly Performance	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					
Serve new psychosis cases by early intervention teams	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%
IAPT - People with common mental health conditions treated within 6 weeks of referral	75%	96.9%	94.6%	95.0%	100.0%	99.0%	95.0%	96.0%	99.0%	96.0%	100.0%	100.0%	100.0%
IAPT - People with common mental health conditions treated within 18 weeks of referral	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%

Provision of the Bitterne Minor Injuries Unit ceased in October.

Outcomes Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Clostridium Difficile Objective	12	0	0	0	0	0	0	1	0	0	0	0	0
Minimising Mental Health Delayed Transfers of Care	7.5%	1.6%	0.8%	0.0%	0.0%	4.7%	6.8%	5.0%	2.3%	3.3%	3.8%	7.0%	1.0%
Mental Health Data Completeness: Identifiers	97%	97.6%	97.6%	97.6%	97.5%	97.5%	97.4%	96.5%	96.9%	96.6%	96.5%	96.3%	96.1%
Mental Health Data Completeness: Outcomes for CPA patients	50%	81.7%	85.4%	87.4%	85.3%	84.2%	83.7%	87.2%	85.3%	85.2%	84.6%	83.8%	82.7%
Learning Disability Access to healthcare Compliance Certification	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Community Services Data Completeness - Referral	50%	95.2%	92.7%	95.2%	95.5%	96.1%	96.3%	99.7%	99.3%	99.3%	99.0%	98.9%	98.8%
Community Services Data Completeness - Treatment Activity	50%	99.8%	99.8%	99.6%	99.8%	99.5%	99.7%	90.8%	95.2%	95.1%	95.2%	95.4%	95.5%

Mental Health Services changed Clinical Record System in October 2015 and created Data Quality problems subsequently.

Monitor Continuity of Service Risk Rating (CoSRR)

The Continuity of Service Risk Rating is designed to reflect the likelihood of a financial breach of an NHS Foundation Trust's terms of authorisation. A rating of 4 reflects the lowest risk and a rating of 1 the highest. We achieved a shadow rating of 2 for 2015/16. Additional Financial Performance information is stated in Section 4.

TDA Accountability Framework

For 2015/16, the NHS Trust Development Authority (TDA) continued its alignment with the Care Quality Commission's (CQC) 5 Domains of quality and safe care provision. Overall achievement is calculated and scored against a rating of 1 -5 with 1 being the lowest and 5 being the maximum score available. We achieved an overall score of 5 in every month of 2015/16, as achieved in 2014/15 also.

A summary against each domain can be seen below:

2015/16	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Responsiveness	5	5	5	4	4	4	4	4	4
Effectiveness	5	3	5	5	5	5	5	5	5
Safe	5	5	5	3	4	4	5	4	5
Caring	5	5	5	5	5	5	5	5	5
Well Led	4	4	3	3	3	3	3	3	3
Overall	5	5	5	5	5	5	5	5	5

Despite achieving the best rating overall available, we are committed to improving on the individual areas through 2016/17 through collaborative working with social care to reduce delayed transfers of care and to ensure all staff have had a meaningful appraisal by the end of Quarter 1. Unfortunately, for 3 Mental Health indicators, data was unavailable since October due to the CRS transition. We will continue to monitor against this Framework until the NHS Improvement Framework is published during 2016.

Achievement against the key national priorities for the TDA Responsiveness, Effectiveness, Safe, Caring and Well-Led Domains can be seen in the following tables:

Responsiveness Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Referral to Treatment Incomplete 52+ Week Waiters	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Diagnostic waiting times	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Delayed Transfers of Care	3.50%	6.29%	3.93%	7.92%	1.23%	6.59%	5.41%	4.49%	3.56%	10.97%	9.97%	9.04%	4.37%
The proportion of those on Care Programme Approach for at least 12 months who have had a CPA review within the last 12 months	95%	97.3%	97.9%	98.8%	98.8%	98.4%	97.7%	92.4%	93.4%	86.2%	82.3%	78.4%	73.8%
The proportion of those on Care Programme Approach (CPA) who have had a HoNOS assessment in the last 12 months	90%	82.4%	91.0%	96.0%	93.3%	92.0%	91.7%	88.8%	84.9%	86.5%	86.7%	83.0%	78.7%

Mental Health Services changed Clinical Record System in October 2015 and created Data Quality problems subsequently.

Delayed Transfers of Care are monitored closely and performance shared with commissioners monthly. The target stated is indicative but an aspirational internally set threshold. The majority of delays have been due to the responsibility of social care in both Southampton and Portsmouth. We are actively working with our partners to reduce the pressure on acute trusts and reduce waiting times.

Effectiveness Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	0	0	0	0	0	0	0	0	0	0	0	0	0
IAPT - Proportion of people who complete treatment who are moving to recovery	50%	51.6%	56.2%	55.0%	53.3%	47.9%	53.1%	53.0%	57.0%	52.0%	53.0%	54.0%	50.0%

Safe Domain

Metric	Target	July	August	September	October	November	December	January	February	March
Serious Incidents rate	27	14	10	9	45	16	11	8	14	18
Patient safety incidents that are harmful	0%	1.20%	2.31%	2.21%	3.38%	1.35%	2.29%	4.30%	3.66%	6.02%
Medication errors causing serious harm	0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
CAS alerts	0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	1.0	0.0
VTE Risk Assessment	95%	100.0%	100.0%	100.0%	100.0%	91.0%	100.0%	100.0%	100.0%	98.0%
Percentage of Harm Free Care	92%	96.7%	98.4%	98.5%	98.6%	96.6%	98.5%	98.5%	97.6%	98.5%
Admissions to adult facilities of patients who are under 16 years of age	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Caring Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Inpatient Scores from Friends and Family Test	60%			93.0%			94.0%			98.0%			94.0%
A&E Scores from Friends and Family Test	46%			99.0%			99.0%			99.0%			
Mixed Sex Accommodation Breaches	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Well led Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Inpatients response rate from Friends and Family Test	30%			47.3%			36.7%			40.0%			41.7%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40%			51.2%			46.4%						52.0%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	58.40%			80.4%			74.8%						79.0%
Trust turnover rate	12%	14.3%	14.4%	14.7%	13.9%	14.2%	14.5%	15.2%	16.0%	15.9%	15.8%	16.1%	16.2%
Trust level total sickness rate	4%	4.2%	4.0%	3.7%	3.9%	3.5%	3.7%	4.2%	4.3%	4.3%	4.6%	4.5%	3.9%
Percentage of staff with annual appraisal	95%	8.6%	23.0%	68.0%	85.4%	88.0%	89.0%	90.5%	93.0%	93.0%	92.4%	92.4%	92.0%

The Trust Turnover rate is a 12 month rolling figure and has remained over the our threshold mainly due to planned workforce reductions but also due to pressures in a few services. Turnover is monitored monthly, by service, through Performance Subcommittees, ensuring staffing levels remain safe.

Trust sickness levels have fluctuated between 3.5% and 4.6% over the last 12 months. This has remained lower than national benchmarks and the March achievement was below the internally set threshold.

Staff with appraisals fell just short of the 95% target at 92% and all staff without an appraisal and their managers have been contacted directly for these to take place in Quarter 1 2016/17.

Key Performance Indicators (KPIs)

Reporting mechanisms were strengthened further during the year, with Data Quality ratings for each KPI metric being included in commissioner returns. This has proved crucial in light of the impact the CRS transition has had on most datasets. On the whole however, performance has been encouraging throughout the year. In the majority of cases, where performance thresholds have not been met, collaborative work with commissioners to resolve performance has taken place, whether by a service redesign or threshold alteration due to increased demand. There has been an agreed focus with commissioners to use meaningful and more outcome focussed metrics moving forward to ensure the quality of patients' treatment is the priority.

There were no confirmed Human Rights violations by us during 2015/16. However, there are two investigations currently pending requiring further scrutiny concerning our mental health services.

the quality of patients' treatment **is the priority**

Trust Priorities

The Trust had 5 main priorities to improve during the year and achievements against each one is detailed below:

1 **Priority 1:**
Our service users

- Adult Mental Health Services met all the National Waiting Times Targets before they were implemented, improving access for service users
- Significant increased access to research for patients and service users by over doubling the 10% target of 800 patients from 44 trials with 1,759 patients from 45 trials
- The successful promotion of the national standards for end of life care, ensuring service users and carers' choice is recognised through an internal audit against the 5 priorities.

2 **Priority 2:**
Our staff

- Management arrangements were successfully realigned for clinical services in Portsmouth, Southampton and Hampshire to support better local care delivery
- The successful introduction of a Talent Management process to ensure we are retaining and developing the leaders of the future
- All NHS England requirements of Appraisal and Revalidation met by deadlines and preparation for nurse revalidation for 2016/17.

3 **Priority 3:**
Our services

- The successful integration and rationalisation of services with Social Care through Portsmouth Locality Hub establishment
- Sexual Health Services successfully implemented online STI testing and reduced waiting times to less than 2 hours for at least 95% of patients
- The new Roads to Recovery Programme was successfully introduced for Adult Mental Health
- Services collaborating with multi-agency partners ensuring all service users can access the right level of intervention required
- Through value chain analyses, the correct level and designation of staff undertaking clinical and managerial activities was ensured
- Clinical Leadership and Operational Leaders within the County-Wide Care Group ensured an integrated approach to clinical and business excellence.

4 **Priority 4:**
Our business

- All sub-contractual terms were reviewed and ensured they all met the minimum governance required
- A Corporate Programme Management Office was fully established, detailing benefits plans for all major programmes across the trust
- Robust quality assurance, governance structures and processes were successfully implemented with the introduction of service line Clinical Governance Leads and monthly Governance review meetings.

5 **Priority 5:**
Our infrastructure

- The implementation of an Enterprise Data Warehouse, providing a platform for 2016/17 enabling a self-serving and visualisation tool for staff to manage their services most effectively for their patients
- The successful transition to a new Clinical Records System before the deadline for the majority of our services.

2016/17 – A look forward

We will have another busy year ahead, particularly with a full CQC inspection over the summer and will need to respond proactively to any concerns or areas for improvement as identified. We will form robust action plans as a consequence and will be performance managed thereafter to ensure completion and compliance.

Another significant initiative being undertaken internally during 2016/17 is the development and implementation of a bespoke Enterprise Data Warehouse (EDW). The aim is to have a central location that stores Operational, Financial, Workforce and Quality data together, which will enable data to be reported quicker and be more accessible to both services and corporate teams.

This will also provide services with more information that they can 'self-serve', triangulate and interrogate at primarily a service level, and subsequently with an aim to team and clinician level where possible. Another intended benefit is to refresh the data more regularly than monthly so services can manage their provision on a more real-time basis.

Other tools that will be developed include a joint project with commissioners, to replace current contractual key performance indicators with clinically devised outcome metrics that aim to ensure that the necessary and clinically relevant performance metrics are being monitored jointly; a KPI Report that details the standard against 6 individual Data Quality assessments and a programme of bespoke Capacity & Demand tools being created for each service.

Environmental responsibilities

Details of environmental responsibilities can be found on page 74 of the Annual Governance Statement.

SJHarri.

Sue Harriman
Chief Executive Officer
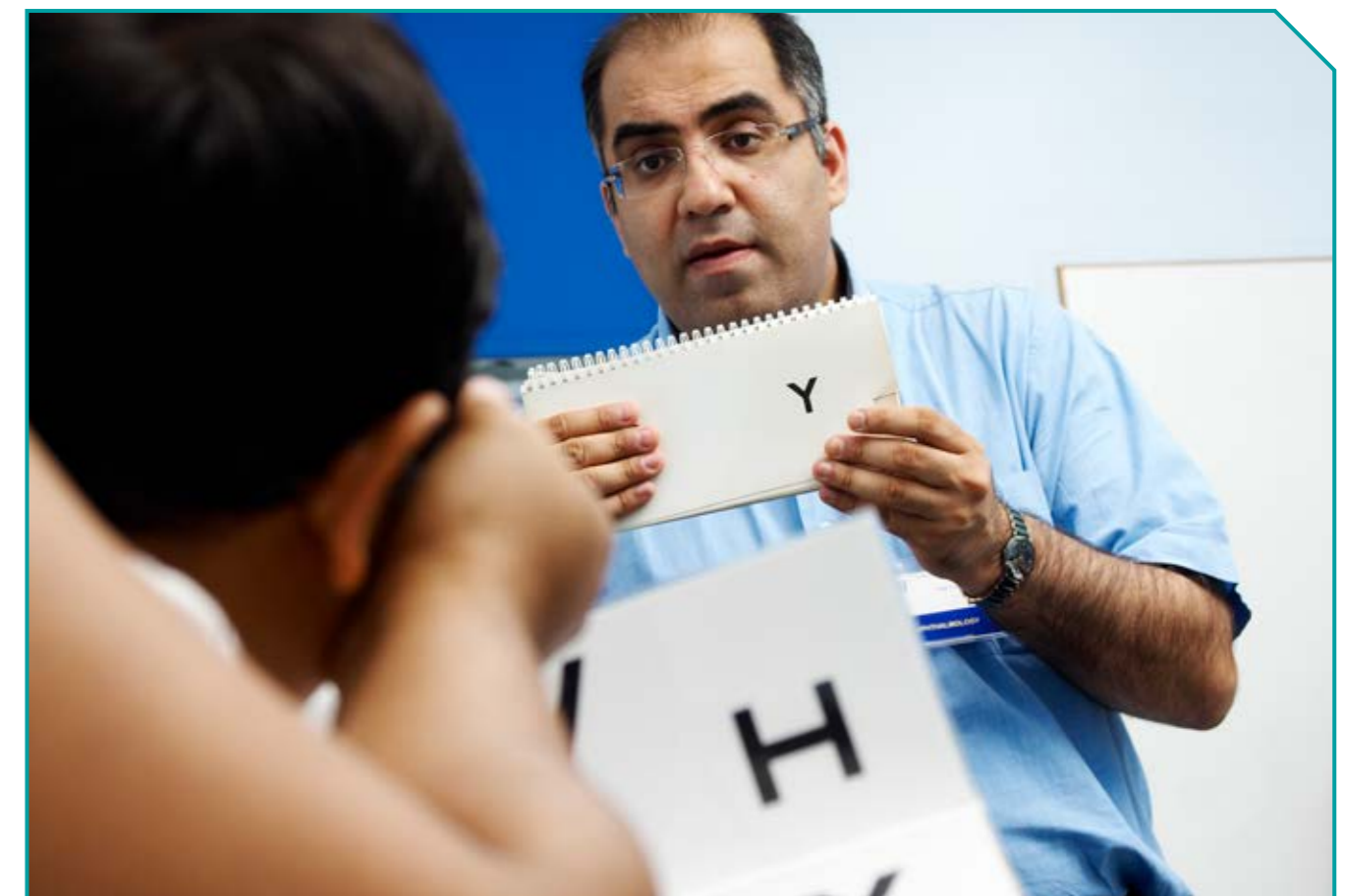
Section 2: Accountability Report

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.

Engagement activities between the Board and Council of Governors is described on page 43.

Meetings of the Board

The Board took the decision in the summer of 2015 to review the frequency of its meetings and now meets every other month in public. Prior to this the Board met ten times a year 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 Director of Finance and Performance, the Chief Medical Officer, Chief Nurse and Chief Operating Officer Southampton and County Services. Together 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.

Due to the number of board personnel changes in year, it was agreed that the role of Deputy Chair and Senior Independent Director be considered in the summer of 2016.

Appointments

Executive director appointments

During 2015/16 appointment was made to the role of the Director of Finance and Performance; the process was conducted with support from Odgers Berndtson, executive recruitment consultants, who provided professional search expertise and Talent Works who supported the Assessment Centre process. In addition we recruited to the role of Chief Medical Officer. Interview panels were convened of representatives of the Remuneration Committee and the Trust Development Authority and with the final appointments being approved by the Remuneration Committee.

Non-executive director appointments

During 2015/16 three Non-executive directors were appointed, supported by Odgers Berndtson, executive recruitment consultants. Interview panels were convened of representatives of the Trust Development Authority, an independent Trust Chair, a shadow Governor and the Trust's Chairman.

The people
Non-executive directors

Dr Alistair Stokes,
Chairman

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. He is currently a governor of the University of West London and chairs the University's Audit and Risk Committee. He is also a Trustee of the Hampshire and Isle of Wight Community Foundation. Alistair is the lead NED for Health and Safety (including Local Security Management).

Qualifications:
BSc, PhD, CDir, FIoD

Mick Tutt

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 and overseen governance and management arrangements in a number of different Trusts and other organisations. He also has experience of working with the CQC and its predecessors, currently as a Specialist Clinical Advisor. 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.

Qualifications:
RMN, SRN, Dip Nursing

Jon Pittam

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 the chair of the Finance Committee and the lead NED for procurement. Jon also chairs the Audit & Risk Committee.

Qualifications:
BSc, CIPFA

David Batters

David is a Chartered Management Accountant who was appointed to the Trust in October 2015. He is the Chief Finance Officer (CFO) for the Nuclear Decommissioning Authority (NDA) which is a non-departmental-body sponsored by the Department for Energy and Climate Change (DECC). He joined the NDA in October 2010 where in addition to being the CFO he is also the Executive Director responsible for 14 nuclear sites across the UK. He is an Executive Board member of the NDA. His appointment with the NDA followed more than twenty years with BAE Systems and predecessor companies in which he held a variety of roles primarily in finance including Mergers & Acquisitions, Planning and Analysis, Reporting, Project Accounting and as a Finance Director of a number of businesses.

Qualifications:
BSc, CIMA

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. Jane 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. Jane chairs the Trust's Remuneration Committee.

Qualifications:
MSc, DipHSM, DipIMS, CBIFM

All non-executive directors have completed a 'test of independence' in year.

Non-executive directors who left in year

Barry Neaves

Barry was appointed to the Trust in April 2011. He is a Chartered Certified Accountant with many years' experience in both the private and not-for-profit sectors. Following a range of accountancy positions, Barry spent 15 years with a major national building society dealing with corporate and housing issues. He was subsequently appointed Group Finance Director of a large social housing group. Barry has undertaken a range of non-executive roles, including acting as a Board Member of the former Southampton City Primary Care Trust. In addition to providing interim finance director services, during his time with Solent NHS Trust he was an audit committee member of the College of Occupational Therapists, a charity trustee and treasurer and a lay person dealing with disciplinary matters in the insurance industry. Barry was the Deputy Chairman, the Chair of the Audit and Risk Committee and lead NED for patient experience.

Qualifications:
BA, FCCA

Barry left on 30th September 2015

Brad Roynon

Brad was appointed to the Trust in April 2011. He retired in December 2010 from being Chief Executive of Southampton City Council where he held this post since 2001 and was responsible for reshaping services increasing efficiencies, improving customer care and developing effective partnerships. Prior to that Brad was Chief Executive of Carmarthenshire County Council between 1997 and 2001 and of East Hampshire District Council between 1988 and 1997. Brad started his career with the NHS as a management adviser with London Teaching Hospitals, where he undertook a wide variety of projects. He later joined the London Borough of Richmond to become Director of the Chief Executive's Office, before moving to East Hampshire. Brad was the chair of the Charitable Funds Committee and lead NED for Safeguarding Children during his time with Solent NHS Trust. Brad was also the Senior Independent Director and provided a channel through which Trust members and governors were able to express concerns, other than through the normal route of the Chairman or Chief Executive.

Qualifications:
Management Services Diploma, Management Services Certificate, HND Hotel Catering and Business Management, Honorary degree Doctor of Business - Southampton Solent University, Member of The Institute of Management and The Society of Local Authority Chief Executives.

Brad left on 31st May 2015

Andrew Cameron

Andrew was appointed to the Trust in June 2015. He joined us knowing he was facing a courageous struggle against cancer. In spite of his illness he was determined to share his vast experience with us, for which we are extremely grateful. Sadly Andrew suffered a setback and passed away suddenly in March 2016.

Andrew had a full career in the Royal Navy during which he trained as a warfare officer, commanded three warships, reaching the rank of Commodore where he was in charge of the Navy's largest surface Flotilla out of Portsmouth. He also worked in the Ministry of Defence and as a Director of Training, HR, and Media and Communications.

After retiring from the Navy, in 2008 he made a second career in the medical charity sector with Marie Curie Cancer Care, and The Arthritis and Musculoskeletal Association. Andrew was also more recently the Chief Executive of the Veterans metal health charity Combat Stress.

He was also a Fellow of the Chartered Management Institute and achieved a MA in International Affairs and Strategic Leadership from Kings College London and the Royal College of Defence Studies.

In his time with us, Andrew was the Chair of the Trust's Charitable Funds Committee and spent valuable time with our services exploring how our charitable funds could be used for the benefit of staff and service users. Andrew was instrumental in driving forward the rebranding of Beacon, Solent NHS Charity. He will be sorely missed.

We offer our sincere condolences to Andrew's family at this very sad time.

Executive Directors

Sue Harriman

Chief Executive Officer

Sue is a registered nurse who trained in the Royal Navy and enjoyed a sixteen year military career. Working in both primary and secondary care, since joining the NHS over twelve years ago, Sue's roles have included Nurse Consultant in Infection Prevention, Director of Nursing and Allied Health Professions (AHP), Managing Director, executive lead for performance, planning and corporate governance before being appointed as Deputy Chief Executive.

Andrew Strevens

Director of Finance and Performance

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 a commissioner (NHS England South Region). He also has a commercial background, having worked for KPMG and B&Q Plc.

Dan Meron

Chief Medical Officer

Dan joined the Trust in January 2016. Dan studied Medicine in 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 is currently completing 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.

Mandy Rayani

Chief Nurse

Mandy trained in Swansea as a Registered Mental Health Nurse (RMN), she 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. In 2007, Mandy took up the role of Deputy Nurse Director at Cardiff and Vale NHS Trust, one of the largest teaching hospitals in the UK. 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. In her role, Mandy provides professional leadership to nurses and allied health professionals. She also has particular responsibility for patient experience, quality governance, risk management and regulatory compliance to ensure we continue to deliver safe, effective and sustainable services.

Alex Whitfield

Chief Operating Officer Southampton and County Services

Alex joined the Trust in July 2012. She provided strong leadership as Chief Operating Officer to Winchester and Eastleigh Healthcare NHS Trust prior to its acquisition by Basingstoke and North Hants NHS Foundation Trust and the creation of Hampshire Hospitals FT. She has a sound understanding of the challenges faced by the local health and social care providers. She leads on the delivery of clinical services for Solent NHS Trust and is building on the excellent collaboration and partnership working established between providers locally. Alex has extensive operational experience in both the private and public sector and is committed to delivering high quality, cost effective patient care.

Qualifications:
MA Engineering, University of Cambridge, leadership expertise at Insead, Oxford University, the Kings Fund and the NHS Top Leaders Programme

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. In December 2014 Sarah took on a wider remit for commercial activities of the trust and was appointed COO Portsmouth Care group in July 2015.

Qualifications:
RGN, BSc, MBA.

Julie Pennycook,

Director of Human Resources and Organisational Development

Having work in the independent healthcare sector for 15 years, Julie joined the NHS in Southampton in 2003 and Solent NHS Trust in April 2011. She leads a comprehensive Human Resources and Organisational Development Department comprising HR Business Partners, Learning and Development, Workforce Information and Planning, Employment Administration, In-house Bank Staffing Service and Occupational Health.

Qualifications:
Chartered Member of CIPD, M.Sc. Human Capital Management.

Executive directors who left in year

Dr Tony Snell

Medical Director

Tony was appointed to the post of Medical Director of Solent NHS Trust in July 2011 having previously held the posts of Chief Medical Officer NHS Hillingdon, Medical Director Harmoni, Chief Executive National Health Fund, Anguilla, Associate Medical Director Orion CRO, Medical Director at Birmingham and Black Country SHA, Medical Director East Kent HA and PCTs, Director of Primary Care Barnet, senior GP partner trainer and fundholder, as well as a Royal Naval Medical Officer. Interested in evidence based practice and managed care models in the USA and NHS, Tony developed and implemented the Primary Care Clinical Effectiveness project (PRICCE). This evolved into QOF. In 2001 he was appointed Co-Vice Chair of the NHS Confederation, nGMS negotiating team, leading on QOF. Tony left in August 2015.

Stuart Ward

Interim Chief Medical Officer

From November 2015, Dr Stuart Ward joined the Trust as Interim Chief Medical Officer working for one day a week, particularly focusing on the Responsible Officer's remit. Stuart is a GP who practices in Chandlers Ford. He was the Medical Director for the Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trust (PCT) Cluster and primary care lead for the South Central Strategic Health Authority (SHA). Most recently he was the Medical Director and Responsible Officer for Wessex Area Team of NHS England. Stuart left the Trust in January 2016 following the arrival of Dan Meron, Chief Medical Officer.

Margaret Ashworth

Interim Director of Finance

Margaret joined the Trust on 30th March 2015 as Interim Director of Finance. Margaret is an experienced Director of Finance and joined us from Sherwood Forest Hospitals NHS Foundation Trust where she was Interim Chief Financial Officer. Margaret has held a number of Board positions within a wide range of NHS, public and private sector organisations, including Chief Financial Officer (Security and Resilience) for the Olympic and Paralympic Games 2012. Margaret left the Trust in September 2015 following the arrival of Andrew Strevens, Director of Finance and Performance.

Robert Steele

Director of Infrastructure

Robert was appointed to the post of Director of Infrastructure in July 2014. He has worked in the NHS for over 30 years and has extensive experience having previously held a number of senior positions in community care and acute hospitals with Lanarkshire Health Board, Gwent Health Authority and Plymouth Hospitals NHS Trust. More recently he was Director of Estates and Facilities at Yeovil District Hospital NHS Foundation Trust. He is also registered with the Department of Health as a Gateway Reviewer.

Robert was responsible for the provision of estates and facilities management and information and technology (IT). Robert left the Trust in October 2015, after which the estates portfolio was incorporated under the management of the Director of Finance and Performance and IT under the management of the Chief Operating Office for Southampton and County Services.

Board development and performance evaluation

The Board has an agreed development plan and this will be refreshed during the year ahead. Workshops are held every two months to focus on developmental and strategic topics. Due to a number of personnel changes to the Board during 2015/16 it was agreed that a full self-assessment appraisal be conducted in the summer of 2016, the results of which will inform a refresh of the Board Development Plan and potential further external assessment. The Board recognises the requirement to conduct an external evaluation every three years in accordance with good governance practice and in accordance with the NHS Foundation Trust Code of Governance (December 2013). The Board has however undertaken external assessments in the past.

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 an internal audit into Governance arrangements, which included observations of the Board and its committees as well as interviews with a number of board members. The Trust is implementing the recommendations identified.

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

Declaration of interests

In accordance with the Code of Governance, non-executive directors confirm their independence annually by declaration 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	• Trustee of Hants & IOW Community Foundation • Trustee of Ringwood Foodbank & Chair • Chair - Avon Valley Concerts
Mick Tutt Non-executive director	• Specialist Advisor /Bank Inspector – Care Quality Commission • Regional director – Committed Network • Pelican Consulting - sole trader offering management advice and support to health and social care organisations
Jon Pittam Non-executive director	No interests to declare
Andrew Cameron Non-executive director	No interests to declare
Jane Sansome Non-executive director	• Director of Sansome & Co Ltd • Interim Managing Director of MYFM Limited.
David Batters Non-executive director	• Full time Chief Financial Officer, Nuclear Decommissioning Authority
Sue Harriman Chief Executive Officer	No interests to declare
Andrew Strevens Director of Finance and Performance	• Attended HFMA Conference December 2015, pass given to VIP lounge and invitation accepted to join Grant Thornton table for gala dinner
Dan Meron Chief Medical Officer	Activity undertaken in last twelve months leading up to declaration 23rd Feb 2016 (appointed to Solent NHS Trust 25th Jan 2016); • All non- NHS activity completed outside of NHS contracted time • Section 12 work (previously undertaken at Avon and Wiltshire NHS Partnership - no work completed for Solent NHS Trust to date). • Lundbeck Institute (Copenhagen) - previous occasional workshop moderation / contributing to the development of teaching materials. Also contracted to previously provide organisational development consulting. Delivered seminar in China 2015. Received honoraria, travel expenses and hospitality for associated work - all work conducted outside of NHS time. • Sponsored attendance by Lundbeck China at Conference in China, October 2015. • Undertaking research-based higher medical degree at School of Medicine University of Southampton - no direct support for training received from any specific company. • Pinstriped Sandals Consulting Ltd - Sole director, - private practice offering consultancy, training and research services. • No shares, direct financial interest, involvement or investments in any pharmaceutical company.
Mandy Rayani Chief Nurse	No interests to declare
Alex Whitfield Chief Operating Officer - Southampton and County Services	• Director of Wessex Academic Health Science Network (non paid) • Dinner at the Kings Fund as a guest of Sussex Community Trust and Capita, August 2015 – Improving Outcomes while delivery savings • Parliamentary tea as part of Westminster Parliamentary Conferences as a guest of Boehringer Ingelheim. Covering health policy, political priorities and a particular focus on long term conditions

Sarah Austin Chief Operating Officer - Portsmouth &Commercial Director	• Close family friend works for Capsticks • Attended working supper; Hotel Terravina Southampton 19th November with Blake Morgan • Attended 2 day event with Portsmouth CCG and GP alliance Feb 2016
Julie Pennycook Director of HR and OD	No interests to declare
Members that have left in year	
Barry Neaves	• Audit Committee Member - College of Occupational Therapists • Trustee and Treasurer- The League of Friends of Romsey Hospital. • Lay Member-Chartered Insurance Institute Disciplinary Committee.
Brad Roynon	No interests declared
Tony Snell	• Associate NED for Wirral Community Trust • Specialist CQC Advisor
Robert Steele	No interests declared
Margaret Ashworth	No interests declared

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

Composition of Board committees at 31 March 2016

Director	Position	Board	Finance Committee	Remuneration Committee	Assurance Committee	MHA Scrutiny Committee	Governance and Nominations Committee	Audit and Risk Committee	Charitable Funds Committee
Alistair Stokes	Chairman	Chair	-	Member	-	Member	Chair	-	-
Mick Tutt	Non-Exec Director	Member	-	Member	Chair	Chair	Member	-	Member
Jon Pittam	Non-Exec Director	Member	Chair	Member	(to attend when available) / to become member once Finance Committee membership relinquished	Member	Member	Chair	-
Jane Sansome	Non-Exec Director	Member	Member	Chair	-	-	-	Member	-
David Batters	Non-Exec Director	Member	Member	Member	-	-	-	Member	-
Sue Harriman	Chief Executive	Member	Member	-	Member	-	Member	Invited	-
Andrew Strevens	Director of Finance	Member	Member	-	-	-	-	Member	
Dan Meron	Chief Medical Officer	Member	-	-	Member	Member	-	-	-
Mandy Rayani	Chief Nurse	Member	-	-	Member	Member	-	Invited	-
Alex Whitfield	COO Southampton and County	Member	-	-	Member	Member	-	-	Member
Sarah Austin	COO Portsmouth and Dir. of Strategy	Non voting	-	-	-	Member	-	-	-
Julie Pennycook	Dir. of HR and OD	Non voting	-	-	Member	-	-	-	-
Members that left in year									
Barry Neaves *Left Sept '15	Non-Exec Director		-		-	✓		Chair	-
Brad Roynon *Left May '15	Non-Exec Director					-	-		Chair
Tony Snell *Left Aug '15	Medical Director		-	-	✓	✓	-	-	-
Robert Steele *Left Oct '15	Director of Infrastructure	Attendee	-	-	-	-	-	-	-
Margaret Ashworth *Left Sept '15	Interim Director of Finance	✓	✓	-	-	-	-	✓	✓
Andrew Cameron	Non-Exec Director	✓	✓	✓	✓	-	-	(attended when available)	Chair

Attendance records for the year ended 31 March 2016

Director	Position	Board (7 meetings)	Finance Committee (12 meetings)	Remuneration Committee (3 meetings)	Assurance Committee (10 meetings)	MHA Scrutiny Committee (4 meetings)	Governance and Nominations Committee (2 meetings)	Audit and Risk Committee (4 meetings)	Charitable Funds Committee (3 meetings)
Alistair Stokes	Chairman	7/7 Chair	4 Non member	3/3	1 Non member	1/4	2/2 Chair	-	-
Mick Tutt	Non-Exec Director	6/7	6/12	2/3	10/10 Chair	4/4 Chair	2/2	1 Non member	3/3
Jon Pittam	Non-Exec Director	7/7	12/12 Chair	3/3	3 Non member	4/4	-	3/3 (Chair from Nov)	-
Andrew Cameron *Joined June'15	Non-Exec Director	3/4	7/9	2/3	6/8	-	-	-	2/2 (Chair from Oct)
Jane Sansome *Joined June'15	Non-Exec Director	5/5	1/5 (member from Nov 15)	3/3 Chair	1 Non member	1 Non member	-	-	-
David Batters *Joined Oct'15	Non-Exec Director	2/3	3/6	0/1	-	-	-	0/2	-
Sue Harriman	Chief Executive	7/7	10/12	-	9/10	-	2/2	3/4	-
Andrew Strevens *Joined Aug'15	Director of Finance	4/4	7/7	-	-	-	-	2/2	-
Dan Meron *Joined Jan'16	Chief Medical Officer	2/2	-	-	2/2	1/1	-	-	-
Mandy Rayani	Chief Nurse	5/7		-	8/10	3/4	-	-	-
Alex Whitfield	COO Southampton and County	7/7	9/12	-	10/10	3/4	-	-	3/3
Sarah Austin	COO Portsmouth and Dir. of Strategy	5/7	6/12	-	2/3 member from Jan 16	2/2	-	-	-
Julie Pennycook	Dir. of HR and OD	5/7	-	2/3	0/3	-	-	-	-
Members that left in year									
Barry Neaves *Left Sept '15	Non-Exec Director	2/4	4/6	2/2	1 Non member	0/2	1/1	2/2 Chair until August	-
Brad Roynon *Left May '15	Non-Exec Director	2/2	1/2	-	1/2	-	-	1/1	1/1 (Chair until May)
Tony Snell *Left Aug '15	Medical Director	3/3	-	-	4/5	2/2	-	-	-
Robert Steele *Left Oct '15	Director of Infrastructure	4/4	5/7	-	-	-	-	-	-
Margaret Ashworth *Left Sept '15	Interim Director of Finance	3/3	5/5	-	2/4	-	-	1/2	-

Audit and Risk Committee

Frequency of meeting: At least quarterly (plus private meeting with External Auditor). During 2015/16 the committee met 4 times.

The purpose of the Audit 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 and the NHS Foundation Trust Code of Governance. 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.

No significant issues regarding the financial statements were considered by the Committee, however a specific request was made by the Committee regarding assurance on the internal control processes surrounding mortality reporting.

No significant issues in relation to the financial statements of 2015/16, operations or compliance were raised by the Audit and Risk Committee during the year.

Audit and Risk Committee composition and attendance 2015/16 is previously summarised.

Details of other committees of the Board are described in the Annual Governance Statement, page 66.

Internal audit

Our Internal Auditors during 2015/16 were KPMG LLP and were appointed until 31st March 2016. 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 65). Due to the significance of the estates strategy and the interdependency of delivery impacting on the Trusts ability to reduce revenue costs and rationale its estates footprint, an additional review was commissioned by the Board in year.

The cost of the internal audit provision for 2015/16 was £48,075 and the fee associated with the additional review on the Estates Strategy was £31,374.

A tendering process was undertaken for the provision of Internal Audit for 2016/17 and 2017/18 and the contract was awarded to PwC.

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:

- The trust's 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 provision to conduct the statutory audit for 2015/16 was £60,500.

We did not commission any non-audit services from our external auditors during 2015/16.

In accordance with the Local Audit and Accountability Act 2014, NHS trusts will be responsible for appointing external auditors for the 2017/18 financial year, as such we will ensure we comply with the necessary requirements and appoint an auditor panel before December 2016.

Disclosure of information to auditors

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

Counter fraud

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. The trust's Counter Fraud provision has received an overall rating of Green (the highest possible rating) from NHS Protect.

We have implemented agreed policies and procedures, such as the Fraud, Corruption and Anti-bribery Policy as well as a Whistleblowing Policy and issues of concern are referred to the LCFS for investigation.

Remuneration

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

Members Council

(Previously known as the Council of Governors)

Elections to our inaugural Council of Governors were announced in August 2013 and since then the Council operated in 'shadow form'. Further to the announcement to step off the Foundation Trust pipeline in December 2015, the Governors and Board took the opportunity in Quarter 4 2015/16 to review their terms of reference and were agreed in Quarter 1 2016/17. Under the revised terms of reference the name of the Council has now been amended to reflect the strengthening engagement with the membership to 'Members Council'.

The Council comprises 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 following table summarises the composition and changes in Council membership in year. The table also summarises the original tenure each member was elected/nominated for; however as a consequence of the decision to step off the FT pipeline, governor tenure will be considered by the Council and Board in due course; in the interim any vacancies concerning staff or public members are being held pending further national guidance or review by January 2017 whichever is sooner.
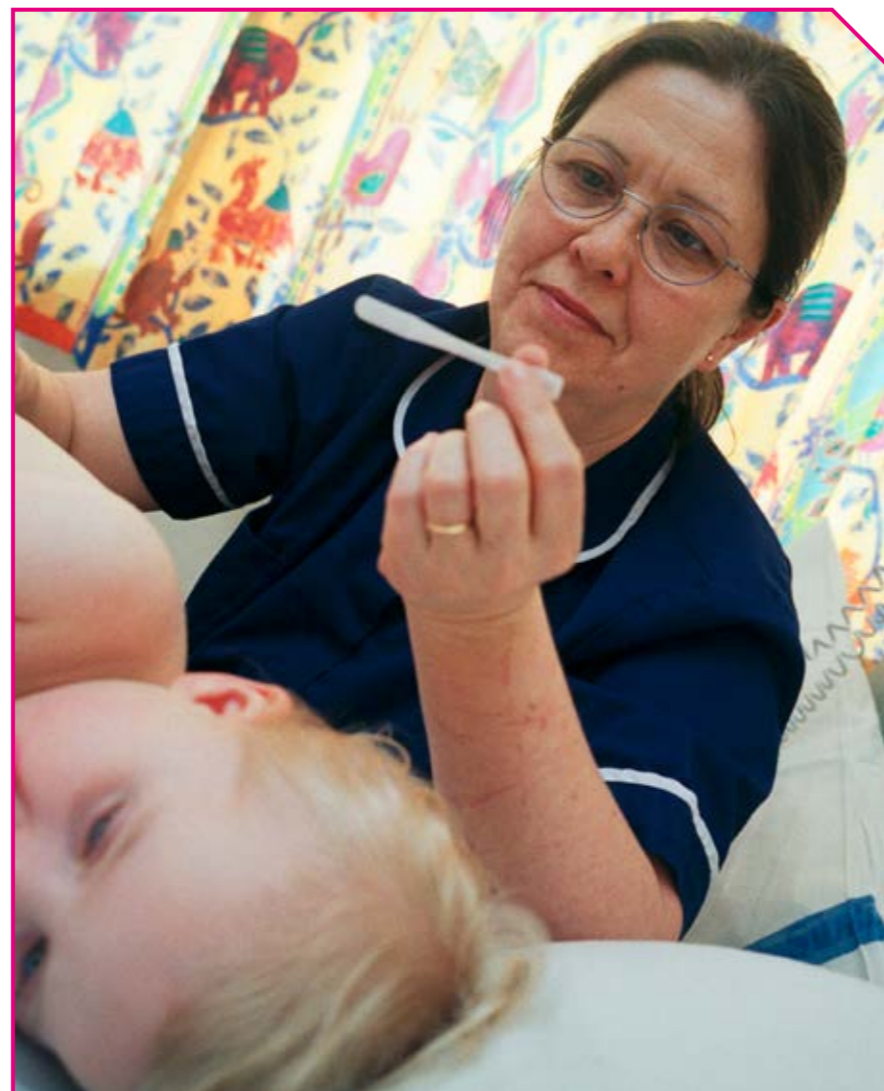
Publicly elected governors (14)		
Name	**Constituency**	**Original Tenure**
Christine Cassell	Southampton	3 years
Clive Clifford	Southampton	3 years
Hope Jackman	Southampton	3 years
David Lickman	Southampton	2 years
Jon Clark	Southampton	2 years
Narcisse Kamga	Portsmouth	3 years
Michael North (Lead Governor)	Portsmouth	3 years
David Stephen Butler	Portsmouth	3 years
Sharon Ward	Portsmouth	2 years
Graham Cox	Portsmouth	2 years
Sharon Collins	Hampshire	3 years
Vacant	Hampshire	(3 years)
Harry Hellier	Hampshire	2 years
Robert Blackman	Hampshire	2 years
Staff elected governors (5)		
Debra O'Brien	Southampton	3 years
Sarah Oborne	Southampton	3 years
Jenny Ford	Portsmouth	3 years
Fran Williams	Portsmouth	3 years
Lucy Foord	Hampshire	2 years

Appointed Governors (6)	
David Williams - Portsmouth City Council	3 years
Councillor Dave Shields - Southampton City Council	3 years
Councillor Peter Latham - Hampshire County Council	3 years
Professor Paul Roderick - University of Southampton* (appointed August 2015)	3 years
Vacant Portsmouth City Clinical Commissioning Group	3 years
Beccy Willis - Southampton City Clinical Commissioning Group (appointed November 2015)	3 years
Governors who resigned during 2015/16	
Dr. Elizabeth Palmer - Southampton City Clinical Commissioning Group	Resigned Sept 2015
Dr. Elizabeth Fellows - Portsmouth City Clinical Commissioning Group	Resigned July 2015
Dr. Chris Stephens - University of Southampton	Resigned July 2015
Cllr Briggs - Hampshire County Council	Resigned July 2015
Pearl Elizabeth Dell May - Public Governor Hampshire	Resigned Jan 2016
Suzannah Rosenberg - Portsmouth City Clinical Commissioning Group (appointed July 2015)	Resigned March 2016

(rotational seat with University of Portsmouth)

The Council held internal elections for the role of Lead Governor in March 2015. Michael North, Portsmouth Public Governor, was announced as Lead Governor serving his second term, for a one year duration from 1 April 2015 to 31 March 2016, and will serve his 3rd term from 1st April 2016. The Lead Governor acts as the central point of engagement between the Trust and the Council.

Council attendance 2015/16

Governor	16 April 2015	13 July 2015	14 October 2015	12 January 2016
Christine Cassell	Apologies	✔	✔	✔
Clive Clifford	Apologies	✔	Apologies	✔
Hope Jackman	Apologies	Apologies	Apologies	Apologies
David Lickman	✔	✔	Apologies	✔
Jon Clark	✔	✔	Apologies	Apologies
Narcisse Kamga	✔	✔	✔	✔
Michael North	✔	✔	✔	✔
Graham Cox	✔	Apologies	✔	✔
Sharon Ward	✔	Apologies	✔	Apologies
David Stephen Butler	✔	✔	✔	✔
Sharon Collins	✔	Apologies	✔	✔
Pearl Elizabeth Dell May	Apologies	Apologies	Apologies	Apologies
Harry Hellier	✔	✔	Apologies	✔
Robert Blackman	✔	✔	✔	✔
Debra O'Brien	✔	Apologies	✔	✔
Sarah Oborne	✔	✔	✔	✔
Jenny Ford	Apologies	Apologies	✔	Apologies
Fran Williams	✔	Apologies	✔	Apologies
Lucy Foord	Apologies	Apologies	Apologies	Apologies
David Williams – Portsmouth City Council	Apologies	Apologies	Apologies	Apologies
Councillor Dave Shields – Southampton City Council	Apologies	✔	Apologies	✔
Councillor Ann Briggs - Hampshire City Council	Apologies	Apologies		
Councillor Peter Latham – Hampshire County Council			Apologies	✔
Dr. Chris Stephens - University of Southampton*	Apologies	Apologies		
Professor Paul Roderick, University of Southampton			Apologies	✔
Dr. Elizabeth Fellows – Portsmouth City Clinical Commissioning Group	✔	Apologies		
Suzannah Rosenberg, - Portsmouth City CCG			Apologies	Apologies
Dr Elizabeth Palmer – Southampton City Clinical Commissioning Group	✔	✔		
Beccy Willis – Southampton City Clinical Commissioning Group			Apologies	Apologies

Name	Interest registered
Christine Cassell	Volunteer for Stroke Association Member of UKIP
Clive Clifford	Lay member of Southampton Local Child Protection Board
Hope Jackman	Nil
David Lickman	Nil
Jon Clark	Wife works for Faculty of Medicine at the University of Southampton
Narcisse Kamga	The Sickle Cell Society MENCAP
Michael North	Nil
Sharon Ward	Nil
Graham Cox	Wife works for Solent NHS Trust Bank Staff Previous education manager for the National Childbirth Trust Member of the Labour Party Member of the Workers Education Association Member of the Higher Education Academy
David Stephen Butler	Portsmouth Royal Dockyard Historical Trust
Sharon Collins	Nil
Harry Hellier	Nil
Robert Blackman	Nil
Debra O'Brien	Nil
Jenny Ford	Nil
Sarah Oborne	Member of St John Ambulance
Lucy Foord	Nil
Fran Williams	Nil
David Williams	Board member of Portsmouth CCG Director of University Technical College Portsmouth (UTC Portsmouth)
Cllr. Dave Shields	Member of Healthwatch England
Cllr Peter Latham	Member of Conservative Party
Professor Paul Roderick	Wife is acting Director of Public Health for Hampshire HCC
Beccy Willis	Brother member of Solent NHS Trust staff Partner works for Southampton City Clinical Commissioning Group and is involved in the Solent contract

Engagement with the Trust and Board of Directors during 2015/16

- The Trust's Chair is also the chair of the Council of Governors

- The Chief Executive Officer, the Company Secretary, one non-executive director (on rotation), and either the Director of Finance and Performance, the Director of Nursing and Quality or the Medical Director, depending on the agenda items, attend each Council meeting

- The entire Board of Directors are invited to join two Council meetings a year

- The Council has established a Membership Recruitment & Engagement Working Group and Planning & Strategy Working Groups which are supported by the relevant Executives and Trust officers. In addition, governor representatives attend Trust meetings such as the Patient Experience Forum and Equality & Diversity Group.

- Board members and governors are invited to key events such as the annual research and development conference

- A number of Governor representatives observe key Board Committees and are invited to meet with the non-executive chairs before / after the meeting to raise any queries. Additionally Governors are also given the opportunity to ask questions at each In-Public Board meeting.

- A governor representative is invited to join executive and non-executive colleagues on Board to floor patient safety visits

- Non-executive directors are invited to attend governor development activities and governor service visits facilitating engagement , and

- Governors and non-executive directors participate in Patient-Led Assessments of the Care Environment (PLACE) inspections.

Our Membership

The aim of our membership is to provide an opportunity for people to share feedback and opinions on how our services could improve, and also for the general public to share ideas for innovation. It also provides Solent with an opportunity to be more integrated with the local communities it serves.

Defining the membership constituencies

Membership of the trust is drawn from two constituencies:

- Public constituency – people aged over 14 based in Southampton, Portsmouth and wider Hampshire and includes patients, service users and carers. We have a total of 7326 public members.

- 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 3476 staff members.

The public constituency consists of three distinct constituencies, with no further subdivisions:

- Portsmouth city – 1875 members

- Southampton city – 2106 members

- Hampshire – 3317 members

Membership targets

Up until 2014, our membership target was 1% of the Portsmouth and Southampton populations and 0.25% of the Hampshire population. However it was agreed by the Board and with the full support of Governors that in year the focus shifts from recruitment to meaningful engagement.

The original aim was to have a membership of 11,340 by December 2015, including staff membership. We currently have just under this at 10,846 members in total (including staff) and are now focusing on ensuring our membership is engaged in a constructive and productive way to both the benefit of the individual members and the organisation.

10,846 members in total

Engagement activity 2015/16

An engagement plan was developed for 2015/16 following a survey which was sent to members asking them how they wished to be engaged with the Trust and how they would like to be communicated with. This survey will be undertaken each year to help inform the upcoming year's engagement plans.

Each quarter Shine magazine is sent to members via email (post for those without email addresses) and includes articles from across the Trust, news, upcoming events, service information and lots more.

A blog entitled "Let's talk health" which features information and advice from experts across the Trust is produced on an adhoc basis (usually every other month) and is sent to members and available via the website. Topics covered in year have included; Nutrition and Hydration, Sexual Health for the over 40 years, breastfeeding, carer's support, clinical research, an article summarising the day in the life of a nurse on duty over the Christmas period, as well as a blog from the Chief Executive, Sue Harriman.

Each month, we hold an event for our members which focuses on a specific service or topic of interest, and is hosted by an expert in that field.

We previously (2015) hosted two different styles of events; one being 'Governor Coffee Mornings', which were hosted by a Governor each month and gave members the opportunity to meet their local Governor and to ask any questions they might have about what is happening across the Trust and also to feedback their ideas for improvement and changes. The other being 'Health and Mind events' which were held quarterly and focussed on a specific topic,

such as Safeguarding and Health promotion. However, following feedback from members and Governors it was suggested that the two evens were amalgamated. We implemented these changes and have hosted three events which have all proved to be very successful, summarised as follows:

- January 2016– 'Improving patient services through research'. This event focussed on the role research plays in helping improve patient care.
- February – 'Falls prevention'. A workshop for the 65 years and over which gave advice on identifying falling hazards in the home, practical ways to reduce the risk of falling and what to do if you do have a fall. People who attended also had the opportunity to learn new exercises and take part in a health MOT including a bone health and balance test. This event received positive feedback.
- March – 'Talking Diabetes', focussing on how to prevent and manage diabetes, as well as how best to support someone with the condition.

During the forthcoming year we have a programme of planned events including:

- April 2016 – 'What does the future hold for Solent NHS Trust'? This event will give members (including staff) a broad understanding of what's happening in the NHS, what's happening in Hampshire and the cities and finally, what the future holds for Solent NHS Trust. Our Directors will be in the audience and on hand to answer any questions.
- May 2016– 'Eating healthily for you and your family' – this event will give parents practical advice about looking after their family, including how to balance their children's diet, tips on getting fussy eaters to be more adventurous and portion sizes for different ages.

Other future events include:
- Talking change – tips and advice on managing anxiety and depression.
- Breastfeeding support
- Patient liaison – your opinion matters
- Podiatry – looking after your feet
- End of life care – supporting a loved one
- Older people's mental health – caring for a friend or relative
- General health MOT – practical advice and health checks
- Getting healthier and staying healthier - tips from our health promotion team.

We will continue to explore and develop engagement opportunities during the year ahead, inviting members and the wider public to provide feedback on our services and organisational plans, to ultimately strengthen our relationship with the community.

Remuneration Report

Remuneration of the Trust's Chief Executive and Directors accountable to the Chief Executive is determined by the Trust's 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 has met three times during 2015/16. 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 Finance Director attend the meetings by invitation, they are not members of the Committee. The number of meetings and attendance is detailed below:

Board Member	25/06/15	14/07/15	14/03/2016
David Batters commenced 05/10/15			X
Andrew Cameron	✓	✓	X
Barry Neaves	✓ (Chair)	✓	
Jonathan Pittam	✓	✓	✓
Jane Sansome	✓	✓	✓ (Chair)
Alistair Stokes	✓	✓	✓
Michael Tutt	X	✓ (Chair)	✓

✓ Attended meeting   x Apologies received

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.

The Trust's policy on the remuneration of senior managers for current and future financial years is based on principles agreed nationally by the Department of Health taking into account market forces and benchmarking. During 2015/16 Gatenby Sanderson 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.

One Director is receiving a salary in excess of £142,500. Paying a salary above this threshold has been agreed by the Trust Remuneration Committee and the Trust Development Authority.

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.

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.

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 2015-16 financial year there has been two early terminations of an Executive Director but no non-contractual payments were made.

The Chairperson and Non-Executive Directors are appointed on a four year term 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 2015-16, all public bodies are required to publish the following information within their 2015-16 Annual Report.

Off payroll engagements in place as at 31/03/16, for more than £220 per day that last longer than six months	
Total number of off pay scale engagements in place as at 31st March 2016	3
Of which, the number that have existed for:	
less than one year at the time of reporting	0
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	2

Note: the two off payroll engagements for four years or more are specialist part time roles which the Trust has been unable to recruit into.

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 01/04/15 31/03/16, at a rate of £220 or more per day and that last longer than 6 months	
Number new engagements, or those that reached six months in duration, between 1st April 2015 and 31st March 2016	1
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to the contractors Income Tax and National Insurance obligations	1
Number for whom assurance has been requested	1
Of which	
assurance has been received	1
assurance has not been received	0
Engagements terminated as a result of assurance not being received.	0

Notes: In any case where, exceptionally, the Trust has engaged without including a contractual clause allowing the Trust to seek assurance as to their tax obligations – or where assurance has been requested and not received, without a contract termination – the Trust has set out the reasons for this.

When an individual leaves after assistance is requested but before assurance is received it has been included within the "No" for whom assurance has not been received.

Personal details for all engagements where assurance is requested but not received within the deadlines, have been passed to the HMRC tax evasion hotline.

If at the time of reporting the Trust is still awaiting information from the individual, it has been reported as "No" for whom assurance has not been received

Instances where the Trust is awaiting information from the individual at the time of reporting has been reported as not received

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Off payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 01/04/15 and 31/03/16.	
Number of off-payroll engagements of board members, and or senior officers with significant financial responsibility, during the year	2
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	11

Period and details of the exceptional circumstances that led to this appointment and period of appointment:
The Finance Director has left the Organisation and this was an interim appointment from 30 March 2015 to 30 September 2015, pending the recruitment of a substantive Finance Director.

Expenses

During the 2015/16 financial year, subsistence and travel costs were paid as follows:

	Number	Number making a claim	2014-2015 £	2015-2016 £
Executive Directors	9	9	11,063	7,986
Non Executive Directors	9	5	9,761	4,355
Shadow Governors	25	6	2,049	869
Total	43	20	22,966	13,210

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

Fair Pay Multiples

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 in Solent NHS Trust in the financial year 2015 -16 was £165k-170k (2014 - 15, £150-155). This was x5 times (2014 - 15, x6), the median remuneration of the workforce, which was £28,561 (2014 - 15, £27,901).

In the 2015 – 16 no employees received remuneration in excess of the highest paid director (in 2014 – 15 there were two). Remuneration ranged from £15k to £167k (2014 – 15, £14k-£178k).

The difference between years equates to vacant periods relating to two executive directors posts prior to the positions being filled substantively.

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 in March 2016 have been excluded; together with honorary appointments, Non-executive directors who receive allowances only, and individuals who were not directly employed by the Trust.

Exit Packages[1]

Changes have continued to take place within the organisation in the 2015 -2016 financial year and whilst we endeavour to do all we can to ensure the continued employment of our staff there have been 33 severance payments totalling £557k made in the year. Eighteen of these payments relate to compulsory redundancies, and fifteen have been due to other payments. 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 2015-16 - Table 1

Exit Package cost band (including and special payment element)	2015-16							
	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	5	15,505	9	37,895	14	53,400	0	0
£10,000 - £25,000	5	86,430	6	98,217	11	118,647	0	0
£25,001 - £50,000	7	266,790	0	0	7	266,790	0	0
£50,001 - £100,000	1	53,000	0	0	1	53,000	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total number of exit packages by type (total cost)	18	421,725	15	136,112	33	557837	0	0

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. Ill health retirement costs are met by the NHS Pensions Scheme and are not included in this 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.

[1]Subject to Audit

Exit Packages agreed in 2015-16 - Table 2

	2015-16		2014-15	
	Agreements	Total Value of Agreements	Agreements	Total Value of Agreements
	Number	£000s	Number	£000s
Voluntary Redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	15	136	30	651
Early Retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice *	0	0	1	53
Exit Payments following Employment Tribunal or court orders	0	0	0	0
Non-contractual payments requiring HMT approval **	0	0	0	0
Total	15	136	31	704

As single exit packages can be made up of several components each of which will be counted separately in this note, the total number above may 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 the Report.

Salaries and Allowances[2]

Name and Title	2015 - 2016					
	(a) Salary and fees including R&R (bands of £5,000)	(b) Expense Payments (taxable) (total to nearest £100)	(c) Performance Pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	Total (a to e) (bands of £5000)
	£000	£00	£000	£000	£000	£000
S Harriman – Chief Executive	155-160	12-13	0	0	20-22.5	175-180
J Pennycook- Director of Human Resources & Organisational Development	90-95	0-1	0	0	12.5-15	105-110
A Strevens – Director of Finance and Performance Commenced – 24/08/15	60-65	5-6	0	0	7.5-10	70-75
D Meron – Chief Medical Officer Commenced – 25/01/16 *	15-20	2-3	0	0	0-2.5	15-20
A Snell – Medical Director Retired – 31/08/15	55-60	10-11	0	0	0	55-60
A Whitfield – Chief Operating Officer	105-110	11-12	0	0	15-17.5	120-125
M Rayani – Chief Nurse	85-90	22-23	0	0	12.5-15	105-110
S Austin – Director of Strategy	95-100	4-5	0	0	12.5-15	110-115
R Steele – Director of Estates Resigned – 01/11/15	55-60	10-11	0	0	7.5-10	65-70
A Stokes – Chairman	15-20	0	0	0	0	15-20
D Batters – Non Executive Director Commenced 05/10/15	0	0	0	0	0	0
A Cameron – Non Executive Director Commenced – 01/06/15 Passed away - 23/03/16	5-10	6-7	0	0	0	5-10
B Neaves - Non Executive Director Resigned 30/09/15	0-5	7-8	0	0	0	0-5
J Pittam – Non Executive Director	5-10	11-12	0	0	0	5-10
B Roynon – Non Executive Director Resigned 31/05/15	0-5	0	0	0	0	0-5
J Sansome – Non Executive Director Commenced – 01/06/15	5-10	1-2	0	0	0	5-10
M Tutt – Non Executive Director	5-10	16-17	0	0	0	5-10

2 Subject to Audit

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.

* Chief Medical officer role is combined with clinical duties from 25/01/16. Only the payments that relates to the Chief Medical officer role is reflected in these figures.

Previous year Salary and Allowances

Name and Title	2014 - 2015					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance Pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	Total (a to e) (bands of £5000)
	£000	£00	£000	£000	£000	£000
S Harriman – Chief Executive Commenced - 01/09/14	90-95	0	0	0	10-15	100-105
R Tolcher – Chief Executive Resigned – 31/07/14	50-55	0	0	0	5-10	60-65
J Pennycook- Director of Human Resources & Organisational Development	90-95	0	0	0	10-15	105-110
M Parr - Director of Finance and Performance Resigned - 12/02/15	150 -155	0	0	0	10-15	165-170
A Snell – Medical Director	125-130	0	0	0	0	125-130
A Whitfield – Chief Operating Officer	105-110	0	0	0	10-15	120-125
C Hillier – Director of Nursing and Quality Retired - 26/07/14	25-30	0	0	0	0-5	30-35
M Rayani – Chief Nurse Commenced - 14/09/14	45-50	0	0	0	5-10	55-60
S Austin – Director of Strategy	95-100	0	0	0	10-15	110-115
R Steele – Director of Estates Commenced – 01/07/14	70-75	0	0	0	10-15	80-85
A Stokes – Chairman	15-20	0	0	0	0	15-20
E Bailey - Non Executive Director Resigned 31/01/15	5-10	0	0	0	0	5-10
B Neaves - Non Executive Director	5-10	0	0	0	0	5-10

Pension Benefits[3]

Name	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent Transfer Value at 31 March 2015	Cash equivalent Transfer Value at 31 March 2016	Real increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension to nearest £100
	£000	£000	£000	£000	£000	£000	£000	£000
S Harriman - Chief Executive	0.0 - 2.5	0.0 - 2.5	20 - 25	70 - 75	374	398	24	0
J Pennycook - Director of Human Resources & Organisational Development	0.0 - 2.5	2.5 - 5.0	10 - 15	40 - 45	245	269	24	0
A Strevens Director of Finance and Performance **	0.0 - 2.5	0	10 - 15	0	95	114	19	0
A Whitfield - Chief Operating Officer Portsmouth and County	(2.5) - 0.0	(2.5) - 0.0	10 - 15	35 - 40	196	197	1	0
M Rayani- Chief Nurse	2.5 - 5.0	7.5 - 10.0	35 - 40	110 - 115	630	685	54	0
S Austin - Chief Operating Officer Portsmouth	(2.5) - 0.0	(2.5) - 0.0	40 - 45	90 - 95	662	668	5	0
R Steele - Director of Estates	0.0 - 2.5	5.5 - 7.5	45 - 50	135 - 140	977	1,042	63	
A Snell – Medical Director	0	0	0	0	0	0	0	Not in pension scheme
D Meron **	5.0 - 7.5	15.0 - 17.5	5 - 10	15 - 20	0	103	103	0

** For senior members appointed during the year prior year comparatives are not available.

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

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

[3] Subject to Audit

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 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, 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.

Sue Harriman
Chief Executive Officer

Our staff

Equality and Diversity

We are committed to providing high quality services which are accessible and appropriate to meet the needs of the diverse communities it serves.

We work collaboratively with internal and external key stakeholders and partners to ensure our services and policies do not discriminate or disadvantage anyone because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sec and sexual orientation. The Equality Act 2010 and Public Sector Equality Duty require that we provide services that are personal, fair and diverse. We want to be recognised as a leader in this and as a Trust we are dedicated to building a culture of inclusivity that encourages and supports and maximises the potential of all our employees.

Our Equality and Diversity Strategy "Equality Standard" sets out our key priorities with a sustainable and evidence based action plan. Through this strategy and plan we are strengthening our culture by establishing Equality Impact leads, improving our employee relations performance and embedding a service delivery model for equality and diversity in each service. Progress of our equality standards is monitored and reviewed by our Equality Impact Group.

We have been committed to reviewing all our HR policies to ensure that we are managing employee relations concerns appropriately within the Trust. Many of these policies are aligned to people workshops to enhance learning and understanding. Our Spot It, Stop It Anti bullying campaign to address both patients and services users and internal issues regarding bullying and harassment is aligned to our Dignity at Work policy and training and development continues to be delivered to develop our staff's wider understanding of this policy.

We continue to encourage and support applications for employment from all individuals. For applicants who disclose a disability, requests for reasonable adjustments are put in place and all applicants and individuals are selected on merit and performance only. We are registered as a "Mindful Employer" and accredited with the Two Ticks disability symbol. We are positive about the recruitment and retention of disabled people and believe that all employees should be treated fairly and valued equally.

Our workforce is predominately female (87 %) and this is the predominant gender in all of the staff groups, with a split in our staff usage as follows:

Staff Group	Female	Male	%Female
Admin & Estates	634	86	88.1%
Directors	5	2	71.4%
Healthcare Assistants and Other Support Staff	706	155	82.0%
Managers and Senior Managers	43	24	64.2%
Medical & Dental	134	48	73.6%
Nursing & Midwives	863	77	91.8%
Scientific, Therapeutic & Technical	616	64	90.6%
Total	3001	456	86.8%
TOTAL	3457		

Exit packages

Details of exit packages can be found on page 50.

Off payroll engagements

Details of off payroll engagements can be found on page 47.

Sickness Absence

We continue to focus on encouraging our staff to look after their health and recognise the positive impact of the wellbeing of our staff . One of our key priorities throughout the year has been to manage attendance at work and work proactively in reducing sickness absence in some service areas.

The introduction of a new Managing Attendance policy has supported staff with a wider focus on health and wellbeing and managing the attendance of staff rather than focusing on absence only. This is further supported by our health and wellbeing strategy which underpins our focus on encouraging our staff to look after their health and wellbeing through identifying trends from our sickness absence reporting system.

During 2015/16, our activities have included:

- Development of a new Managing attendance and wellbeing Policy supporting by an interactive workshop
- Flu vaccinations clinics and occupational health campaigns
- 24 hour confidential free advice line for staff and their immediate family
- Fast track physiotherapy referrals
- Counselling service

The graph below shows sickness absence rates for April 2015 to March 2016. Sickness rates have fluctuated throughout the period, with a peak of 4.8% in November. The rolling absence rate however emphasises the rate based on the preceding 12 month rolling average, and we are presently 4.3%, with the trend seen to be dropping. The average for community and mental health trusts for 12 months to November 2015 was 4.7%.

Solent Absence - April 2015 to March 2016
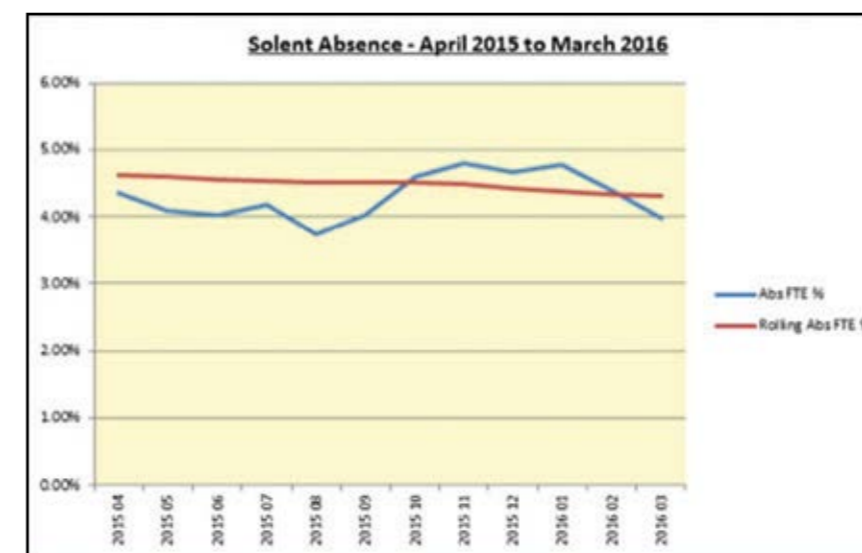
Staff Engagement and consultation

Effective two- way communication between the Trust, our staff, patients and the wider community is crucial and we acknowledge the importance of improving levels of staff engagement. We recognise that high levels of staff engagement will contribute to a positive environment and if we get the culture right, we can ensure we have a motivated and valued workforce which ultimately impacts positively on our patient care.

We have a variety of methods to achieve comprehensive staff engagement which include:

- Staff Impact Forums – staff meet to contribute to decision making
- Monthly "Ask Sue" forums – staff are invited to contact the CEO to ask any question and gain an immediate response
- Weekly staff news letters
- Weekly managers news
- Senior leaders workshops
- Back to the Floor – member of the executive team spend time working in a team across the organisation
- Executive drop in sessions
- Leadership and management development workshops

Staff consultation remains the foundation in our engagement agenda in particular where staff are facing or are affected by change. 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 with our policies throughout. There have been no consultations completed in this year in relation to major service redesign. The Trust has however continued to engage across a variety of specific initiatives where staff have been invited to contribute, feedback and participate including, the development of Trust values, our clinical records system and the introduction of the Total Quality Management programme.

NHS Staff Survey 2015/16

The 2015 Annual Staff Survey was carried out by Pickers Institute Europe between October and December 2015. 1,487 staff, out of 3,349 eligible staff, returned their completed questionnaire, giving a response rate of 44.4% compared to last year's response rate of 48.1%. The national average response rate for combined Mental Health, Learning Disabilities and Community Trusts was 44%.

	2013/14		2015/16		Trust improvement/ deterioration
	Trust	National average	Trust	National average for combined Mental Health Learning Disability and Community Trusts	
Response rate	48%	48%	44%	44%	- 4%

Our overall employee engagement score declined from 3.71 (out of 5) in 2014 to 3.69 compared to the national average for combined Mental Health, Learning Disabilities and Community Trusts of 3.81.

Overall Staff Engagement
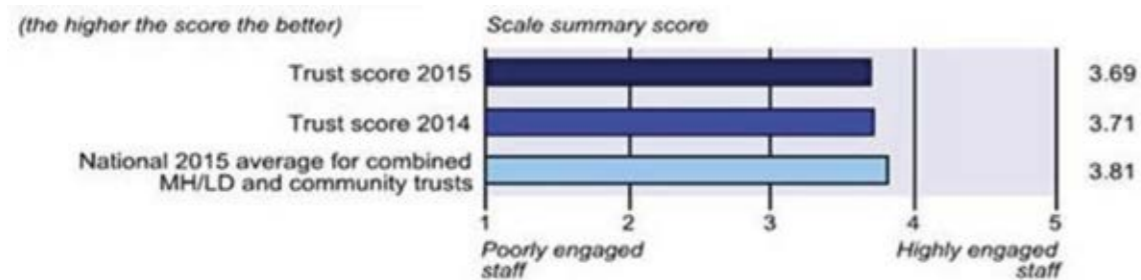
The results from the survey showed that number of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months is 4% below national average which is the same as the percentage of staff experiencing physical violence from patients, relatives or the public. Staff who received an appraisal within the last 12 months remained the same as in 2014 at 94% which is 3% above the national average and our staff reported being confident and secure in reporting unsafe clinical practice.

The following table highlights the key findings for which we compare most favourably with other combined Mental Health, Learning Disabilities and Community Trusts in England:

Top four ranking scores	2013/14		2015/16		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	8%	8%	11%	15%	-3%, however 4% better than national average
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	23%	24%	24%	28%	-1%, however 4% better than national average
Percentage of staff appraised in last 12 months	94%	90%	94%	91%	No change, however 3% above average
Staff confidence and security in reporting unsafe clinical practice	76%	72%	3.75	3.70	Not directly comparable to 2014. New Key finding.

The following table highlights the key findings for which we compare least favourably with other combined Mental Health, Learning Disabilities and Community Trusts in England, suggesting areas that will be seen as areas of focus for action planning:

Bottom four ranking scores	2013/14		2015/16		Trust improvement/ deterioration
	Trust	National Average	Trust	National Average	
Staff satisfaction with level of responsibility and involvement	3.82	-	3.80	3.90	Not directly comparable to 2014. New key finding
Staff satisfaction with the quality of work and patient care they are able to deliver	73%	75%	3.70	3.89	Not comparable to 2014
Percentage of staff able to contribute towards improvements at work	69%	70%	69%	74%	No change
Percentage of staff agreeing that their role makes a difference to patients / service users	88%	90%	87%	89%	Not comparable. Score calculation changed

Nationally the 2015 NHS Staff Survey results indicate that there is significant pressure facing those working in the NHS. Our results show we have made some progress year on year, however we do have a number of key findings that require us to further explore and plan for change.

In response to this years' feedback from the survey, during the coming 12 months our focus will be on the following areas:

- Reviewing resourcing requirements to meet demands
- Developing quality management tools to support staff to deliver quality care
- Improving our reporting channels with staff to enable concerns to be raised
- Implementation of an employee engagement delivery plan

An organisational engagement/action plan is being developed and will be monitored quarterly at Workforce Development Committee to review progress throughout the year.

Information on policies and procedures with respect to countering fraud and corruption

One of the basic principles of the NHS is the proper use of public funds. It is therefore important that all staff working for us and with us are aware of the risk of fraud, corruption, theft, and other illegal acts involving dishonesty. The ultimate aim of all counter fraud work is to support improved NHS services and ensure that fraud within the NHS is clearly seen as being unacceptable. All fraud, bribery and corruption (collectively referred to as economic crime) in the NHS is unacceptable and we are committed to supporting anti-bribery and corruption initiatives and recognise the importance of having appropriate policies and procedures in place to ensure that all staff are aware of their responsibilities.

We have a number of policies and procedures in place including risk assessments, adherence to codes of conduct, compliance to policies and various routes through which staff can raise any concerns or suspicion.

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 Solent NHS Trust when we require objective advice and assistance relating to strategy, structure, management of our organisation. This year we have sought advice and assistance from external consultants relating to corporate financing and property related issues.

We also ensure that contractors have complied with the relevant tax and national insurance requirements. Further information about off-payroll engagements on page 47.

We have continued to grow our internal bank service, which has enabled us to reduce our excess and overtime costs significantly. Agency costs have gradually decreased over the year, resulting in an end of year percentage of 1.7% usage. This is partial attributable to a recognised shortage of community nurses. Introduction of TDA compliance regarding agency usage has also provided further reduction.

	Substantive	Bank	Excess	Overtime	Agency
Grand Total	93.7%	3.7%	0.6%	0.3%	1.7%

Occupational Health and Wellbeing Service

The Occupational Health & Wellbeing team supports the Trust in meeting our responsibilities to support staff and managers to create a safe and healthy work environment where the health and wellbeing of employees is highly valued and encourages and supports staff to maintain and adopt healthy lifestyles. The Service offers a comprehensive Occupational Health and Wellbeing service and was SEQOHS accredited (Safe, Effective, Quality Occupational Health Service SEQOHS) accreditation in 2014 and successfully maintained accreditation as part of the annual review process in 2015.

We recognise that if we invest time and effort in looking after our staff that this will impact positively on patient care. To demonstrate our on-going commitment to staff health & wellbeing we have recently signed up to several of the NHS Responsibility Deal Health at Work Pledges and we are also a signatory of Mindful Employer. These good practice initiatives provide an excellent mechanism to support delivery of our Workforce Health & Wellbeing strategy. We also recognise that good engagement, communication and support strategies to promote health and wellbeing are fundamental to the successful implementation of our Strategy. The Health and Wellbeing Strategy Implementation group, which includes members of staff, managers, and representatives from staff side, HR and Occupational Health, continues to take forward health and wellbeing initiatives. The group have focused on several key areas over the past year to include mental wellbeing and prevention of musculoskeletal disorders and this work has established a platform for further work in these areas in 2016-17.

As a provider of mental health services we place great importance on the mental wellbeing and strive to achieve the same high standards for our staff as we do for people using our services. We are signed up to Time to Change and initiated a staff mental health survey in 2015 to engage staff in looking at their experiences of the Trust in supporting staff mental health and wellbeing. As part of our efforts to keep this topic firmly on the agenda we implemented a mental wellbeing features for our staff. The features address the key themes identified in the survey and supports an implementation plan to help us act on the feedback from staff to include reducing stigma around mental health and develop manager training. Our Employee Assistance Programme (EAP) service offers a range of staff support services to include online and face to face counselling, resources on mental health, managing stress and coping with crisis. Our Occupational Health team offers bespoke training on stress management and sessions to help promote a healthy lifestyle.

Musculo-Skeletal (MSK) disorders are the second highest cause of staff absence in the Trust (similar to the national picture). In 2015-16 a work stream was initiated to focus on prevention and early identification of problems. An MSK feature has been made available to all staff to help promote awareness of injury prevention strategies and how to seek help when symptoms develop. In September we also launched a workplace support programme with one of the services and this was facilitated by Occupational Health nurses and physiotherapy staff who worked intensively with several multidisciplinary community teams with a special focus on general health and wellbeing and musculoskeletal issues. The aim was to address clinical and non-clinical challenges and to support staff and managers to

implement changes in practice to help improve individual wellbeing and reduce Organisational MSK risk. Whilst the project evaluation has not yet been completed early indications demonstrated from staff feedback show that the approach taken has impacted positively in terms of raising awareness for staff, thinking differently, improved awareness of the support services available to them and feeling valued and motivated to initiate team health and wellbeing activities as part of a sustainable health & wellbeing programme. The work around MSK will continue into 2016-17 to ensure more teams benefit from the high visibility of Occupational Health support directly within the workplace.

In response to the increasing life expectancy and rise of the state pension age the population are working longer we initiated work to look closely at our age profile to help with the development of a Working Longer Strategy so we can be proactive in planning for our future workforce. This work stream continues into 2016-17 as part of a long term plan to maximise the use of people's life skills and experience to help achieve Solent's objectives.

Health and Safety

We are committed to the safety and welfare of our colleagues and patients and have remained compliant with Health and Safety regulations and requirements in year. We have not been inspected or investigated by external authorities such as the Health and Safety Executive, Fire Authority or Environmental Officer as a result of any specific incidents or concerns.

The CEO has delegated responsibility for Health & Safety to the Chair of the Health and Safety Sub- Committee (Chief Nurse), with authority to act upon the decisions reached by the Committee. The Sub-committee meets quarterly.

NHS Constitution

The NHS Constitution was established in 2009 and revised in March 2013. 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 values as set out in the NHS Constitution and undertake an annual review of our compliance which is reported to our In-public Board meeting.

> We operate in accordance with the principles and values as set out in the NHS Constitution and undertake an annual review of our compliance.

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

The Secretary of State has designated the Chief Executive as Accountable Officer of Solent NHS Trust.

The relevant responsibilities of the Accountable Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in Managing Public Money published by the HM Treasury.

Under the NHS Act 2006, the Secretary of State has directed Solent NHS Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Solent NHS Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the *Government Financial Reporting Manual* and in particular to:

- observe the Accounts Direction issued by the Secretary of State including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;

state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and prepare the financial statements on a going concern basis.

- prepare the financial statements on a going concern basis

The Accountable Officer is 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 Act. The Accountable Officer is 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 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.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *Accountable Officer Memorandum.*

SJHam.

Sue Harriman
Chief Executive Officer

Date: 31 May 2016

Enhanced quality governance reporting

During 2015/2016 we continued to ensure that the arrangements in place to govern quality and safety of services were and continue to be fit for purpose, responsive and effective. The quality assurance scrutiny and reporting arrangements have developed with greater alignment to the CQC inspection standards so that at team and corporate level compliance with the CQC five domains- safe, caring, responsive, effective and well-led, can be clearly articulated and evidenced. Attention is given to operational quality governance through the newly established Quality Improvement and Risk Group with risks escalated through to the Assurance Committee and then to Board, as appropriate. Of particular note is the development of the quality dashboard to support monitoring of key quality and safety indicators at service and corporate level. The dashboard will be further developed during the coming year.

The Quality Account provides more detail of the governance arrangements in place and reflects the achievements against the quality priorities set for 2015/2016. The Quality Account also sets out the quality priorities identified for 2016/2017 based upon Trust objectives and feedback from key stakeholders such as patients, carers and commissioners. The Quality Account can be found on page 92.

2015/2016 has seen a high level of activity focused on improving patient/service user experience. Implementation of the Friends and Family Test (FFT) has continued to be supported across all service lines and feedback received has been used to influence service improvements. The overall feedback received through

FFT and other local feedback mechanisms has been positive however feedback received through the formal complaints process has been used to inform further improvement work such as review of the Customer Care Training programme. Other improvements as a result of feedback include improved patient information and changes to appointment arrangements.

As an organisation, we have also pledged to support carers through publication of the Carers Pledge as well as collaborating with other health and social care providers to develop the Carers Strategies in both cities served by the Trust. This work will continue throughout 2016/2017 in line with the Health & Social Care Act.

A number of our teams have received recognition for their work in supporting patient care and these are outlined in the Quality Account for 2015/2016.

Later this year, in June 2016, we will be inspected by the Care Quality Commission (CQC). We were last inspected as an entire organisation by the CQC in March 2014 and although formal ratings were not allocated at that time the report highlighted the very positive, caring and compassionate contribution made by all our staff. The three key areas for improvement identified by the last inspection have all received attention by the Trust and significant progress has been made in other areas recommended for consideration.

Progress has continued to be made against the 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.

Annual Governance Statement

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 2016 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 25 of the Annual Report.

The individuals who serve on the Board and changes to appointments can be found on page 26 of the Annual Report.

> 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.

Figure 1 illustrates the Committees of the Board.
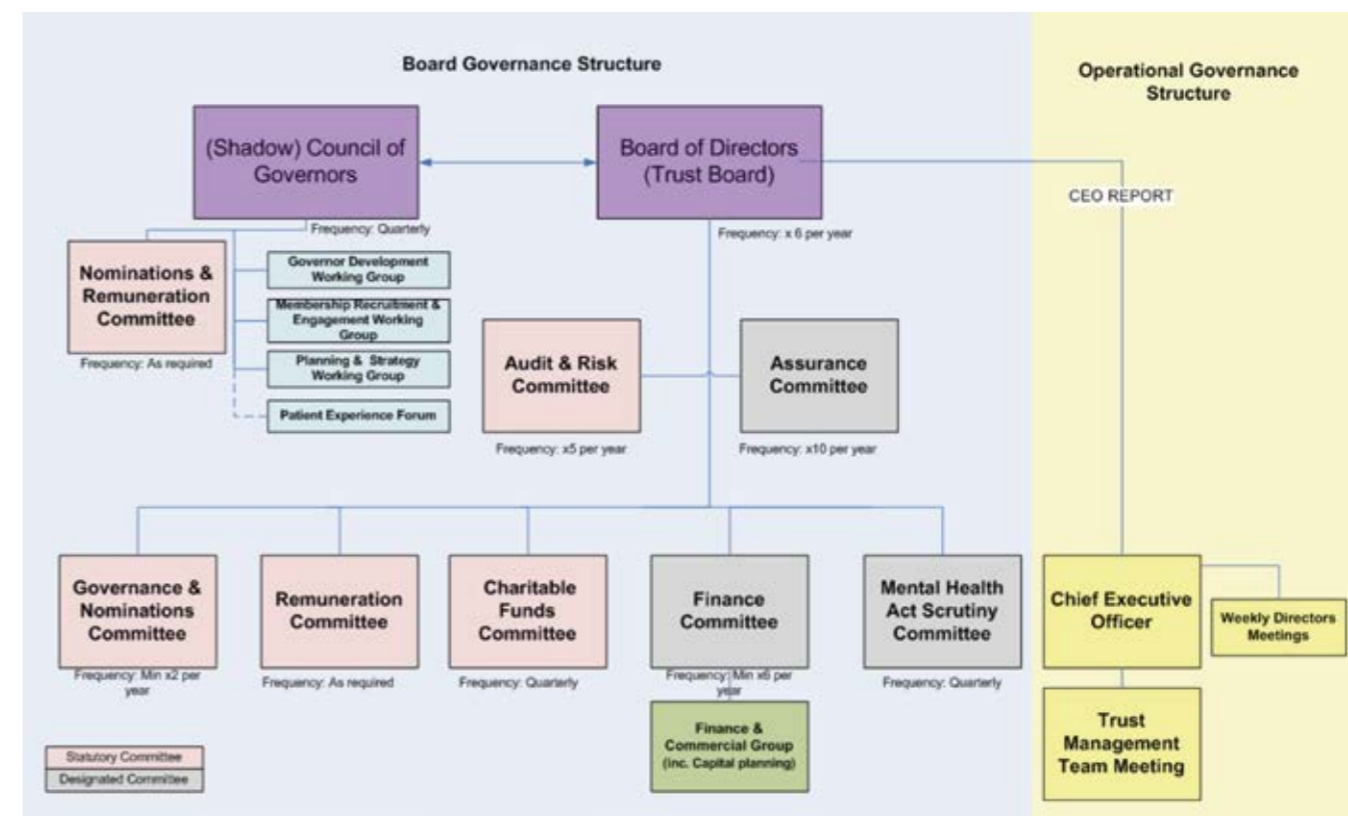
A summary of the role of the Audit & Risk Committee is found on page 37 of the Annual Report and internal audit opinions for the audits carried out in year are as follows:

Audit title	Opinion
Core financial systems (non pay expenditure)	Substantial Assurance with minor improvement observations
Governance arrangements review	Significant assurance with minor improvement potential
Data quality and referral to treatment (RTT)	Significant assurance with minor improvement potentiation
IT contract management	Significant assurance with minor improvement potentiation
Cost Improvement Plan and Setting and Monitoring	Partial assurance with improvements required
Service Line Governance	Significant assurance with minor improvement potentiation
Requested assignments (opinions therefore not provided)	
HQ relocation	No formal opinion given

Governance and Nominations Committee

Frequency of meeting: At least twice a year and as required. During 2015-16 the Committee met twice.

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 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 the Trust Development Authority. 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 2015-16 the Committee met three 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 note decisions of the Clinical Excellence Awards), allowances and terms of service for the Chief Executive and other Executive Directors.

Charitable Funds Committee

Frequency of meeting: Quarterly (or as required). During 2015-16 the Committee met three 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 2015-16 the Committee met ten times.

The Assurance Committee is responsible for seeking assurance and scrutinising all matters relating to quality and regulatory compliance; including seeking assurance of progress against action plans across the organisation including those generated for example, from Care Quality Commission visits.

The Committee has been established to enable the Board to obtain assurance that high standards of care are provided by the Trust, and in particular that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- promote quality, safety and excellence in patient care;
- identify, prioritise and manage risk;
- ensure the effective and efficient use of resources
- protect the health and safety of Trust employees
- ensure that all statutory requirements are complied with

The Committee also seeks assurance that the development of all clinical governance activities within the service lines improves the quality of care throughout the Trust as well as assuring the Board of the organisation's compliance with national and local statutory requirements with regard to clinical care. Assurance on all aspects of quality (including patient safety and experience, infection control, health and safety, safeguarding, risk management, research and development, clinical effectiveness, clinical audit and oversight of quality impact of the Cost Improvement Plans) as

well as Regulatory Compliance is sought from the Committee's reporting groups (via the Quality Improvement & Risk Committee) and via the service line 'deep dives'.

Finance Committee

Frequency of meeting: At least six times a year. During 2015-16 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, the financial recovery programme and financial control, business management (including overseeing the implementation of Service Line Reporting and Service Line 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 2015-16 the Committee met four times.

The central purpose of the Committee is to oversee the implementation of the Mental Health Act 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 Trusts external legal advisors provide update training in relation to the Mental Health Act.

Attendance records at the Board and its committees are included within the Annual Report page 36.

Highlights of Board Committee Reports

The Board has an agreed annual cycle of business and receives monthly 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 update 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 65 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.

An Independent Financial Investigation was commissioned to understand what factors contributed to the significant financial deterioration in the financial year ended 31 March 2015 and how the Trust could improve its financial performance going forward. The work was completed in October and the recommendations have been implemented.

Performance Evaluation of Board

Details can be found within the Annual Report of the processes undertaken in year.

Capacity to handle risk

Risk management and quality governance 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 monthly CEO report on all significant risks.

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

- Clinical Risk Manager - senior manager responsible for developing and overseeing the implementation of the Risk Management Framework, risk procedures and administering the corporate risk register. The Clinical Risk Manager is also responsible for the emerging Patient Safety agenda working with local patient safety initiatives and forums.

- Clinical Directors - accountable for risk and clinical governance within their respective service lines, supported by the Operational Directors and Governance Leads.

- 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 a newly established Quality Improvement and Risk Group which is chaired by

the Chief Nurse and these are then scrutinised at the Assurance Committee. A rolling programme of service line deep dive reports are also provided to the Committee. The service line structure provides high levels of autonomy increasing the effectiveness and accountability of the clinical services.

- Operational Directors and Heads of Service – responsible for managing operational risks originating within their service areas.

- 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.

- In addition, the Chief Operating Officer for Southampton and County Services ensures emergency planning and disaster recovery plans are established and regularly tested.

- 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. The Service Line AGS' are presented annually to the Assurance Committee.

The Trust has established processes to formally assess all Cost Improvement Plans (CIPs) and other transformation schemes, against the potential or foreseeable risks which could impact on quality via a Quality Impact Assessment (QIA) which identify key leading indicators. A gateway approach to the agreement of CIPs and QIAs has been embedded with signoff 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

Formal training is provided through the Risk Management and Learning and Development Teams to ensure staff are equipped to manage risk appropriately. Training includes; the legal framework, risk management principles, escalation processes, accountabilities, risk assessment, hazard identification, root cause analysis, investigator training, risk management and the principles of being open/duty of candour.

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 firmly embedded within the Trust and incident reporting is openly and actively encouraged to ensure a culture of continuous improvement and learning and there are appropriate deterrents, for example concerning fraud and corruption. The organisation understands that successful risk management requires participation, commitment and collaboration from all staff.

The Risk Management Framework (including strategy, policy and processes) provides an overarching framework for the management of internal and external risk and describes the accountability arrangements, processes and Trust's risk tolerance. 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 clear risk appetite, risk culture, philosophy and resources for risk management

- 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 fraud, however we cannot be complacent. Notifications from the Counter Fraud team improve our knowledge and awareness of the risk of fraud.

- The wider public via their elected governors, can raise concerns or issues concerning risk via the various meetings the governors attend and observe and via the established communication channels.

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. The Trust also considers, using the assessments, how its policies, procedures and service planning takes into account the diverse needs of those intended to benefit from them. Following the completion of the equality impact assessment any issues identified would be appropriately reported through the risk management process.

> **Formal training is provided through the Risk Management and Learning and Development Teams to ensure staff are equipped to manage risk appropriately.**

Risk assessment process

The organisation has structured risk assessment and management processes in place. This also includes having trained, service-based risk assessors in place to undertake assessment to support local management. Service 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 risks scoring 12 or above being escalated to the corporate risk register, in accordance with the risk appetite, agreed by Board. Figure 2 illustrates the risk reporting structure.

Figure 2

Risk identification and measurement

Risk identification establishes the organisation's exposure to risk and uncertainty. The process used by the Trust include, but is not limited to; risk assessments, adverse event reports including trends and data analysis, Serious Incidents Requiring Investigation (SIRI), claims and complaints data, business decision making and project planning, strategy and policy development analysis, external/internal audit findings / recommendations and whistle blowing.

As the organisation has implemented online web incident and risk reporting, this has provided the ability for real time reporting and escalation and aligns existing systems used for incident, complaints and claims reporting. In turn this has enabled the 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.

The organisations strategic risks (scoring 12 or over), as detailed within the Board Assurance Framework in year relate to:

- The current IT infrastructure is vulnerable and various services could fail impacting on clinical and corporate services ability to deliver effectively. Mitigations include the implementation of the infrastructure transformation plan by the end of September 2016.

- Risk to financial sustainability - there is a risk that the Trust is unable to demonstrate it can continue to operate as a financially viable standalone entity. Cuts to Public Health spending within local authorities may make the provision of services untenable for financial or quality purposes. Mitigations include on-going discussions with Local Authorities in relation to service provision as a consequence of public health cuts, we are refreshing our commercial strategy and a detailed planning schedule linked to the work of the financial recovering plan.

- Future organisational function -there is a risk that the Trust does not position itself to deliver city based integration and a strong Solent based parent group company. Mitigating actions include further refinement of the organisation's strategy and the development of city based and organisational wide plans aligned to system changes. Clarification on structure, leadership and multiagency accountability will be required as the organisation moves through the period of change and in consideration of the developing Sustainability & Transformation Plans.

The highest operational risks in year concern:

- Staffing gaps which have led to workforce challenges particularly within our Portsmouth Community Nursing and Adult Mental Health Services (AMH), risking impact on patient experience and safety. Whilst teams remain under significant pressure due to vacancies and sickness, the services continues to address the staffing challenge with comprehensive action plans including recruitment, retention, staff engagement and service redesign. In addition the risk to patient safety is managed and audited and reported daily. The national agency restrictions have also compounded the risk and it is acknowledged that there are national difficulties in recruiting into specialist roles such as AMH nursing. Further information is provided within the significant issues section on page 76.

- Information Management and Technology – including:

  o data quality – there is a risk that some management information is invalid. As a consequence of implementation of the new Clinical Record System (CRS) there is a risk that reporting systems and management information is not complete which may impact on accessing patient information as well as delays in reporting contractual performance. Support to services as a consequence of the CRS rollout continues. During 2016/17 and as part of the overarching Data Assurance Programme, a Data Quality Improvement Plan will be implemented to track the validation and audit of data underpinning local and national KPI's. Each audit will apply data quality kite marks to each KPI. These kite marks measure the quality of data through a number of dimensions - accuracy, validity, reliability, timeliness, relevance and completeness.

  o Infrastructure vulnerabilities, fragility and connectivity as well as a risk of data loss impacting on clinical effectiveness and productivity. Mitigating actions include refreshed business continuity plans and the migration to a new infrastructure by end of September 2016 which will provide stability as well as disaster recovery functionality.

  o Instability of the Online risk management reporting system – impacting on front line services ability to report incidents in a timely way

- Service specific risks concerning access, for example within our podiatric surgery service and Speech and Language Service in West Hampshire, impacting on patient care and quality. Further information is provided within the significant issues section on page 76.

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

Serious Incidents Requiring Investigation and incidents involving Information Governance (IG) matters

During 2015/16 we registered 176 Serious Incidents Requiring Investigation (SIRIs); 104 of which related to incidents concerning pressure ulcer management/care. Other SIRIs concerned unexpected deaths (27), suboptimal care (6), patient accident (6), allegations against a healthcare professional (5), as well as delayed diagnosis, treatment delays, concerning communication, safeguarding adults, Venous thromboembolism (VTE). We also investigated and responded to 11 Information Governance SIRIs, all of which are categorised as:

- Five Confidentiality Breaches – One became unfounded

- Five relating to Personal Information being sent to the wrong address

- One related to Personal Information being left in an unsecure area for a short period of time

Our commissioners provide scrutiny to our SIRI process and confirm closure on investigations once appropriate assurance has been sought.

Information Governance Toolkit and data security

In March 2016 the Trust achieved Level 2 or above standard in relation to the forty-fiver requirements outlined in the national Information Governance Toolkit, which requires a considerable number of requirements and arrangements which must be achieved. This includes ensuring that at least 95 % of staff have completed Information Governance Training annually, which is a nationally recognised as an extremely challenging standard.

Data Security is a significant part of the IG Toolkit in terms of providing assurance and compliance at a Level 2. All Information Governance SIRI's are also reported and monitored using the IG Toolkit, which automatically reports these incidents to the Information Commissioner's Office, for investigation.

The IG Toolkit and all risks/incidents are closely monitored by the Trust's Senior Information Risk Owner (SIRO), Alex Whitfield, Chief Operating Officer and the Trust's Caldicott Guardian, Dr Daniel Meron – Medical Officer.

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.

The Trust has continued to monitor implementation of the action plans developed in response to the CQC inspection which took place in March 2014. Action was taken to address the 'must do' area for improvement which were identified as

The Trust has reported full compliance with the registration requirements of the Care Quality Commission through the year and routinely receives visits and inspections.

- A review of access to Sexual Health Services to reduce waiting times and walk-in patients being turned away

- Consider the physical environment of the Kite Unit in line with published expert guidance

- Ensure that case loads of each mental health community team are supported by adequate levels of skilled and experienced staff

Monitoring of the implementation of the actions taken has continued at Care Group level supplemented by Board oversight through activities such as Board to Floor visits, review of performance management information and Friends and Family Test feedback. The Trust is currently preparing for the next CQC inspection which is scheduled to take place at the end of June 2016.

Quality Governance Arrangements

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 Clinical Governance who is responsible for supporting the Service Line Clinical Director in the delivery of the quality, safety and governance agenda. The Clinical Governance leads 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 a newly established Quality Improvement & Risk Group and the Assurance Committee.

Specific Trust wide arrangements in place which support robust quality governance and assurance include:

- A Quality Impact Assessment process- for all CIP schemes and service changes/reconfiguration

- SIRI (Serious Incident Requiring Investigation) process including Root Cause Analysis (RCA) investigation and SIRI panel arrangement

- CQRM (Contract, Quality & Risk Management Meeting) monthly meetings with commissioners

- 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 patients

- 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)

- Monitoring of quality indicators through the Service Line performance sub-committee meetings

- Monthly review of the Corporate Risk Register

- Care Group level performance review meetings.

In addition the Board is appraised of any key quality and safety matters at the beginning of each Board meeting.

The 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.

A 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 92.

Assurance on the Corporate Governance Statement

Throughout the year and in shadow form, the Trust has assured itself of the validity of the Corporate Governance Statement via the completion of a compliance tool in relation to Monitor licencing and Board Statement requirements which were periodically presented to the Board. Compliance statements are supported by underpinning evidence.

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, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Trust undertook a review of the impacts of climate change for delivering our services and in response to the Sustainable Development Unit guidance implemented a Sustainability and Carbon Management Strategy. This incorporated a Sustainable Development Management Plan and a Carbon Reduction Action Plan, these are reviewed at least annually to ensure they remain relevant and reflect the changing estate. This plan of action 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 with new measures in progress as part of our management plan and regular monitoring against our baseline is in place to record the achieved reductions against target. This also accords with the emergency preparedness and civil contingency requirements ensuring that this 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 documents were refreshed in 2015/16 and a decision rights framework for clinical service lines will be progressed during the year ahead. 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.

- Cost Improvement Plans (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 mental health, community services, corporate services, intermediate care (NAIC) and restraint benchmarking projects during 2015/16 as well as giving consent for Solent's data to be included in the development of the provider-based content in the National Mental Health Intelligence Network's (NMHIN) mental health profiles.

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 June 2015, we commenced our transition to a new Clinical Record System (CRS) for the majority of services. This created some expected data quality issues in the reporting of activity and performance. However, national and mandatory reporting requirements were prioritised for reporting and validating. Where data has been available and assured, we have maintained the maximum ratings available against both the TDA's Delivering for Patients Accountability Framework 2015/16 which encompasses the national quality and performance standards (including elective waiting data) and Monitor's Risk Assessment Framework.

The Data Assurance Programme being implemented during 2016/17 will aim to increase data quality and validity.

On a monthly basis, each Care Group's performance against its Quality, Financial, Workforce and Contractual standards is reviewed at Executive Level in detail, before reporting through to the Trust Management Team monthly meetings and finally to Trust Board through the monthly Board Performance Report. Contractual and Quality performance is discussed with commissioners directly on a monthly basis through Contract Review Meetings where outlying performance issues are addressed and monitored.

As stated in the Audit Results Report for the year ended 31 March 2016, our external auditors anticipate issuing a qualified 'except for' value for money conclusion and an unqualified opinion on the Trust's financial statements.

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. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

Solent NHS Trust has produced its annual Quality Account in compliance with these requirements, and in doing so has consulted with our membership and key stakeholders in order to meet the publication deadline.

We have clear plans to meet the all detailed requisites in relation to new requirements associated with Annual Quality Reports, as per the specific requirements laid out in the standards and guidance produced by Monitor for Foundation Trusts (Annual Reporting Manual).

One specific element of these requirements is to provide 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, which can then be 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

The Data Assurance Programme being implemented during 2016/17 will aim to increase data quality and validity.

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 the Trust Development Authority and local commissioners). A copy of the Quality Account is available on page 92 of the Annual Report.

The Quality Improvement Strategy is currently being reviewed to reflect the refreshed value statements being developed within the Trust and the work planned for 2016/17 in supporting an enhanced focus on quality improvement linked to embedding cultural change.

Significant issues during 2015/16

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 appraised 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:

- The Portsmouth Community Nursing team experienced a significant increase in staff leaving the service, which resulted in staffing capacity issues impacting on the quality of service provided. As a consequence the service experienced a rise in the number of complaints and there was also a risk in the number of SIRIs. Immediate actions were taken to mitigate the staffing risk, and an interim advisor worked with the team over a 4 month period to put in place immediate and medium term actions to both provide a safer service and implement key service improvements. The action plan continues to be monitored and reviewed and the situation will remain on the risk register until agreed de-escalation milestones are reached. A review into lessons learnt was reported to the May Assurance Committee and Board.

- Additionally, a number of other services experienced difficulties recruiting due to national staff shortages,

including the Adult Mental Health Service which has resulted in the over reliance on agency staff. As a consequence the service is undergoing transformation to consolidate wards and is implementing improved electronic rostering practices.

- Throughout 2015/16 significant attention has been paid to the management and prevention of pressure ulcers (PU) in both inpatient and community settings due to the overall number of incidents that have been considered through the SIRI process. Based upon an internal review of the handling of PU incidents a new approach was piloted (SWARM meetings, i.e. rapid review meetings) which has had a positive impact upon PU incident handling and identification of learning outcomes. Further work will be continuing throughout 16/17 with the aim of further reducing PU incidents.

- In October 2015 it was identified that the Trust was experiencing difficulties with the on line incident reporting system and consequently transferred to a manual process in line with business continuity plans. This had a direct impact upon availability of real time information which in turn led to a backlog of uploading SIRIs onto the national reporting system (STEIS). Additional resources were deployed to alleviate the backlog of incidents created during this time, the backlog was successful cleared and it is important to note that regardless of the IT challenges all incidents were triaged and responded to appropriately

- The Trust constructively supported system working to ease pressures within Queen Alexandra Hospital resulting in the diversion

of staff from community settings. This further impacted on the resource availability for Portsmouth community nursing services. Consequently new pathways of care are being implemented to ensure sustainable staffing models.

- The Trust continued to operate in a financially challenged environment in year with an adjusted deficit of £5.1m. Internal processes have continued to be strengthened during the year and enhanced scrutiny through the Finance Committee continues to give greater assurance to the Board.

- Additionally, a number of key milestones associated with the IT migration were delayed as a consequence of the IT provider negotiations and contract reset process. Since then the IT infrastructure has stabilised and a significant change programme associated with IT transition has been enacted. All staff are expected to migrate onto new IT platforms and hardware by September 2016.

- The Annual Staff Survey took place between October and December 2015 and the response rate was 44.4% compared to 48% return last year. Whilst we saw a slight improvement in staff looking forward to going to work, positive interest in health and wellbeing and being able to make suggestions to improve work in teams, we did not significantly improve in any areas of the 60 questions presented. Unfortunately we have significantly worsened across 8 key areas which we will focus on as areas of improvement during 2016/16. These areas include; resourcing and support for our staff, quality of care, creating a workplace that

staff would recommend to others, employee engagement programme, reporting of concerns/incidents and a continued focus on health and wellbeing of our staff. We will be addressing the issues highlighted in the staff survey via the implementation of an engagement / action plan which will be monitored quarterly via the Workforce Development Committee.

- Following implementation of strict national nursing agency guidelines in November 2015, we have seen a steady decline in the use of nursing agency. The highest percentage of usage has consistently been within Adults Portsmouth Community Nursing due to the challenges outlined previously. The implementation of a recruitment and retention plan along with introduction of new framework for agencies is predicted to enable us to achieve the target of 3% agency nursing costs by summer 2016. Our In House bank continues to grow in size with over 70% fill rate of shifts attributed to bank staff alone and further supports the reduction of agency use.

- Operational performance was also impacted in year as summarised as follows:

  ○ Chlamydia Screening in Hampshire - despite screening more individuals than in previous years, sufficient positive chlamydia screens to reach the target were unable to be found, which may lead to a performance fine from commissioners. Additionally, spinal surgery contractual issues at Portsmouth Hospitals Trust have resulted in additional pressure on the Musculo-Skeletal (MSK) Physiotherapy teams who manage patients with back pain in the community. This has impacted adversely on waiting times and key performance indicators for our MSK service.

  ○ Speech and Language service in West Hampshire - unfortunately demand significantly exceeds commissioned capacity and waiting times have grown. We attempted to negotiate ongoing additional funding, but eventually, with great regret, we have given notice on the service as we believe

we can no longer run the service to an acceptable standard for the funding available. Notice is currently being worked through, with some additional support from commissioners to support the waiting list.

  ○ Childrens' therapies Service in Hampshire -when we took over the children's therapies service in Hampshire in 2014, there were differential waits in different parts of the county. During the year the Board were informed of some children having to wait too long. Recruitment into children's therapies, specifically Occupational Therapy, has been difficult at times but recruitment and waiting times are much improved now, compared to the start of the year.

  ○ Podiatric Surgery - the service is run by a single podiatric surgeon and is a high quality service, popular with patients. Capacity is limited by the individual surgeon and by the availability of theatre space and as such demand outstripped capacity during the year and immediate action was taken. The service was closed on the Choose and Book system, to prevent any new patients booking via this route. This left the service to treat patients already on the list and patients referred in through the Portsmouth city block contract. Waiting times are unfortunately still long, and additional theatre capacity is being sourced.

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 content of the Quality Account 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 (KPMG) 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

- the findings of relevant internal audits, including an assessment of significant assurance with minor improvement opportunities concerning the effectiveness of our governance processes in a recent audit.

- the scrutiny given to the Clinical Audit programme by the Audit and Risk Committee

- the periodic review of the Quality Governance Assurance Framework, and now 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 SIRI Panel and Service Line Clinical Governance Groups.

The Head of Internal Audit Opinion (HOIA) concluded an opinion of substantial assurance and that there is generally a sound system of internal control concerning financial and

management processes. The HOIA confirmed that the controls are designed to meet the Trust's objectives and are generally applied consistently.

I 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, I believe Solent NHS Trust has a generally sound system of internal controls that supports the achievement of its objectives.

SJHarm.

Sue Harriman
Chief Executive Officer

Date: 31 May 2016

Section 3:
The Auditors Report

Independent Auditors report to the Directors of Solent NHS Trust

We have audited the financial statements of Solent NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, and the related notes 1 to 40. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

the table of salaries and allowances of senior managers and related narrative notes on pages 52 and 53;

the table of pension benefits of senior managers and related narrative notes on page 54;

the tables of exit packages and related notes on pages 50-51;

the analysis of staff numbers and related notes on page 56; and

the table of pay multiples and related narrative notes on page 49.

This report is made solely to the Board of Directors of Solent NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Directors' Responsibility Statement in relation to the Accounts, set out on page 84, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the Statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;

- the reasonableness of significant accounting estimates made by the directors; and

- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Solent NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and

- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

In respect of the following we have matters to report by exception:

- Proper arrangements to secure economy, efficiency and effectiveness

We report to you by exception if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion on reporting by exception

The Trust planned a deficit of £5.2million for the year ended 31 March 2016 and reported a deficit of £5.1 million in its financial statements for the year then ended. The Trust is forecasting a further deficit of £4.5 million for 2016/17, driven by planned non-recurrent investment. This forecast is dependent upon achieving £14.4 million from a cost improvement plan, of which c.£1 million is still to be identified. The Trust reported a cumulative breakeven deficit position of £6.8 million as at 31 March 2016, which is the second year of cumulative deficit. This would result in a likely cumulative deficit, at the end of the three year breakeven recovery period, of £11.3 million, which would mean the Trust will breach its duty, under paragraph 2 (1) of Schedule 5 the National Health Service Act 2006, to break even.

This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion on reporting by exception

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Solent NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

We certify that we have completed the audit of the accounts of Solent NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Helen Thompson

for and on behalf of Ernst & Young LLP Southampton

1 June 2016

> In our opinion the financial statements give a true and fair view of the financial position of Solent NHS Trust as at 31 March 2016.

Section 4:
The Accounts

Directors' responsibility statement in relation to the accounts

The Directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the NHS Trust and of the income and expenditure of the NHS Trust for that period. In preparing those financial statements, 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; and state whether applicable International Financial Reporting Standards have been followed, as detailed in the Statement of Accountable Officers Responsibilities on page 62, subject to any material departures disclosed and explained in the financial statements.

We have complied with HM Treasury's guidance on cost allocation and setting charges for information as required.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the financial statements.

Foreward and Statement on Financial Performance

In our fifth year of trading we have ended 2015-16 by achieving three of our four financial statutory duties, as described on the following pages.

We did not achieve our breakeven duty, a measure of financial stability, with an adjusted retained deficit of £5.1m reported in 2015-16. However, the planned 2015-16 deficit was £5.2m and we therefore performed better than plan.

The 2015-16 financial statements have been prepared in accordance with the Department of Health Group Manual for Accounts 2015-16.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 Manual for Accounts 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.

Sue Harriman
Chief Executive Officer

Date: 31 May 2016

Financial Review & Statutory Duties in relation to the Accounts

Keeping staff informed

In year we kept our staff informed of the financial status of the Trust via the Performance Report presented within the In Public Board papers, together with the Board minutes as well as communications directly from the Chief Executive and director briefings. We also encouraged staff to suggest ideas to help with savings and efficiencies.

Break-even position (a measure of financial stability)

The Trust has a statutory duty to achieve break-even in the year. The Trust has not achieved this as it reported an adjusted deficit of £5.1m in 2015-16, however the planned was a deficit of £5.2m. 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 £3.9m cash outflow for 2015-16 which it is permitted to undershoot. Actual external financing requirements for 2015-16 were £0.5m cash inflow and therefore the Trust achieved the target with a positive variance of £4.4m.

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 £4.7m for 2015-16. Its actual fixed asset investment was £4.7m in line with the limit.

Want to find out more?

Included on these 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 1

Financial Statements

Statement of Comprehensive Income for year ended 31 March 2016

	2015-16 £000	2014-15 £000
Employee benefits	(118,911)	(124,709)
Other costs	(71,662)	(65,455)
Revenue from patient care activities	161,968	165,152
Other Operating revenue	16,886	22,088
Operating surplus/(deficit)	**(11,719)**	**(2,924)**
Investment revenue	21	29
Other gains and (losses)	(94)	(189)
Finance costs	(133)	(40)
Surplus/(deficit) for the financial year	**(11,925)**	**(3,124)**
Public dividend capital dividends payable	(3,239)	(3,376)
Retained surplus/(deficit) for the year	**(15,164)**	**(6,500)**
Impairments and reversals taken to the revaluation reserve	(17,207)	(557)
Net gain/(loss) on revaluation of property, plant & equipment	419	13,027
Total comprehensive income for the year	**(31,952)**	**5,970**

Financial performance for the year

	2015-16 £000	2014-15 £000
Retained surplus/(deficit) for the year	(15,164)	(6,500)
Impairments (excluding IFRIC 12 impairments)	10,165	423
Adjustments in respect of donated asset respect elimination	(63)	(197)
Adjusted retained surplus/(deficit)	**(5,062)**	**(6,274)**

Statement of Financial Position as at 31 March 2016

	31 March 2016 £000	31 March 2015 £000
Non-current assets	88,721	115,213
Current assets	17,038	16,972
Current liabilities	(18,019)	(16,495)
NET CURRENT ASSETS / (LIABILITIES)	**(981)**	**477**
TOTAL ASSETS LESS CURRENT LIABILITIES	**87,740**	**115,690**
Non-current liabilities	(5,310)	(1,308)
TOTAL ASSETS EMPLOYED	**82,430**	**114,382**
FINANCED BY TAXPAYERS' EQUITY	**82,430**	**114,382**

Statement of Changes in Taxpayers' Equity for year ended 31 March 2016

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2015	**6,435**	**77,690**	**30,257**	**114,382**
Changes in taxpayers' equity for 2015-16				
Retained surplus/(deficit) for the year		(15,164)		(15,164)
Net gain / (loss) on revaluation of property, plant, equipment			419	419
Impairments and reversals			(17,207)	(17,207)
Transfers between reserves		912	(912)	0
Net recognised revenue/(expense) for the year	**0**	**(14,252)**	**(17,700)**	**(31,952)**
Balance at 31 March 2016	**6,435**	**63,438**	**12,557**	**82,430**
Balance at 1 April 2014	**213**	**83,753**	**18,224**	**102,190**
Changes in taxpayers' equity for 2014-15				
Retained surplus/(deficit) for the year		(6,500)		(6,500)
Net gain / (loss) on revaluation of property, plant, equipment			13,027	13,027
Impairments and reversals			(557)	(557)
Transfers between reserves		437	(437)	0
New temporary and permanent PDC received - cash	11,222			11,222
New temporary and permanent PDC repaid in year	(5,000)			(5,000)
Net recognised revenue/(expense) for the year	**6,222**	**(6,063)**	**12,033**	**12,192**
Balance at 31 March 2015	**6,435**	**77,690**	**30,257**	**114,382**

Statement of cash flows for the year ended 31 March 2016

	2015-16 £000	2014-15 £000
Net cash inflow/(outflow) from operating activities	7,009	(11,882)
Net cash inflow/(outflow) from investing activities	(6,523)	(3,663)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**486**	**(15,545)**
Net cash inflow/(outflow) from financing activities	4,304	6,030
INCREASE / (DECREASE) IN CASH	**4,790**	**(9,515)**
Cash at the beginning of the period	785	10,300
Cash at year end	**5,575**	**785**

Better Payment Practice Code: Measure of Compliance 31 March 2016

	2015-16		2014-15	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	26,399	51,159	28,684	46,274
Total non-NHS trade invoices paid within target	24,109	46,770	23,961	37,341
% non-NHS trade invoices paid within target	91%	91%	84%	81%
Total NHS trade invoices paid in the year	1,395	18,376	1,560	38,627
Total NHS trade invoices paid within target	1,196	14,778	1,224	28,820
Percentage of NHS trade invoices paid within target	86%	80%	78%	75%

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 are continuing to improve our financial strength, service quality and performance within a financial envelope subject to year on year cost reductions.

We ended 2015/16 reporting an adjusted deficit of £5.1m with Board recognition that there are more challenging years ahead. We delivered cost savings of £10.7m in the year and we acknowledge that it will be necessary for some service areas to transform and redesign the way services are provided, without compromising quality in order to achieve future cost saving targets.

The key challenges we face in 2016-17 are as follows:

- delivery of the deficit target of £4.5m
- delivery of a challenging efficiency savings programme
- responding to the increased competition from other providers and other commissioning intentions and
- ensure cost effective usage of all of our estate

The internal control processes for managing risks are outlined in the Annual Governance Statement found in page 64.

Having considered the challenges we face, particularly with reference to our operating plans 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.

The financial statements included within section 4 were approved by the Trust Board and signed on its behalf by

SJHarr.

Sue Harriman
Chief Executive Officer

Date: 31 May 2016

Section 5: Quality report incorporating the Quality Account 2015/16

Part One. Our commitment to quality

1.1 Welcome from Solent NHS Trust's Chief Executive, Sue Harriman

Welcome to our Quality Account for 2015/16. Each year all providers of NHS healthcare services are required to produce an annual Quality Account for publication.

I am pleased to have this opportunity to share information on the quality of the services we deliver, the improvements and progress we have made over the past year, and some of our key strategic plans for next year.

Thank you for taking the time to read this document. It is important to Solent NHS Trust that we confirm our continued commitment to improving the quality and safety of the care we provide. This report is one important way in which we can tell people about the quality of our services, and how we continually strive to improve.

Importantly during the last year, after careful consideration, we took the decision to step off the Foundation Trust pipeline and whilst this does not mean we will not revisit this in time to come, it was felt that for now it is the right thing to do.

There have been a few changes to our Board since last year; we welcomed a new Director of Finance, Andrew Strevens, Chief Medical Officer Dr Daniel Meron and Non Executives Jane Samsome, David Batters and Andrew Cameron. Sadly Andrew suddenly passed away in April this year so we are now in the process of appointing a new Non Executive Director.

The past year has presented the Trust with some challenges not least to maintain high quality care while responding to rising demand and a significant financial pressure. I am pleased to say that we have met these challenges, but this would not have been possible without the dedication and commitment of Solent staff. I thank them for their professionalism, energy and dedication.

Every part of the NHS continues to face unprecedented challenges due to rising demand and costs in the face of falling investment. Many of the services which local people rely upon are delivered by Solent NHS Trust working in partnership with other organisations, for example local authorities, GPs and other Hospital Trusts. Together we have been seeking new solutions which allow us to transform the way in which quality care is provided.

Effective leadership is vital in delivering high quality health services and something we are continuing to build on in 2016/17 through the continuation of our Leadership and Management Development Programme.

The results of our NHS Staff Opinion Survey were disappointing and indicate some significant challenges for us in terms of staff experience. Recognising the impact of staff experience on delivering care on patient experience, we have acknowledged the results of the survey and we are working hard to improve things for our staff.

As Chief Executive I have embarked upon a series of

events which enable me, not only to meet with frontline staff in locations across the Trust, but also to engage with them through a range of media, including a recently introduced blog. By listening to our workforce, as well as our service users and public, I believe that we will be in a better position to continue to deliver improved, responsive services.

We have made significant investment in information technology during the last year specifically with the implementation of a new Clinical Records System across the Trust and the continued migration to new infrastructure which is due to be completed by September. This will result in improvements for staff working in the community and improve communication between teams and services, ensuring an excellent standard of safety and quality relating to patient care.

We are committed to quality and providing care that is safe, effective and provided in an efficient manner. It is important that service users, patients and their families are assured of the quality of our services and can see easily 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 to tell us if they would recommend our services to their friends and family. Whilst we are pleased with the results, it is a challenge to ensure that everyone has the opportunity to give this feedback. We are therefore developing a range of methods to enable all service users to be able to provide us with timely feedback in all areas we deliver our services whether in a hospital, health centre or in a patient's own home. In turn, we will continue to strive to demonstrate what we have done as a result of the feedback received.

There has been much publicity about ensuring safe staffing levels and we have been required to publish details of the nursing staff on duty in our in-patient wards. This information is available on the NHS Choices and Solent NHS Trust Websites. We also provide an explanation of any variances. However it remains a challenge to ensure that we map our staff capacity in community settings to the demand, particularly with the rise in the complexity of care required for some of the people we look after in their own homes. We are actively working with our staff and commissioning partners to develop services which are responsive to such demand enabling compassionate care and best practice to be consistently provided by a skilled and competent workforce.

This Quality Account provides a summary of our achievements, this year, based on the core elements of quality, namely Safety, Experience and Effectiveness. Our achievements against this year's priorities have been monitored monthly at Board and Service Line Level.

As a Trust we are particularly proud of a number of achievements realised during 2015/16. These include, but are not limited to the following examples:

- Re accreditation for Investment in People and Health and Well Being Award

- Retained the Adelaide, Portswood and Nicholstown GP Surgeries, through a tender process due to good service delivery

- Recognition as an organisation with a good reporting culture which learns from mistakes.

Whilst some new organisational and quality priorities have been identified for 2016/2017, through collaboration with,

and feedback from staff and governors, people who use our services, carers, partners and other stakeholders, a number of priorities are a continuation of last year's objectives. This is deliberate, and they are supported by new and ambitious targets to further improve the way we deliver care.

Whilst the Trust will continue to deliver against the priorities identified in previous years, a significant amount of work associated with these priorities has become embedded into mainstream practice. It is therefore right that we bring greater focus to related but more specific areas of service delivery. One example of this will be the work the Trust progresses in the delivery of the Trust Quality Improvement Programme which is a range of focused activities across the Trust which will enable staff to deliver specific elements of our identified quality goals. We plan to use established and proven quality improvement tools and techniques to equip staff to meet our quality commitments. Our approach to embedding a culture of continuous quality improvement will be underpinned by the model for improvement and delivered through the adoption of nationally recognised collaborative models.

Over the last three months, through consultation with our staff, we have also refreshed our vision and values. Going forward these values will underpin the way we work together, with our communities and our partners to ensure that we focus on doing what matters for people who need and use our services.

Our values are:

Honesty	Everyone counts	Accountable	Respectful	Teamwork
Open & honest	Inclusive and valuing everyone	Accountable for our actions	Showing respect, dignity & compassion	Working together

Looking ahead Solent NHS Trust will maintain its focus on the quality of care, safety and the wellbeing of our staff and the people who use our services. 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.

The content of this report has been reviewed by Solent NHS Trust's Board, therefore on behalf of the Board and to the best of my knowledge; I confirm the information contained in it is accurate.

SJHarriman

Sue Harriman
Chief Executive Officer

1.2 Quality Assurance

As an organisation that seeks to continually improve, we have taken and will continue to take steps to quality assure our current activities in order to maximise the service user experience.

Our Trust Board holds ultimate accountability for the quality of services provided by the Trust. In order to ensure that there is a robust quality assurance operating, the Board has established a sub-committee (the Assurance Committee).

The Assurance Committee is chaired by a Non-Executive Director and includes other Trust Board members, lead clinicians from all clinical services and corporate leads with responsibility for risk and quality management.

Trust Board members have continued to participate in visits to clinical services which are known as 'Board to Floor' visits. This provides board members with opportunities to triangulate evidence, speak to service users and staff about their experience and to ensure that there is an open and transparent culture within the Trust.

Visits have taken place to the following areas in 2015/16:

2015			
2nd March 2015- Mental Health Recovery Teams- St Mary's Community Health Campus, Portsmouth	20th April 2015- Adults West- Community Nursing and Palliative Care	12th June 2015- Child and Family- The Orchards (CAMHs) Southampton	15th July 2015- MSK Service- Stoneham Centre, Southampton
3rd August 2015- Dental- Bitterne Health Centre Southampton	25th August 2015- Child and Family BRS (Behaviour Resource Team)	8th September 2015- Mental Health- Oakdene, Portsmouth	25th September 2015- Sexual Health- St Mary's Community Health Campus, Portsmouth
19th October 2015- Dental- Royal South Hants Hospital, Southampton	29th October 2015- CAMHS Battenburg Clinic	7th November 2015- Adults Southampton Fanshawe, Royal South Hants Hosputal, Southampton	16th November 2015- Sexual Health Royal South Hants Hospital , Southampton
7th December 2015- LTC- Snowdon, Western Community Hospital, Southampton	20th December 2015- Lower Brambles, Royal South Hants Hospital, Southampton		

2016			
28 January 2016- Adults Portsmouth Jubilee House	11 February 2016- Primary Care and Long term conditions Southampton	22 February 2016- Adults Portsmouth QA MSK Team	10 March 2016- Primary Care and Long term Conditions Southampton

We have also developed a programme of Mock CQC Visits to determine how we rank against the Key Lines of Enquiry and act on information from CQC Intelligent Monitoring.

The executive team have considered intelligence gathered from a variety of sources including:

- Quality Account priorities
- Contractual performance indicators from quality contract
- Commissioning for Quality and Innovation (CQUIN)
- Trust Development Authority (TDA) targets
- CQC intelligent monitoring
- Patient surveys and feedback
- Staff surveys and feedback
- Quality and risk reports (Clinical Governance) including incidents, compliments and complaints
- Quality Impact Assessment (QIA)monitoring
- Corporate governance reports -Board Governance Assurance Framework (BGAF) and Quality Governance Assurance Framework (QGAF).

1.3 Equality

Underpinning the delivery of the commitments set out in this Quality Account – in particular, the five quality improvement priorities identified in Part Four – will be an on-going focus on promoting equality. We will aim to improve the quality of service, access and outcomes for service users of all protected equality characteristics.

This is a fundamental operating principle for our organisation and examples of how we will continue to achieve this in 16/17 include:

- Strengthening the data collection of protected characteristics of our patients and people who use our services
- Benchmarking our equality performance against key priority areas within the NHS Equality Delivery System 2
- Undertaking equality impact assessments on all business cases, plans and policies to ensure that the meet the needs of, and do not disadvantage service users or staff of any protected characteristics.

1.4 A Year of Achievements

This part of the Quality Account provides a review the last year for our Trust, and demonstrates our successes and learning during 2015. Some of the highlights of the year have been:

SEPTEMBER
Jackie Bennett, a Community Palliative Matron for the Trust and the Marie Curie Project, was shortlisted as one of the five finalists in the Kate Granger Awards.

NOVEMBER
Our Trust was named as one of the top 120 places to work in the NHS, after it made it onto the list which was compiled by the Health Service Journal (HSJ), Nursing Times and supported by NHS employers.

OCTOBER
A number of our services showed why we are known as an excellent provider of community and mental health services at the Best of Health Awards run by The News in Portsmouth.

JUNE
Our Musculoskeletal (MSK) Specialist Physiotherapy Team won a Health Education Wessex SHINE award. The Service, which is run jointly with Portsmouth Hospital Trust, won the Chair's Highly Commended accolade.

JANUARY
The Solent Dementia Network was launched, working in partnership with Dementia UK, to give the Trust's dementia nurses and healthcare professionals.

JULY
A new mental health recovery service in Portsmouth was officially launched. Working in partnership, Solent Mind and Solent NHS provide the Portsmouth Support and Recovery Service, based at St Mary's Community Health Campus.

OCTOBER
The Trust's research team had cause to celebrate after they were named one of the most active research Care Trust's in the UK for 2014/15 in the National Institute for Health Research's league tables.

Part Two: Statements of Assurance from the Board for 2015/16

This section of our Quality Account includes mandated information that is common across all organisations' Quality Accounts.

This information demonstrates that we are performing to essential standards; measuring clinical processes and performance; and are involved in national projects and initiatives aimed at improving quality.

2.1 Review of Services

We are a specialist provider of community and mental health services with an annual revenue of £179m for 2015/16, with a workforce in excess of 3,400 staff (equating to nearly 3,100 whole time equivalent posts) and delivering over 1.25 million service user contacts per annum.

A wide range of community and mental health services are provided to over a million people living in Southampton, Portsmouth and wider Hampshire. Services are provided from a number of different locations, including community hospitals, as well as numerous outpatient and other settings within the community such as health centres, children's centres and within service users' homes.

We operate primarily within the local market area of Portsmouth, Southampton and wider Hampshire. We encourage people from our local communities to become members and governors of the Trust to allow them to have a greater say in how things are run and to help us shape the future of the Trust. Our services are grouped into three clinical care groups:

the Portsmouth Care Group, the Southampton Care group and the County Wide Care Group.

During 2015/15 Solent NHS Trust provided and/or sub-contracted a wide range of relevant health services. More detail on the services provided by us can be found on our website

http://www.solent.nhs.uk

We have reviewed all the data available on the quality of care in all of these services.

The data reviewed has covered the three dimensions of quality (clinical effectiveness, safety and patient experience), ensuring that this Quality Account presents a rounded view of the quality of services provided. We hope that this will enable readers to gain a clear and balanced understanding of what quality means to us.

2.2 Participation in Clinical Audits and national Confidential Enquires

Clinical Audit

During 2015 – 2016, 21 national clinical audits and two national confidential enquiries covered health services that Solent NHS Trust provides. During that period Solent NHS Trust participated in 100 per cent of the national confidential enquiries and 100 per cent of the national clinical audits which we were eligible to participate in.

A wide range of community and mental health services are provided to over a million people living in Southampton, Portsmouth and wider Hampshire
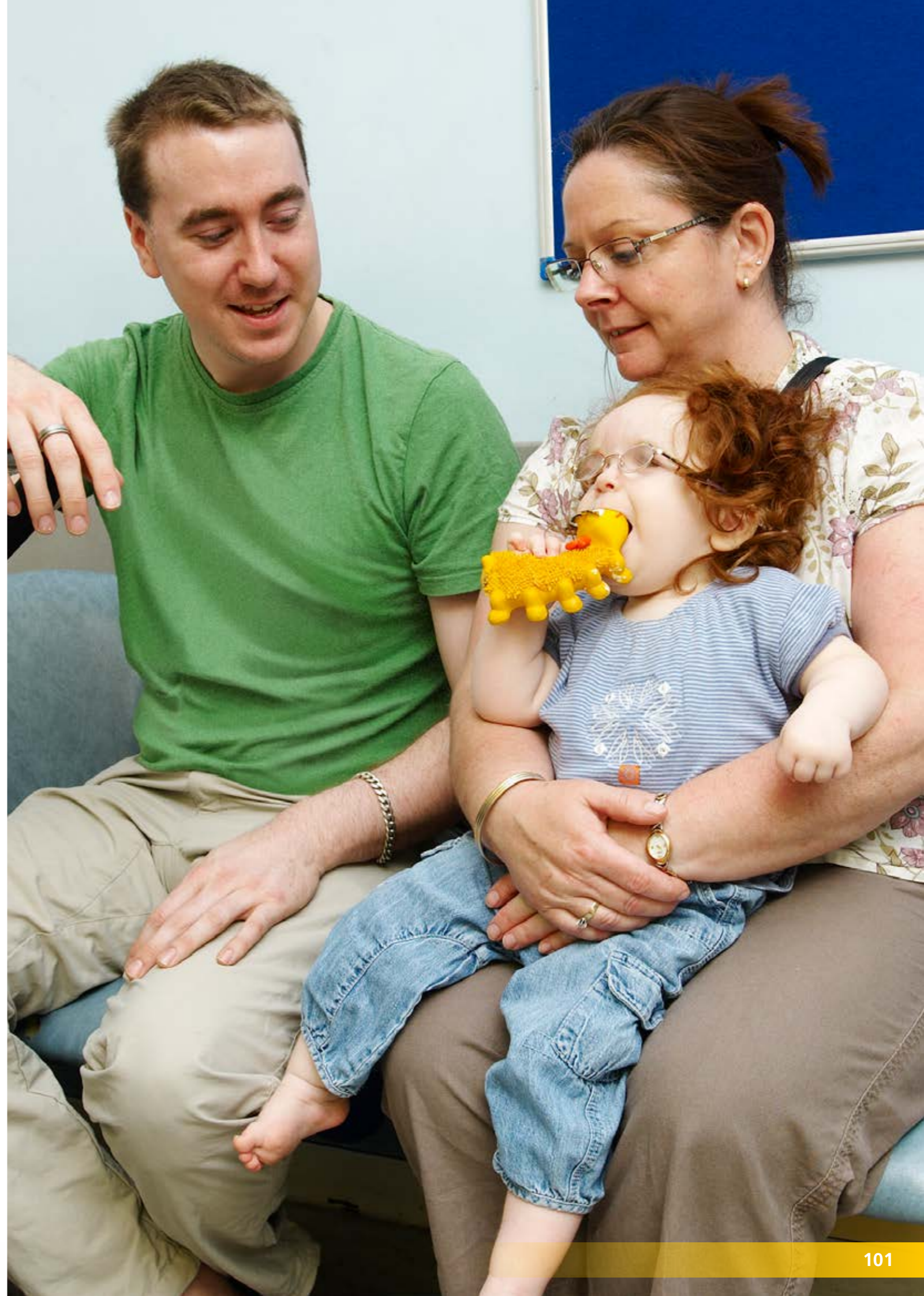
The national clinical audits and national confidential inquiries that we were eligible to participate in during 2015 – 2016 are as follows:

Eligible National Clinical Audits /National Confidential Inquiries	Participated
National Confidential Inquiry into Suicide and Homicide	Yes
Mental Health CQUIN audit: Improving physical healthcare to reduce premature mortality in people with severe mental illness (Indicator 4a)	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Organisational Audit	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Clinical Audit	Yes
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing Valproate for bipolar disorder	Yes
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing for ADHD in children, adolescents and adults	Yes
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing for people with learning Disabilities	Yes
End of Life Care: Dying in Hospital	Yes
National Confidential Enquiry into Patient Outcomes and Deaths Sepsis Study	Yes
National Audit of Intermediate Care	Yes
National Audit of Cardiac Rehabilitation	Yes
National Paediatric Diabetes Audit	Yes
National UK Parkinson's Audit	Yes
National Diabetes Footcare Audit	Yes
Sentinel Stroke National Audit	Yes
Management of under 16's in sexual health clinics	Yes
Partner notification for HIV infection	Yes
Routine monitoring of adults with HIV infection	Yes
Management of Gonorrhoea	Yes
NCEPOD Chronic Neurodisability study	Yes
NCEPOD Young People's Mental Health	Yes

The national clinical audits and national confidential inquiries in which we participated, and for which the data collection was completed in 2015 – 2016, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Eligible National Clinical Audits /National Confidential Inquiries	Percentage Number of Cases Submitted
National Confidential Inquiry into Suicide and Homicide	78.5%
Mental Health CQUIN audit: Improving physical healthcare to reduce premature mortality in people with severe mental illness (Indicator 4a)	100%
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Organisational Audit	n/a
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Clinical Audit	100%
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing Valproate for bipolar disorder	100%
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing for ADHD in children, adolescents and adults	100%
End of Life Care: Dying in Hospital	100%
National Audit of Intermediate Care	100%
National Paediatric Diabetes Audit	n/a
National UK Parkinson's Audit	n/a
Management of under 16's in sexual health clinics	100%
Partner notification for HIV infection	100%
Routine monitoring of adults with HIV infection	n/a
Management of Gonorrhoea	n/a

The reports of 15 national clinical audits were reviewed by Solent NHS Trust in 2015 – 2016, via our service line governance structure.

The reports of 107 clinical audits were reviewed during 2015 – 2016. Examples of these and some of the actions we intend to take to improve the quality of healthcare are shown below:

Service Line	Audit Title	Actions taken to improve the quality of healthcare
Child and Family	Usage and monitoring of antipsychotic medication prescribed in children and adolescents in the Orchard Centre 2015	• Better documentation of substance misuse. • To improve monitoring and documentation of pre-treatment screening parameters. • To improve monitoring and documentation of movement disorders. • To ensure all patients on antipsychotic medication are reviewed every six months. • To improve monitoring and documentation of physical and biochemical parameters every six months. • To maintain the good work in all areas where 100% target was achieved
	Safer Sleep	• To feedback audit results at citywide forum and at monthly team brief. • To amend 6-8 week contact template to include a prompt to record discussion.
Adult Services Portsmouth	Re-audit of NICE guidance relating to Documentation at Memory Clinics	• GP letter will be sent within 14 days of first patient contact • Letters will include lead professional/ care coordinator • Letter proformas will be used • Records entry will be made within one day of contact
	The Learning Disability Prescribing in Mental Health audit	• All patients are now first seen by a support worker who measures indicators of physical health such as height and weight, checks blood results and ensures paper work is up to date • The consultant then reviews these measures and makes recommendations to the patient and the family • A local re-audit has shown these processes are working well
Adult Services Southampton	Falls Audit	• Staff training on issues and sharing audit results with them via the governance groups and staff forums • Further improvements in the falls assessment process • More consistent screening for patients admitted to our caseloads
	National Audit Chronic Pulmonary Obstructive Disease (COPD)	• Offer a comprehensive variety of exercise facilities and other activities to engage the patient in a more active, social and quality-filled life • Ensure a more efficient seamless transfer from in-patient to out-patient service. • Achieving two practice tests therefore falling in line with best practice • To clarify to the patient more succinctly what exercise regime they have agreed to undertake post PR
Primary Care	StartBack Audit	• Education around the management of patients psychosocial factors • Engagement/ education of GP's • Physiotherapists departments only accept patient referrals with completed STarT Back scores • Reception continue to hand out any necessary patient questionnaires • Devise a questionnaire for patients that drop out/DNA to assess whether their symptoms improved or treatment wasn't what they expected/ wanted
Adult Mental Health Services	Audit of Non CPA Care Plan Standards.	• Out-patient letters have been changed to adopt a format that demonstrates all areas that present good practice are covered. • A process whereby the care plan is shared with the service user is being adopted
Specialist Dental Services	Recording Parental Consent	• Parental Consent paperwork to be included in new patient paperwork at first clinic appointment • All child patients should have a record made of who can give parental consent in the Parental consent field on R4 • Reminder to staff included in monthly dental newsletter. • Receptionists will include parental consent paperwork with new patient paperwork at first appointment and to follow up the recording of details
Sexual Health Services	Partner Notification for adults newly diagnosed with HIV infection British HIV Association National Audit 2014	National Recommendations • All clinical services should review their results carefully and strive to improve PN completion for HIV. • PN efforts should focus on ex -regular and casual known as well as regular contacts. • Clinical services should not apply a fixed time limit after which to stop addressing unresolved PN. Local Recommendations: • Recommend PN is followed up at each appointment for the first year at diagnosis, and again each time sexual history is reviewed (at least annually).

2.3 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by us in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1724. We have recruited to 45 studies on the National Institute of Health Research portfolio across a range of services. Solent NHS Trust continues to be at the top of the National League tables for research activity in Care Trusts.

Clinical impact from research:

Research is about improving patient care, treatment and clinical outcomes. Often, participating in research gives those that use our services access to novel treatment that they would not have had as part of normal care. Patients and staff also benefit from being involved in treatment based on the latest evidence and from contributing to improving what we know about conditions. Our aim is to give as many of our patients and staff as possible, the opportunity to participate in research. We also work in partnership with local Universities and Health Education England (Wessex) to offer a clinical academic training programme and career pathway for our clinicians, and strive to ensure that those that use our services are involved in all of our research activity and priority setting.

Our key areas of research in 2015/16 were:

- Dementia – investigations into genetic causes, and trials of interventions to delay progression or reduce symptoms (for example agitation), support for carers of people with communication difficulties

- Mental Health – validation of outcomes measures around quality of life, use of social networks to support recovery, trials of smoking cessation interventions, pathways for the treatment of schizophrenia

- Sexual Health – antibiotic use in the treatment of gonorrhoea, screening for Chlamydia

- Parkinson's Disease – interventions to prevent falls (including Dance therapy)

- AHDH – parenting programmes to support parents who have children with challenging behaviour, delivered face to face and online

- Diabetes – devices to support self-monitoring of blood glucose levels

- Primary Care – a range of studies on self-management of conditions, digital interventions, screening for Hepatitis in homeless populations

- Physiotherapy – post surgery interventions and therapy, treatment of lower back pain & shoulder pain

- Podiatry – use of diagnostic imaging for wounds, treatment for rheumatology, interventions for those with diabetic ulcers

We have recruited to 45 studies on the National Institute of Health Research portfolio across a range of services. Solent NHS Trust continues to be at the top of the National League tables for research activity in Care Trusts.

Solent Care Home Research Partnership (CHRP)

We have developed a research partnership with care homes to open up access to clinical trials to residents, their family and staff. The benefits of conducting research in care homes have been numerous; improved knowledge, improved training for staff and bringing local care homes together to improve the quality of life for their residents. One key study has been investigating ways to deal with agitation amongst those with dementia in care home settings. Irene, one of the care home managers, has said:

"We are passionate about improving the quality of life of our residents but also about improving the lives of all those living with dementia. We feel by taking part in research that we are learning at the same time as contributing to all those people."

As a result of this research, families and care home staff have reported that they now feel able to take patients out of the care home for walks or trips to the local shops, something they were unable to do previously. The mechanisms to reduce agitation have increased quality of life for the residents and their families.

More information can be found on our website, www.solent.nhs.uk/research.

Experiences of being involved in research: Christopher's research story:

Christopher is a retired computer programmer from Southampton. In February 2013 Christopher was diagnosed with Parkinson's Disease. Since his diagnosis he has signed up take part in a number of research projects. Recently he has been involved in the PDSafe trial. This project is investigating whether a tailored home based exercise programme, carried out with the support of a physiotherapist, can help improve balance and strength and reduce falls in people with this condition. Since being involved in the trial Christopher has started walking confident enough to travel again and has recently been on holiday to Iceland and walked up a glacier – in his words: "Parkinson's or not I am going up that glacier!"

Christopher thoroughly enjoyed his experience of being involved in PD Safe, he said:

"Being involved in the research was good for me."

He is aware that he would not have ordinarily received the same therapy.

A patient research ambassador - Mary's story:

Roger, my husband, a retired airline pilot was diagnosed with vascular dementia in March 2014. Between October 2010 and September 2015 I had met him, married him, cared for him and I am now his widow. I made up my mind from the onset of the diagnosis that our life was going to be normal; dementia would live with us not rule our lives. The more his caring needs increased the more I was determined to fight it. But slowly it etched away at our lives; he became a different person, unable to live a normal life relying entirely on my support. This however, gave me the drive to support research teams in finding a cure.

As a carer, my belief was that numerous campaigns highlighting the illness never showed the real picture, I wanted to be able to have an involvement in getting the "raw" message out into the public domain so it could be fought and research was top on the agenda. I started by participating in research – the first was a genetic study on Systemic Inflammation in Dementia. I was proud to be helping in some small way.

When Roger passed away I became even more passionate to support research and generate interest in its studies. I want to be able to encourage people to understand that unless a cure for this illness is found it will destroy future generations. As my story portrays it does not discriminate, it can suddenly strike and life changes for ever for the sufferer and their family. By talking of my experience I hope I can encourage others to realise research into the cause, diagnosis and treatment can and is happening but only with ongoing support and resources.

Impact of research active clinicians – a case study from Podiatry:

As a Trust, we have implemented a clinical academic career pathway in which our clinicians can work in joint roles between local universities and our clinical services. In these roles, staff see patients in clinics, carry out research and support the development of other staff to deliver care based on the best evidence. We have a variety of roles, from short internships, to clinical academic doctorates, and senior post-doctoral specialists.

Lindsay Cherry is a specialist podiatrist with one of these joint roles. Her academic role is based at the University of Southampton, and involves research and teaching. Her clinical role is based in our community clinics and a specialist multi-disciplinary team who care for patients with complex foot health problems. Her clinical role aims to prevent deterioration in foot health, hospital admissions, amputations or loss of life. Being based in a clinical team means that Lindsay can understand patient needs, where gaps are in care and what questions the research needs to address. She says it helps her 'understand the real world possibility of the solution that the research suggests' and also keeps her up to date on the best diagnostic and treatment options.

Lindsay supports a number of improvement projects across her service, and is supporting more junior staff to get involved in research. She also has a patient and public partnership group who work with her on service development, and sits on national advisory groups for foot health guidelines and research. The specialist service is currently being considered for Centre of National Excellence Status.

2.4 Commissioning for Quality and Innovation (CQUIN)

A proportion of Solent NHS Trusts income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between Solent and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. For 2015/16 the value of the CQUIN payment was £2.5m

We are pleased to report that we have achieved a significant number of our agreed CQUIN schemes for 2015/16 which is a reflection of the hard work of staff across the organisation. We would like to take this opportunity to say 'thank you and well done' to everyone involved.

The CQUIN scheme agreed with our CCG commissioners for 2015/16 is detailed below:

CQUIN Status Summary- 05.05.16

CQUIN Status Summary - East Contract	CQUIN Value		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Local														
Heart Failure	£150,700	ECQ1	80%	80%	57%	80%	80%	86%	100%	80%	71%	100%	80%	79%
In-Reach	£301,396	ECQ2	100%	33%	100%	100%	100%	100%	100%	100%	100%	67%	67%	67%
Respiratory	£150,700	ECQ3	84%	84%	100%	89%	89%	100%	84%	89%	95%	89%	89%	93%
Adult Mental Health	£242,320	ECQ4				50%			50%		50%			100%
Mental Health Safety Thermometer (MHST) - AMH	£50,000	ECQ5A				80%			60%			100%		100%
Mental Health Safety Thermometer (MHST) - OPMH	£71,959	ECQ5B				90%			100%			100%		100%
Funding Without Measures	£112,655													
National														
Cardio Metabolic Assessment and Treatment for Patients with Psychoses	£55,680	ECQ6				100%					100%			50%
Funding Without Measures	£407,068													
Total:	**£1,542,478**													

CQUIN Status Summary - West Contract	CQUIN Value		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Local														
Stroke Six Month Reviews	£50,025	WCQ1						88%	0%	100%	100%	100%	100%	100%
Falls and Bone Health	£268,673	WCQ3			100%			100%			100%			100%
Person Centered Planning (PCP)	£268,673	WCQ4			100%			50%			100%			100%
National														
Urgent Care	£115,146	WCQ5	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dementia	£115,146	WCQ6	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total:	**£817,661**													

CQUIN Status Summary - NHS England Contract	CQUIN Value		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Local														
Embedding quality systems in HIV Networks	£32,693	NH1				100%			50%					75%
HIV: reducing unnecessary CD4 monitoring	£32,693	NH2												0%
Health Visiting Solent East	£48,600	NH3				100%			88%			100%		80%
Health Visiting Solent West	£51,325	NH4				100%			88%			100%		80%
Child Health Information Services	£17,884	NH5	100%	100%	100%			100%				75%		100%
Total:	**£183,195**													

2.5 Registration with the Care Quality Commission (CQC)

Solent NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without conditions'. The Care Quality Commission has not taken enforcement action against Solent NHS Trust during 2015/16.

Solent NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16.

- Solent NHS has participated in a Thematic Review of Integrated Older Peoples Services in Portsmouth and a looked after children and safeguarding review in Southampton. The Portsmouth review did not identify any compliance actions or requirements. The Southampton review identified a number of actions for Solent, UHS and Southern Health, all of which have been complied into a joint action plan for the CCG.

In March 2014 Solent NHS trust was selected as one of a range of trusts to be inspected under CQC's revised inspection approach to mental health and community services. Although as a pilot site we did not receive a formal rating for this inspection the inspectors reported that our services were Safe, Caring, Effective, Responsive and Well led. A copy of the full report can be accessed at; www.cqc.org.uk/sites/default/files/new_reports/AAAA0657.pdf

We have been notified by the CQC that they will be visiting again to inspect the Trust at the End of June this year (2016) we are looking forward to this visit and to receiving our first formal rating under the new inspection process.

2.6 Data Quality

We recognise that high quality patient information promotes the speedy and effective delivery of patient care and that accurate and timely management information, derived from patient data, is essential to the planning and delivery of service improvements.

Solent NHS Trust submits monthly data sets containing inpatient and outpatient activity to the Health and Social Care Information Centre (HSCIC). The HSCIC publish a data validity score each month which assesses the data for completeness and compliance with the NHS National Data Dictionary Standards. Our current score as at month 11 15/16 is 96.6 per cent of data is complete and accurate in accordance with national NHS data standards. This is above the national average of 96.2 per cent and the above the Wessex regional average of 96.4%. This score is calculated from a number of specified data items submitted to HSCIC via the Secondary Users Service (SUS). This score is reported to Board each month along with a service line breakdown.

A Data Quality and Referral to Treatment Audit was undertaken by our internal auditors, KPMG in 15/16. The audit reviewed the process for reporting against the referral to treatment indictor to ensure it complied with national guidance. It also assessed the design and operation of controls in place to ensure appropriate data recording was taking place and reviewed some sample cases to ensure systems were operating effectively. A similar process was followed to look at data quality processes in general and some additional analytics where undertaken to check data integrity. As a result of this audit an assessment of "Significant assurance with minor improvement opportunities" was given as to the effectiveness of our data quality and referral to treatment arrangements.

The Trust Data Assurance Team has an established programme of reporting, service engagement and data validation to ensure robust data quality is available to meet the clinical and business needs of the organisation. The Trust is compliant with Information Governance Toolkit requirements and scored level 2 for the relevant categories in 15/16.

The Data Assurance Teams key objectives for 15/16 where met in the following ways:

- Continue to build stronger relationships with services by engaging with service line staff through the development of the Data Assurance Intranet pages, attending user groups and service line meetings, disseminating data quality reports and providing guidelines for staff

- Working together with the Performance and Information Systems Teams to continue to improve data quality through the identification, monitoring and resolving of data quality issues post-migration to the new CRS system.

- Promoting greater confidence in Solent NHS Trust data by our commissioners through the implementation of a Data Quality Improvement Programme for 15/16 and including a data quality RAG rating against all key performance indicators reported to commissioners.

- Developing a "kitemark" procedure using the Audit Commission 6 data quality standards to create a scoring mechanism to measure data quality for each KPI.

Solent NHS Trust procured and implemented a new Clinical Record Systems (CRS) in 2015/16 as would be expected this has had a negative effect on our overall data quality for those services that migrated to the new system. This has created a new challenge for the Data Assurance Team to:

- Identify new data quality issues

- Produce new monitoring tools and documentation for staff

- Explore new ways of engaging with staff to raise awareness of the importance of following standard operating procedures when entering data.

- Address concerns raised by commissioners regarding the quality and reliability of NHS data.

An enhanced Data Assurance programme is being put in place for 16/17 to address these issues. During 16/17 the Data Assurance Team will:

- Instigate a regular internal audit programme for service lines which will include a three year rolling KPI validation programme for national, contractual and internal KPI's. This will include the implementation of the "kitemark" data quality standard for all reports.

- Continue to engage with services to address data issues and provide support and guidance on good practice, maximising the use of online conferencing and social media to communicate messages to staff

- Maintain policies and procedures related to good data governance and raise awareness with staff

- Work closely with the Information Systems Data Warehouse Team to ensure good data management processes are adhered to and agree data cleansing rules, change control procedures and NHS Data Dictionary standards are applied to data held with the data warehouse environment

- Be open and transparent with commissioners and statutory bodies regarding the quality and reliability of NHS data highlighting data issues and mitigating actions as appropriate.

2.7 Information Governance

Solent NHS Trust has completed the Information Governance Toolkit Assessment as a Mental Health Trust for the period April 2015 - March 2016 and is compliant with all 45 requirements, having attained 73 per cent compliance, which has been graded as Green - Satisfactory.

All organisations that have either direct or indirect access to NHS services must complete an annual Information Governance Toolkit Assessment and agree to additional terms and conditions.

What is Information Governance (IG)?

Information Governance is to do with the way organisations 'process' or handle information.

It covers personal information (i.e. that relates to patients/service users and employees) and corporate information (e.g. financial and accounting records). IG provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- the Data Protection Act 1998
- the common law duty of confidentiality
- the Confidentiality NHS Code of Practice
- the NHS Care Record Guarantee for England
- the Social Care Record Guarantee for England
- the international information security standard: ISO/IEC 27002: 2005
- the Information Security NHS Code of Practice
- the Records Management NHS Code of Practice
- the Freedom of Information Act 2000.

What is the IG Toolkit?

The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance set out above and presents them in one place as a set of information governance requirements.

The organisations described below are required to carry out self-assessments of their compliance against the IG requirements.

Solent NHS Trust has completed the Information Governance Toolkit Assessment as a Mental Health Trust and is compliant with all 45 requirements, having attained 73 per cent compliance.

Information Governance Toolkit V10 Summary Report for 2015/16

As of March 31 2016 Solent NHS Trust had achieved a Level 2 or above in all requirement areas, as mandated by the IG Toolkit. A breakdown of the Trust's compliance is provided below:

Level 3 20% 9 Requirements / Level 2 80% 36 Requirements
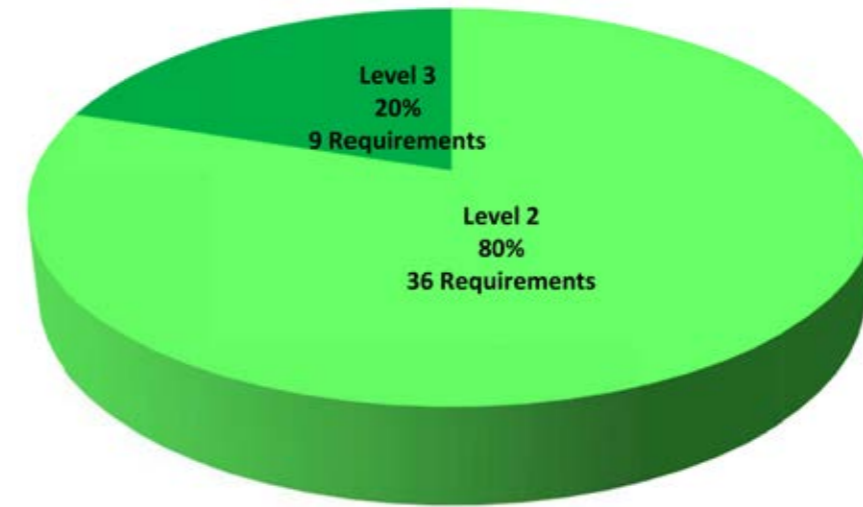
What are the IG requirements?

There are different sets of IG requirements for different organisational types. However all organisations have to assess themselves against requirements for:

- Management structures and responsibilities (e.g. assigning responsibility for carrying out the IG assessment, providing staff training).
- Confidentiality and data protection.
- Information security.

IG Toolkit Category	Compliance Level
Information Governance Management	80%
Confidentiality and Data Protection Assurance	81%
Information Security Assurance	66%
Clinical Information Assurance	80%
Secondary Use Assurance	66%
Corporate Information Assurance	77%
Total	73%

Freedom of Information (FOI) requests 2015/16

The Freedom of Information Act 2000 is part of the Government's commitment to greater openness and accountability in the public sector, creating a climate of transparency, a commitment supported by Solent NHS Trust. The Trust is required under IG Requirement 603 to annually monitor and review compliance with the Freedom of Information Act 2000 and how it meets the standards.

The aim of this review is to assess Trust compliance for 2014/15 in:

• Ensuring all requests relating to Solent NHS Trust were responded to within 20 working days.

• Ensuring adequate policies and procedures are in place.

• Ensuring all staff are aware of the FOI Act 2000 and their responsibilities.

• Ensuring all requests are acknowledged within two working days.

• Ensuring requestors are satisfied with how their request was undertaken and the outcome of the request.

• Ensuring the organisation has an up-to-date and effective Publication Scheme.

Responding to FOIs

In 2015/16 for the period 1 April 2015 – 31 March 2016 Solent NHS Trust received a total of 215 FOI requests. The time frame for responding to FOI requests is 20 working days. As of Friday 8 April 2016, eight requests are currently not due. Solent NHS Trust's current compliance level is 92.3 per cent compliance in 2015/16, with a total of 16 requests breaching.

Subject access requests/access to records requests 2015/16 and responding to Data Protection Act 1998 requests

Solent NHS Trust under Section 7 of the Data Protection Act 1998 is required to monitor compliance with an individual's rights to access their personal information, including requests for deceased patient records (to whom the Data Protection Act does not apply) under the Access to Health Records Act 1990. The Trust should endeavour to respond to all requests within 21 days (but no later than 40 days – inclusive of weekends and bank holidays) from receipt of all information e.g. ID check and fee.

Requests for information can be received by (but not limited to) the following:

• Patients

• Patient representatives e.g. solicitors, advocates, etc

• Parents of children under 18 years

• Relatives of deceased patients

• Police

• Department of Work and Pensions

• Other health care provides

• Mental health tribunals.

In 2015/16 for the period 1 April 2015 – 31 March 2016 Solent NHS Trust received and complied with 871 requests to access information from the categories above. As of April 8 2016 84 requests are currently not due. Solent NHS Trust's current compliance level 84 per cent compliance (to date) with the mandatory timeframe in 2015/16. Solent NHS Trust will continue to provide awareness of this requirement and the importance of time frames throughout the Trust and will review processes and practices to ensure an increased level of compliance.

2.8 Clinical coding

Clinical coding is the translation of written medical terminology into alphanumeric codes. Each code is a set of characters that classify a given entity. Clinical Coders extract the relevant information from a source document and assign 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 incidence of diseases and in acute trusts is used in the development of reference costing for contractual purposes. Solent NHS Trust is responsible for providing accurate, complete, timely coded clinical information to support commissioning, local information requirements and the information required for the Commissioning Data Set (CDS) and central returns.

A Clinical Coding Policy exists which outlines the procedures, practices and data flows that underpin the delivery of high quality coding in line with local and national standard. Solent NHS Trust employs one trained part-time clinical coder for coding inpatient stays in hospital. The coder uses hospital discharge summaries and information recorded in the Trust Clinical Records System to inform the coding of hospitals stays.

Each year the coding process is audited by an external accredited auditor. Solent NHS Trust has achieved a top level three rating for the last two 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.

The Data Assurance Team also maintains a programme of internal audits throughout the year; this includes the sending of a sample of coded records to consultants for validation and approval.

Solent NHS Trust has achieved a top level three rating for the last two years

2.9 Department of Health Mandatory Quality Indicators

We have reviewed the required core set of quality indicators which Trusts are required to report against in their 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).

2.9.1 Preventing People from Dying Prematurely - Seven Day Follow-Up

The data made available with regard to the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care.

NHS Organisation(s)	2014-15	2015-16	National Average	Other Trusts – Highest	Other Trusts – Lowest
Solent NHS Trust	100%	99%	96.9% (Q3 15-16)	100% (Q3 15-16)	50% (Q3 15-16)

2.9.2 Enhancing Quality of Life for People with Long-term Conditions – Gatekeeping

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

NHS Organisation(s)	2014-15	2015-16	National Average	Other Trusts – Highest	Other Trusts – Lowest
Solent NHS Trust	100%	100%	97.4% (Q3 15-16)	100% (Q3 15-16)	61.9% (Q3 15-16)

2.9.3 Ensuring that People have a Positive Experience of Care – Readmissions

The percentage of patients aged (i) 0 to 15 and (ii) 16 or over readmitted to a hospital, which forms part of the trust during the reporting period 2015/16. Solent NHS Trust does not provide inpatient units for children therefore, as there are no admissions, this is not applicable.
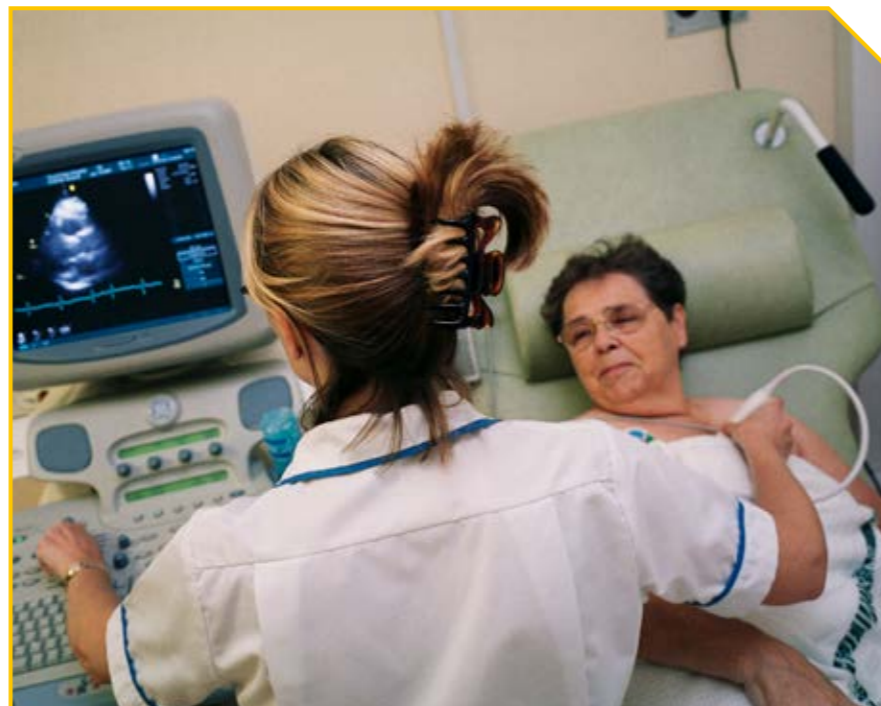
2.9.4 Ensuring that People have a Positive Experience of Care – Community Mental Health Patient Survey

To measure performance against this survey, Solent has used the question "overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?"

In the patient survey report published by the Care Quality Commission, 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. In the chart below the black diamond represents the score for Solent NHS Trust which is 'about the same' as most other trusts in the survey.

A diamond in the red section would indicate a result 'worse' than expected when compared with most other trusts in the survey while a diamond in the green section would indicate a result 'better' than expected when compared.

Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	2014	2015	National Average 2015
Yes, always	78%	74%	73%
Yes, sometimes	18%	19%	20%

Solent NHS Trust considers that this data is as described for the following reasons:

- 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 2014 survey questionnaire was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service. New questions were added and existing questions modified. This means, and is confirmed by the CQC, that the results from the 2014 and 2015 surveys are not comparable with the results from previous surveys.

Solent NHS Trust has implemented an action plan to improve the quality of its mental health services by:

- Care plans to be written in the first person
- Making the service more accessible by opening up to direct referrals from the police and ambulance services
- Talking about our customers in team meetings
- Review the Friends and Family Test (FFT) analysing comments and identifying any issues requiring investigation
- Improve patient involvement
- Provision of a physical health nurse post to provide education and advice to service users and staff in the community teams
- The physical health and well-being team have one additional whole time equivalent (WTE) to address parity of esteem
- All clinic rooms contain physical health monitoring equipment
- Solent Mind is now co-located with the community teams and access to information to increase offers to service users
- Transformation project looking at housing provision placements and local housing available
- Reviewing the pathway for people who use our services to ensure interventions happen in a timely way.

2.10 Duty of Candour

This is contractual duty under the Health and Social Care Act 2014 requiring Trusts to ensure that patients/families are informed of incidents causing moderate, severe harm or death and then provided with support. This includes receiving an apology, as appropriate, the investigation findings and actions to prevent recurrence are shared.

On 27 November 2014, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, brought this into force through Regulation 20 (Ref 3). The Regulation states that (1) "A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity".

The Care Quality Commission (CQC) guidance accompanying the new duty of candour prescribes how the terms "openness", "transparency" and "candour" are to be interpreted,

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Candour is defined in The Francis report (Ref 15) as:

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Duty of Candour requires support of patient safety and quality improvement process through clinical governance frameworks to ensure lessons are learned. Accountability through the Chief Executive to the Trust Board ensures implementation of changes and effectiveness reviews. Findings should be disseminated to staff to facilitate learning. Establish practice-based systems, continuous learning programmes and audits to monitor implementation and effects of change.

Solent NHS Trust encourages all groups of independent contractors to adopt the policy of duty of candour with patients following adverse events, particularly when patients are harmed.

The Trust is committed to fulfil its obligation around 'Duty of Candour' by communicating with patients, their relatives and carers about any failure in care or treatment, whether they be the results via:

- A Patient Safety Incident (PSI)
- A complaint
- A claim

2.0 Solent NHS TRUST Process/Requirements for Being open and Duty of Candour

In collaboration with the Duty of Candour Policy:

- The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate to apply Duty of Candour.

- In determining who will be responsible for communicating with the patient/family/carers the individual should:

  - Have a good understanding of the relevant facts

  - Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to patients, carers and colleagues

  - Be willing and able to offer an apology, reassurance and feedback to patients and/or their carers.

  - Be able to maintain a relationship with the patient and/or their carers and to provide continued support and information:

- The initial Duty of Candour discussion with the patient and/or their carers should occur as soon as possible after recognition of the incident. Non Registered Staff should provide an initial apology that the incident has occurred to the patient and/or their carers and then ensure they handover to a Health Care Professional at the earlier opportunity. It is important to note that saying sorry is not an admission of guilt but is an empathic response.

- All discussions and communication with the patient, their family or carers should be carefully detailed in the patient clinical records.

Additionally, in reviewing the care for that patient, the interaction with the patient, their family or carers should be detailed within the investigation report.

- Following any investigation the outcome must then be communicated with the patient/service user or their family.

Solent NHS TRUST Improved Process Implemented for Duty of Candour

As we strive to continuously improve, we have reviewed our processes and updated them as follows:

- Developed and Implement the new template Duty of Candour Letters x3 - Appendix One

- Developed and Implemented the new Duty of Candour Flow Chart - Appendix Two

- Legal Services Manager is producing a spread sheet tracking system of Duty of Candour Compliance

- A copy of each Duty of Candour letter to be sent to the Legal Services Manager to file.

Solent NHS Trust Staff training

All staff receive an induction from the Trust which includes a quality presentation and this incorporates a discussion on the Duty of Candour which is undertaken by a member of the Quality and Risk Team. The Duty of Candour process is also included during the RCA/Risk management training.

The Trust has developed and launched an e-learning course to ensure all staff are aware of roles and responsibilities and are clear about expectations.

Monitoring Compliance

Monitoring of compliance and effectiveness will be via a confidential planned audit using an appropriately sampled population.

Measurable objectives	Monitoring / audit method	Monitoring responsibility	Reporting arrangements
Duty of Candour compliance completed	Audit of all incidents resulting in moderate harm, severe harm or death	Legal Services Manager	Audit Committee

The Legal Services Manager will monitor the number of Duty of Candour completed and provide a yearly audit compliance report which will be included in future Quality Account.

Part Three: Review of Quality Performance in 2015/16

3.1 Delivery of Quality Account Priorities for Improvement in 2015/16

We have made significant progress against all eight of our 2015/16 Priorities for Improvement. Summaries of our key achievements are detailed in this section. Each achievement reflects the commitment of our staff, service users and carers to continually improving quality.

	Priority	Measures for Success	What we achieved
	This describes the aim of the Priority we set for 2015/16	This details the goals we set to measure how well we delivered against this priority	This is what we delivered
1	Implementation of a Quality Improvement Programme which enables delivery of the Trust Quality Improvement Plan through development of quality improvement skills within Service Lines. Particular focus will be given during 2015/2016 on improving handover and transfer of care working through the Wessex Patient Safety Collaborative	• A reduction against baseline from 2014/2015 in complaints associated with discharge and transfer of care. • A reduction against the end position reported for 2014/2015 overall the number of pressure damage incidents whilst in Solent care. • An increase in the number of joint investigations/reviews undertaken when things go wrong or issues are raised (SIRI/HRI investigations). • An increase in the numbers of patients/service users providing positive feedback about their experience of care as measured against the 2014/2015 baseline. • An increase in staff reported confidence in quality improvement skills and knowledge. The baseline position will be captured during Q1 of 2015/2016 to enable measurement for improvement by end of 2015/2016.	• Teams from both Southampton and Portsmouth participated in the Wessex Patient Safety collaborative Programme focussing on improving handover and transfer of care. • Significant work has been undertaken to improve the management of Pressure Ulcers within the Trust. • The Pressure Ulcer Steering group has been reviewed and the Terms of reference refreshed. • The historical back-log of pressure ulcers has been cleared with. • Processes now enable identification of who the main care provider is, therefore enabling joint investigations and reporting to take place. • Staffing shortages have prevented us from achieving as much progress as desired in relation to staff confidence in improvement skills and knowledge, therefore this priority will be reviewed to continue in part for the new financial year.

| 2 | Development and implementation of agreed acuity and dependency tools for use by the Trust District Nursing Teams and in-patient teams as appropriate to the speciality to support Safe Staffing in line with national requirements. | • An agreed tool for use in District Nursing teams will be available and piloted in all relevant teams across the Trust.
• A mechanism to enable monthly reporting on safe staffing (nursing) within District Nursing teams will be established and teams will report monthly.
• Acuity and dependency in District Nursing teams will be articulated in discussions with Commissioners.
• Nurse staffing related incident reports will reduce.
• Acuity and dependency tools will be used in all in-patient wards and outcomes reported through service line governance arrangements. | • Much work has been undertaken to research what is being used within other NHS organisations, which included reviewing NHS England –Community Nursing Workforce Planning – Scoping Exercise March 2015, which had reviewed 5 organisations who had implemented acuity and dependency tools. This work was being undertaken across both Portsmouth and Southampton Community Nursing teams.
• Benchmarking of how service delivery is undertaken in Portsmouth and Southampton.
• A team of senior community nurses also visited the Isle of Wight to review their acuity and capacity tool.
• In May 2015 - working group formed in response to the need for the "the right staff, with the right skills in the right place" (NHS England 2012). The work of this group continues. |

| 3 | Implementation of the Trust Patient Experience Framework with the aim of improving levels of patient/service user feedback ensuring the 'You Said- We Did' approach is visible in all clinical areas where Solent NHS Trust provides care. | • FFT uptake rates will improve and be sustained in line with the agreed Quality Schedule.
• Formal complaints about poor patient experience of care will reduce when measured against the 2015/2015 baseline.
• Instances of local resolution of concerns will increase and the requirement for second responses to complaints will reduce.
• Plaudits received by services will increase local target will be agreed with service lines. | • The FFT is available across all service areas and feedback is reviewed at trust overall level and service level. The majority of feedback is positive and complimentary but where indicated improvement plans implemented.
• You said we did posters are provided for services for display where appropriate. There are some examples of good practice but this is an area we want to build upon next year. The number of complaints received by the PALs and Complaints Service has seen a reduction over the last year (3.5% down).
• Services are being actively encouraged to resolve complaints locally, and this has meant an increase in the overall figure for the corresponding period (11% up)
• The number of second responses has remained low, however it has not been possible to demonstrate a reduction.
• Unfortunately there has been a reduction in the number of plaudits received (4.5%) however, this may possibly be because other forms have feedback, such as FFT are being actively promoted. |

4	Embedding of the Accessible Information Standards due to be issued in June 2015 through the provision of the infrastructure required to comply with the standards. This work will bring focus to inclusion and shared decision-making.	• An improvement in the number of patients/service users and carers who confirm that our information is in an acceptable format for them. (A feedback questionnaire will be used). • Accessible Information champions in all Service Lines identified. • Complaints relating to poor communication will be reduced.	• Please see section 3.2 for a full review of the years progress • Sharing local evidence and knowledge relating to AI practice • Facilitating inclusive patient feedback on the draft standards, as summarised in a national publication • Contributing to NHS England's national implementation event. • Within the Trust, developments relating to AI have been achieved through the Health Education England (Wessex) funded project, led by Dr Clare Mander. This project aims to develop and pilot a tiered model of AI training. The project milestones are summarised below; • The development of a co-produced/co-designed 'Accessible Information Awareness DVD' with patients living with AI needs (Tier 1). The DVD is currently available on the Trust website see www.solent.nhs.uk/AI. It has been recognised nationally as best practice and is already in use within other Trusts across the UK. • Hosted a regional AI support event in December 2015 aimed at launching the awareness DVD and exploring a joined-up approach to supporting individuals with AI needs across organisations in the local area; in line with the new national standards. • Exploratory work with two services in Solent NHS Trust (one integrated community rehab team and one in-patient unit) to develop a self-directed learning and resource packs relating to embedding AI into practice (Tier 2).

5	Implementation of the Carers Framework so that the Trust can demonstrate compliance with the requirements of the Care Act.	• Positive feedback on carer experience of interaction with the Trust/Trust services will be captured (through FFT mechanisms). • Carers will report feeling appropriately engaged in the development and delivery of care.	• We have worked in partnership with Portsmouth City Council and Portsmouth CCG to develop Portsmouth Carers Strategy 2015-2020 and have identified specific priorities for Solent in relation to identification of carers, awareness training of our staff and signposting carers for support. • We continue to work in partnership with Carers in Southampton on the development of their strategy. • Carers are offered the opportunity to respond to the Friends and Family Test. • We gave the public including carers the opportunity to give feedback on out Patient Experience Strategy which includes priorities for carers.
6	Promotion of National Standards for End of Life Care, ensuring that patients and carers choice is recognised and facilitated to ensure that a positive outcome is achieved as measured by those directly involved.	• No complaints about the carer experience of End of Life care provided by the Trust. • Increased plaudits acknowledging the care provided by the Trust. • Confirmation of achievement against recognised best practice. • Audit of performance against the five priorities of care will evidence progress.	• There has been one complaint about the carer experience of End of Life care provided by the Trust which is an improvement on the previous year. • A group was established to lead this work within the trust. • New end of life care prescription charts have been developed are now available for use in Southampton and Portsmouth. Training can be accessed by staff that need to use these charts. • An audit tool has been developed and has been in use in Quarter 4 (Jan-Feb 2016), the findings of this audit will be reviewed and shared in due course.

7	Enhance governance arrangements from Ward to Board through refreshed Clinical leadership development and the launch of both nursing and AHP strategic frameworks focused on professional standards and practice.	• The Nursing Strategic Framework will be developed and launched. • The Allied Health Professionals (AHP) Strategic Framework will be developed and launched. • All staff will be able to confirm their professional lead and be clear about the reporting arrangements within their Service Line and beyond as appropriate to role. This will be measured through staff reported experience, questionnaires and the staff survey. • Nursing and AHP job descriptions will be reviewed, updated and consistent across the Trust. • Single competency frameworks will be developed for Nurses and AHPs.	• The Nursing Strategic Framework has been written by nurses in the Trust and is ready for launching. • The AHP Framework has been written by AHPs in the Trust and is ready for launching. • Work has taken place within services to clearly identify professional reporting lines. There is still more improvement needed. • Job descriptions have been reviewed and a standard format has been piloted within the Children and Families Service for roles which were being advertised for recruitment. • Work has progressed on the competency frameworks, this work will continue into the new financial year.
8	Deliver an audit programme linked to care improvements, quality standards and NICE guidelines whilst working with Commissioners on the development of outcome focused service specifications aligned to national community indicators.	• Examples of improvements to clinical care as demonstrated via the audit process. • Dashboards for community indicators which highlight the quality and safety of our care in a quantifiable way will be in place. • An audit plan will be in place and compliance against the plan monitored and reported.	• Every service line develops their own audit plan in response to areas of concern, NICE guidelines requiring review, improvement priorities etc. Reports on completion are generated centrally for local teams to review progress against the plan each month at service line audit groups and care group governance groups. Progress is reported to the Trust Assurance Committee quarterly and the Audit and Risk Committee every six months. • Audits are also monitored for areas where learning or good practice can be applied to other areas within the Trust and shared via the Trust Clinical Audit and Service Evaluation Group. Examples of improvements as a result of the clinical audit process can be found on the table on pages 12-14. • Dashboards that include community indicators are operational in some clinical areas. The project has been delayed by the phased implementation of a new Electronic Patient Record – the dashboards will now include quality indicators, clinical outcomes and patient reported outcome measures.

3.2 Spotlight on Accessible Information (AI)

2015 saw the launch of the new NHS England Accessible Information Standard, which Solent NHS Trust contributed to. Our contribution consisted of:

• Sharing local evidence and knowledge relating to AI practice

• Facilitating inclusive patient feedback on the draft standards, a summary of this work was published in the national journal RCSLT Bulletin (Royal College of Speech and Language Therapist Bulletin)

• Contributing to NHS England's national implementation event.

Within the Trust, developments relating to AI have been achieved through the Health Education England (Wessex) funded project, led by Dr Clare Mander. This project aims to develop and pilot a tiered model of AI training. The project milestones are summarised below:

• The development of a co-produced/co-designed 'Accessible Information Awareness DVD' with patients living with AI needs (Tier 1). The DVD is currently available on the Trust website see www.solent.nhs.uk/AI. It has been recognised nationally as best practice and is already in use within other Trusts across the UK.

• We hosted a regional AI support event in December 2015 aimed at launching the awareness DVD and exploring a joined-up approach to supporting individuals with AI needs across organisations in the local area; in line with the new national standards.

• We have undertaken exploratory work with two services in Solent NHS Trust (one integrated community rehab team and one in-patient unit) to develop a self-directed learning and resource packs relating to embedding AI into practice (Tier 2).

Additional developments outside of the AI project;

• Embedding AI as a regular topic on the Patient Experience Forum.

• Exploration of AI reporting requirements on the clinical record system used within the Trust.

• National publication of local developments – two peer-reviewed publications relating to AI research in the field of adult learning disability, a conference presentation relating to medic's revalidation and our inclusive patient feedback approach.

It doesn't stop here! Below are a number of sequential objectives that need to be achieved in order to meet the national standards and to continue to consolidate previous best practice:

• Recruit a Thematic Lead for AI.

• Ensure that all staff have basic AI awareness training – achieved by making the 'Accessible Information Awareness DVD' mandatory training on e-learning.

• Ensure that a new AI template is added to SystmOne with an alert to prompt staff to complete. The template will be informed by an AI screen that is been developed and piloted through the AI Training Project. Once embedded into practice, a six month follow-up audit and AI needs analysis to be completed using data from the templates.

• Complete the Health Education England (Wessex) funded project which will provide an opportunity to train staff to a champion level.

• Set-up an AI forum to include AI champions and patients living with AI needs to act as an advisory group.

• Ensure that all corporate events are inclusive to people with AI needs i.e. AGM and public facing publications.

• Subject to funding – explore the feasibility of setting-up an AI resource centre to be managed by a new 'Accessible Information Officer' (Band Four). This resource centre will provide staff with the necessary equipment and expertise to produce accessible resources in-house.

• Research – again subject to funding, conduct an economic impact assessment to analysis the implementation of AI practice.

• Continue to work in partnership with neighbouring organisations to ensure a patient-centred approach to the implementation of the national standards.

3.3 Quality Performance

During this year we have introduced a new style of quality reporting to enable teams to see this information in a dashboard format. Below is an example of these dash boards.

Service Line Quality Report

+ Detail | + Comments
− Detail | − Comments | Print

Month: Mar-16
Service: TRUST

Trend key: Improving | Static | Declining

| 14-15 Average | 499.0 | Total number of incidents | N/A |
| Month actual | 417 | | |

| 14-15 Average | 248.4 | Total number of patient incidents | G |
| Month actual | 207 | | |

| 14-15 Average | 5.0% | Percentage of patient incidents moderate or above | R |
| Month actual | 13% | | |

| Month target (<=) | 3 | Total number of high harm patient falls | G |
| Month actual | 2 | | |

| Month target (<=) | 13 | Total number Grade 2 PU in Solent Care | G |
| Month actual | 10 | | |

| Month target (<=) | 2 | Total number Grade 3 PU in Solent Care | R |
| Month actual | 6 | | |

| Month target (<=) | 4 | Total number Grade 4 PU in Solent Care | G |
| Month actual | 3 | | |

| 14-15 Average | 14.3 | Total number of information governance breach incidents | A |
| Month actual | 17 | | |

| 14-15 Average | 10.8 | Total number of restraint incidents | G |
| Month actual | 5 | | |

| 14-15 Average | 0.7 | Total number of seclusion episodes | R |
| Month actual | 1 | | |

| 14-15 Average | 27.7 | Total number of formal complaints received | G |
| Month actual | 20 | | |

| 14-15 Average | 9.0 | Total number of service concerns received | R |
| Month actual | 24 | | |

| 14-15 Average | 499.0 | Total number of incidents | | | | | | | | | | | N/A |
| Month actual | 417 | | | | | | | | | | | | |

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2015-16		468	474	496	347	416	387	367	396	384	437	466	417	5055
2014-15		474	505	553	542	461	527	521	463	451	521	470	500	5988

| 14-15 Average | 248.4 | Total number of patient incidents | | | | | | | | | | | G |
| Month actual | 207 | | | | | | | | | | | | |

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2015-16		211	201	189	162	170	171	200	217	215	272	259	207	2474
2014-15		213	230	253	242	199	253	284	256	235	300	268	248	2981

3.4 Performance against Key National Priorities

Monitor Risk Assessment Framework

Of all the Monitor Risk Assessment Framework metrics, 19 were applicable to us. Achievement is monitored monthly and performance reported through to Board. We maintained the Governance Risk Rating of zero throughout the year which is the best score attainable. However, due to the cessation of the Bitterne Minor Injuries Unit in September, Accident and Emergency performance was no longer monitored and four other metrics were not monitored against from October until the end of the year due to the Clinical Records System transition.

Achievement against the key national priorities for the Monitor Access and Outcomes Domains can be seen below:

Access Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Referral to Treatment Admitted	90%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%	100.0%	98.0%	100.0%	100.0%	100.0%
Referral to Treatment Non Admitted	95%	98.6%	99.1%	100.0%	99.8%	99.4%	95.6%	99.4%	98.9%	98.6%	100.0%	99.8%	99.5%
Referral to Treatment Incomplete	92%	99.7%	100.0%	99.4%	99.4%	99.7%	100.0%	99.3%	99.3%	99.5%	100.0%	100.0%	99.9%
A&E All Types Monthly Performance	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					
Serve new psychosis cases by early intervention teams	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%
IAPT - People with common mental health conditions treated within 6 weeks of referral	75%	96.9%	94.6%	95.0%	100.0%	99.0%	95.0%	96.0%	99.0%	96.0%	100.0%	100.0%	100.0%
IAPT - People with common mental health conditions treated within 18 weeks of referral	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%

Outcomes Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Clostridium Difficile Objective	12	0	0	0	0	0	0	1	0	0	0	0	0
Minimising Mental Health Delayed Transfers of Care	7.5%	1.6%	0.8%	0.0%	0.0%	4.7%	6.8%	5.0%	3.3%	2.3%	3.8%	7.0%	1.0%
Mental Health Data Completeness: Identifiers	97%	97.6%	97.6%	97.6%	97.5%	97.5%	97.4%	96.5%	96.9%	96.6%	96.5%	96.3%	96.1%
Mental Health Data Completeness: Outcomes for CPA patients	50%	81.7%	85.4%	87.4%	85.3%	84.2%	83.7%	87.2%	85.3%	85.2%	84.6%	83.8%	82.7%
Learning Disability Access to healthcare Compliance Certification	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Community Services Data Completeness - Referral	50%	95.2%	92.7%	95.2%	95.5%	96.1%	96.3%	99.7%	99.3%	99.3%	99.0%	98.9%	98.8%
Community Services Data Completeness - Treatment Activity	50%	99.8%	99.8%	99.6%	99.8%	99.5%	99.7%	90.8%	95.2%	95.1%	95.2%	95.4%	95.5%

*Mental Health Services changed Clinical Record System in October 2015 this subsequently created Data Quality problems.

TDA Accountability Framework

For 2015/16, the NHS Trust Development Authority (TDA) continued its alignment with the CQC's five domains of quality and safe care provision. Overall achievement is calculated and scored against a rating of one -five with one being the lowest and five being the maximum score available. We achieved an overall score of five in every month of 2015/16, as achieved in 2014/15 also. A summary against each domain can be seen below:

2015/16	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Responsiveness	5	5	5	4	4	4	4	4	4
Effectiveness	5	3	5	5	5	5	5	5	5
Safe	5	5	5	3	4	4	5	4	5
Caring	5	5	5	5	5	5	5	5	5
Well Led	4	4	3	3	3	3	3	3	3
Overall	5	5	5	5	5	5	5	5	5

Despite achieving the best rating overall available, we are committed to improving on the individual areas through 2016/17 through collaborative working with social care to reduce delayed transfers of care and to ensure all staff have had a meaningful appraisal by the end of Quarter one. Unfortunately, for three Mental Health indicators, data was unavailable since October due to the CRS transition. We will continue to monitor against this framework until the NHS Improvement Framework is published during 2016.

Achievement against the key national priorities for the TDA Responsiveness, Effectiveness, Safe, Caring and Well-Led Domains can be seen below:

Responsiveness Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Referral to Treatment Incomplete 52+ Week Waiters	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Diagnostic waiting times	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Delayed Transfers of Care	3.50%	6.29%	3.93%	7.92%	1.23%	6.59%	5.41%	4.49%	3.56%	10.97%	9.97%	9.04%	4.37%
The proportion of those on Care Programme Approach for at least 12 months who have had a CPA review within the last 12 months	95%	97.3%	97.9%	98.8%	98.8%	98.4%	97.7%	92.4%	93.4%	86.2%	82.3%	78.4%	73.8%
The proportion of those on Care Programme Approach (CPA) who have had a HoNOS assessment in the last 12 months	90%	82.4%	91.0%	96.0%	93.3%	92.0%	91.7%	88.8%	84.9%	86.5%	86.7%	83.0%	78.7%

Effectiveness Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust	0	0	0	0	0	0	0	0	0	0	0	0	0
IAPT - Proportion of people who complete treatment who are moving to recovery	50%	51.6%	56.2%	55.0%	53.3%	47.9%	53.1%	53.0%	57.0%	52.0%	53.0%	54.0%	50.0%

We are pleased to have a culture of reporting and learning within Solent NHS Trust, the rise in the number of patient safety incidents that are harmful is an indicator of this good reporting culture. Each of these incidents is appropriately investigated and any lessons learned are shared across the organisation to help to prevent any recurrence.

Caring Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Inpatient Scores from Friends and Family Test	60%			93.0%			94.0%			98.0%			94.0%
A&E Scores from Friends and Family Test	46%			99.0%			99.0%			99.0%			
Mixed Sex Accommodation Breaches	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Well Led Domain

Metric	Target	April	May	June	July	August	September	October	November	December	January	February	March
Inpatients response rate from Friends and Family Test	30%			47.3%			36.7%			40.0%			41.7%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work	40%			51.2%			46.4%						52.0%
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment	58.40%			80.4%			74.8%						79.0%
Trust turnover rate	12%	14.3%	14.4%	14.7%	13.9%	14.2%	14.5%	15.2%	16.0%	15.9%	15.8%	16.1%	16.2%
Trust level total sickness rate	4%	4.2%	4.0%	3.7%	3.9%	3.5%	3.7%	4.2%	4.3%	4.3%	4.6%	4.5%	3.9%
Percentage of staff with annual appraisal	95%	8.6%	23.0%	68.0%	85.4%	88.0%	89.0%	90.5%	93.0%	93.0%	92.4%	92.4%	92.0%

Part Four – Priorities for Quality Improvement in 2016/17

This part of the Quality Account looks forward to 16/17, and the specific priorities that we will be working on throughout the next 12 months in order to deliver continuous quality improvement to for the people who use our services. In deciding these priorities, we have reflected upon:

- Our understanding of the health and social care needs of the local population, as evidenced by health profiles and other statistical analysis, as well as by direct feedback provided to us by service users, families and carers;

- Guidance and directives issued nationally by the Department of Health and NHS England;

- The five questions used by the CQC in their inspections of services:
  - Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well led?

- The requirements of our local commissioners

- Our own vision for our direction of travel

These priorities cover the three domains of quality (experience, effectiveness and safety).

We have also validated that these priorities are achievable in line with our current and future resources, and that they firmly put the focus on quality first and foremost - for this reason, we have aligned our priorities to the five domains of quality referenced throughout this document.

Thus, our priorities for 16/17 are:

Priority No. 1	
Quality Domain	Patient Safety & Effectiveness
Priority for Improvement	**Quality Improvement (QI)** Develop a culture of continuous quality improvement building workforce capacity and capability through a focussed programme of quality improvement skills development.
Aim	To enable and empower staff to identify opportunities for improvement and implement changes. To enable and empower staff to demonstrate improvement via a range of formal measurement techniques.
Actions	1. The Trust will design and provide a QI Programme. 2. Each service line will identify at least quality improvement project 3. Each service line will identify a team to implement the project 4. Each QI project will be registered and measurable improvements identified. 5. All QI teams will report measures of improvement as part of the project. 6. The Trust Board and Senior management team will receive training in QI methodology
Desired Outcomes	1. Completed quality improvement projects with summary reports on improvements achieved (minimum one per service line) 2. At least 50 staff trained in Quality Improvement methodology, to act as champions 3. Evidence of patient engagement in each project

Priority No. 2	
Quality Domain	Effectiveness
Priority for Improvement	**Parity of Esteem** To provide services which ensure that mental health and physical health needs are assessed and given equality of consideration when planning and delivering care.
Aim	For patient/service users to experience services which provide holistic care ensuring that physical and psychological well-being needs are recognised.
Improvement Measures	• Agreed physical health screening tools will be made available through system one. • Agreed mental health screening tools will be made available through system one. • Identified staff will be trained in the use of the screening tools and care planning • A Trust audit schedule will be designed and implemented.
Outcome Measures	Patients known to mental health services will be screened for physical health needs and care planned in line with guidance. Dementia screening will be completed for all eligible patients/service users and care planned in line with findings.

Priority No. 3	
Quality Domain	Service User Experience
Priority for Improvement	The Trust will create the environment in which service users/patient and carer involvement (co-production) is embedded at all levels: from individual care planning to service transformation change. Promote a culture where the value, contribution and rights of carers are recognised and respected by our staff.
Aim	To ensure that the service user/patient/care voice is heard and used to inform service delivery. To support staff to be confident to engage service users/patient/carers in service change. To enable patients to be equal partners in care. To have a mechanism for identifying and signposting carers so that support can be accessed.
Improvement Measures	1. FFT uptake rates will increase 2. A system for recording carers/caring responsibilities will be developed and in place via S1 3. Guidance will be developed and made available to staff which supports engagement and involvement of service users/patients. 4. Accessible Information standards will be implemented across the Trust 5. Patient/service user information will be provided in a variety of accessible formats
Outcomes	• There will be a demonstrable improvement in the numbers of FFT responses submitted • Patient/service users involvement in service change/transformation will be evidenced within all services • Services will be able to evidence changes based on feedback (FFT/Complaints) • There will be evidence of patient/service user/carer involvement in care planning, evaluation and service change. • Complaints regarding communication will reduce.

Priority No. 4	
Quality Domain	Patient Safety and Effectiveness
Priority for Improvement	To provide agreed tools for use within the Trust which enable nurses to manage staffing levels and respond to the changing complexity and levels of the care of patients on their caseload or in their ward.
Aim	To provide safe, effective and responsive care to patients where staff feel supported and report safe staffing levels.
Improvement Measures	• Agreed acuity tools will be available for each identified service: Community nursing, Adult Mental Health (AMH), inpatient children services, rehabilitation in-patient. • Key staffing metrics will be agreed for each service and reported through governance arrangements. Exceptions will be escalated to the Board.
Outcome Measures	Appropriate measures will be developed as part of the implementation of the tool and will be identified by the end of quarter two

Priority No. 5	
Quality Domain	Experience
Priority for Improvement	**Professional Standards** To support staff within the Trust to deliver care and services which demonstrate the Trust's values and enable clinical staff to meet the professional standards set by their regulatory body.
Aim	For the Trust's values to be embedded in all aspects of work. For clinical staff to be able to demonstrate compliance with regulatory standards. For patients/service users/carers to report that staff have acted professionally, demonstrated honesty, valued and respected them and engaged them in all aspects of their care and treatment.
Improvement Measures	**What are the improvement measures?** • The Nursing Strategic Framework will be launched and embedded. • The Allied Health Professionals (AHPs) Strategic Framework will be launched and embedded. • All clinical staff will be able to confirm their professional lead and be clear about the reporting arrangements within their service line and beyond as appropriate to role. This will be measured through staff reported experience, questionnaires and the staff survey. • The review and standardisation of nursing and AHP job descriptions will be completed, updated and consistent across the Trust. • The development of Single competency frameworks will be completed for Nurses and AHPs.

Appendix one: Feedback from Key Stakeholders

Southampton Clinical Commissioning Group

Southampton City Clinical Commissioning Group is pleased to comment on Solent NHS Trust's Quality Account for 2015/16. 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 in identifying areas for improvement.

There is a clear message within the Quality Account that Solent aims to provide patient centred care through continuous quality improvement and the report has highlighted some of the positive improvements made during 2015/16. These include; continued working with social care partners to reduce delayed transfers of care, joint working with Dementia UK to launch Solent Dementia Network and achieving an overall rating of 5 for every month during 2015/16 against Trust Development Accountability Framework.

It is disappointing to see only 3 of the 8 priorities were fully achieved during 2015/16, with a further 5 partially met. Additionally the demonstration of measures of success is not as robust in some areas as would be expected. Of the five that were not fully achieved, the one priority that has been the least developed is "Development and implementation of agreed dependency and acuity tool". Solent has undertaken a lot of background and scoping work to progress this priority but does not have an acuity tool in place to pilot. Many of the priorities listed in the Quality Account will continue to be a focus for Solent during 2016/17 and these have been captured within Solent's Priorities for Quality Improvement in 2016/17.

The Trust is to be congratulated for efforts to reduce incidence of pressure ulcers over 2015/16, and in reducing the backlog of Serious Incidents (SIs). For Information Governance Toolkit compliance, the Trust achieved 73%. However with information security assurance and secondary use assurance both achieving 66%, it would have been helpful to see what the Trust is doing to improve compliance in both these areas.

Commissioners are also expecting Solent to continue to improve the consistent reporting of key performance data, which has affected contracted reporting requirements with Solent's transition to a new clinical IT system.

The feedback from staff for both the Friends and Family Test and the National Staff Survey highlights the continued challenges that Solent has to improve the experience of staff. However the Trust has recognised the need to benchmark their performance against key priority areas of the Equality Delivery System 2.

Overall the Quality Account reflects both the challenges experienced by Solent over the last 12 months and highlights the work undertaken through Solent's ambition to improve the quality of services.

The Quality Account on the whole meets the minimum national requirements, which has been strengthened through the inclusion of patient stories; and Solent has covered the new reporting considerations (NHS England letter dated 3 February 2016) by outlining how they are meeting Duty of Candour.

Solent should be proud of the initiatives undertaken during 2015/16 to engage with patients, carers and staff. Of specific note are the Board to floor visits, the Solent Care Home Research Partnership (SCHRP) work undertaken to engage with care homes and achievements on Accessible Information.

The CCG fully supports the quality priorities for 2016/17; of the five identified priorities, four continue to build on the 2015/16 indicators and one is new. Southampton City CCG would expect to see in the 2016/17 Quality Account a better interpretation of how priorities have been achieved against the measures identified.

Southampton City CCG is satisfied with the Quality Account for 2015/16 and we look forward to continue working closely with the Trust over the coming year to further improve the quality of services for the people of Southampton.

Portsmouth Clinical Commissioning Group

NHS Portsmouth CCG is pleased to support the Trust in its publication of the 2015/16 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 recognises that the Trust has experienced significant challenges during 15/16 particularly in relation to the recruitment and retention of community nursing staff. The CCG has been actively involved in supporting the Trust with continuous monitoring and by making additional funding available to support both senior management and front line capacity. We are pleased that the Trust is now reporting a significant improvement in recruitment and retention.

The Trust has an excellent history of appropriate reporting of Serious Incidents, which is indicative of its open and transparent approach around issues affecting patient safety. However there have been ongoing challenges in terms of the timeliness of reporting and the quality of investigations. We acknowledge the Trust has plans in place to address these issues. The Trust has always demonstrated excellent engagement and working relationships with the CCG in matters and has welcomed challenges posed by the CCG to ensure services are safe for patients.

The introduction of the new Clinical Record System has been a challenge for frontline staff and for data collection but is vitally important to enable joined up care for Portsmouth patients as this system is shared with nearly all our GP Practices.

The CCG applauds the Trust for the significant role it is taking in research activity.

During the last year, Commissioners have undertaken a number of visits to services and had the opportunity to talk to staff and patients. We have been encouraged that these visits have demonstrated a committed workforce who are focussed on providing quality healthcare for patients.

We recognise the progress that has been made against the 2015/16 priorities and encourage the Trust to continue to prioritise these areas so further improvements can be made and maintained.

We are supportive of the Trust's five priorities for quality improvement in 2016/17 but would encourage the Trust to look at setting itself the challenge of some additional improvement measures against these priorities as the year progresses.

Healthwatch Southampton

Healthwatch Southampton welcomes the opportunity to make formal comment on the draft of Solent NHS Trust Quality Account 2015/16.

In Southampton, the Solent NHS Trust provides in-patient care at the Western and Royal South Hants hospitals. Recent PLACE inspections revealed a high standard of cleanliness, and attention to patient dignity. The Trust is to be congratulated on working hard at patient and public engagement. We fully understand the decision to 'step off the Foundation Trust pipeline'.

The Chief Executive's makes it clear that 'every part of the NHS continues to face unprecedented challenges due to rising demand and costs in the face of falling investment.' We welcome the various initiatives to transform the way in which quality care is provided by working with other provider organisations and we hope that this cooperation will continue.

It is unfortunate that again this year the CEO has had to report that the results of the NHS Staff Opinion Survey were disappointing. There is no doubt that the impact of staff experience can affect the delivery of care and overall patient experience and we support her view that the Trust needs to work hard to improve things for their staff.

We strongly support the efforts to gain improved patient feedback not just for the friends and family test but by other means and in all areas where the Trust delivers its services. As we commented last year, we also believe that patients and families would welcome the Trust demonstrating what they have done as a result of the feedback received and so welcome the intention to improve on this.

We applaud the fact that Solent NHS Trust continues to be at the top of the National League tables for research activity in Care Trusts; this is of benefit not just to those immediately affected by the trials but much wider. The Solent Care Home Research Partnership is especially welcomed. The individual stories to demonstrate the benefit of research are interesting and informative.

We are pleased that Solent NHS Trust score for data recording is above the Wessex regional average and the above the national average and it is pleasing that they have been rated at level three

Healthwatch Southampton engaged with Solent NHS trust during the year to explore its compliance with the duty of candour and we were pleased that the Trust is taking this matter very seriously and as far as we can judge they operate an open and transparent policy.

Last year the Southampton Health Overview and Scrutiny Panel recommended that for the 2015/16 Quality Account consideration is given to ensuring that it is easier to identify if the targets linked to the stated priorities have been achieved. Assessing the results from the year under review, given in part 3 of the account, it is still difficult to determine how successful the trust has been in achieving the targets as there is very little quantitative data. Despite this it is clear that the Trust has made significant progress. It is unfortunate that

staff shortage has impacted on the Quality Improvement Programme and we support the intention to carry this forward. The concept of 'You Said- We Did' is supported and we also consider that the intention to resolve issues locally is the correct approach and should lead to a reduction in the number of serious complaints being escalated. The work with carers in Southampton is welcomed. End of life care is a very emotive subject with the public and we are pleased that there has been an improvement in the number of complaints. The new style of quality reporting which will enable teams to see this information in a dashboard format should prove beneficial.

Considering the proposals for the year ahead we support the five priorities as well as those that are being carried forward. We look forward to an effective relationship with the Trust and will do what we can to help the trust achieve its objectives.

Appendix two: Statement of Directors' Responsibilities in Respect of the Quality Account

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.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support 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 2015/16 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 2015 to June 2016

- Papers relating to Quality reported to the board over the period April 2015 to June 2016

- Feedback from commissioners dated 06/06/2016 and 13/06/2016

- Feedback from local Healthwatch organisations dated 22/05/2016

- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 10/05/2016

- The [latest] national patient survey 21/10/2015

- The [latest] national staff survey 23/02/16

- CQC Intelligent Monitoring Report dated 22/02/2016

- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

Chief Executive
30 June 2016

Chairman
30 June 2016

Appendix three: Glossary of Terms

AI - Accessible information

Accessible information (AI) is all about making information easier to understand for people living with communication and information needs. AI is a supportive process that involves the identification of individual's needs, production of information in a way that meets their needs; and, for many, communication support in the delivery of the information.

Clinical Audit

Clinical audit is a process that has been defined as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change

Clinical Pathway

One of the main tools used to manage the quality in healthcare concerning the standardisation of care processes. It has been proven that their use reduces the changes in clinical practice and improves patient outcomes.

Commissioners

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. To a certain extent they replace primary care trusts (PCTs), though some of the staff and responsibilities moved to the local authorities' Public Health teams when PCTs ceased to exist in April 2013).

CRHTT – Community Resolution Home Treatment Team

The Crisis Resolution Home Treatment Team (CRHTT) is a team of mental health professionals working within Solent NHS Trust.

CROS -Consumer Related Outcome Scale

Tool available to support recovery. Questionnaire that asks questions around five themes. Self-assessment rating scale.

CQC- Care Quality Commission

The independent regulator of health and social care in England, aiming to make sure better care is provided for everyone in hospitals, care homes and people's own homes. www.cqc.org.ukCQUIN - Commissioning for Quality and Innovation

Measures which determine whether we achieve quality goals or an element of the quality goal. These achievements are on the basis of which CQUIN payments are made.

Duty of Candour

The Duty of Candour is a statutory duty which requires all health and adult social care providers registered with CQC to be open with people when things go wrong and to inform them about the outcome of investigation into why something went wrong.

Friends and Family Test

The Friends and Family Test (FFT) is a feedback tool that enables people who use our services to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses and opportunity to give free text comments. The FFT provides a mechanism to highlight both good patient experience and identify where improvements are needed based on patient feedback.

Healthwatch

Healthwatch England is the national consumer champion in health and care. Healthwatch have significant statutory powers. Local Healthwatch is based on your local authority area www.healthwatch.co.uk

HRI

High Risk Incident

I.G. Information Governance

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information.

Information Asset Owner

Information Asset Owners (IAO) are senior individuals whose role is to understand what information is held, what is added and what is removed, how information is moved, and who has access and why.

KPI - Key Performance Indicator

A set of quantifiable measures that the Trust adopts to gauge or compare performance in terms of meeting its strategic and operational goals. KPIs vary, depending on the priorities or performance criteria.

LTC - Long term condition

Long term conditions (also called chronic conditions) are health problems that require on-going management over a period of years or decades. They include a wide range of health conditions including diabetes, chronic obstructive pulmonary disease and cardiovascular disease.

Monitor

Independent Regulator of NHS Foundation Trusts - www.monitor-nhsft.gov.uk

NIHR

National Institute for Health Research

Commissions and funds research. www.nihr.ac.uk

PCT - Primary Care

Primary care is the care provided by people you normally see when you first have a health problem. It might be a visit to a doctor or a dentist, an optician for an eye test or a trip to a pharmacist to buy cough mixture. NHS walk-in centres and the NHS Direct telephone service are also part of primary care.

PLACE - Patient Lead Assessment of the Care Environment

An annual assessment of food and cleanliness of inpatient healthcare sites in England that have more than 10 beds.

Pressure Ulcer

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as "bedsores" or "pressure sores". Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

RAG rating

RAG (Red, amber, green) is the name given to a simple colour coding of the status of an action or step in a process.

Safety Thermometer

The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care, including falls and pressure ulcers.

TDA - Trust Development Authority

The NHS Trust Development Authority (TDA) is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers.

SIRI

Serious incident requiring investigation.

Contact Us:

For more information about anything contained in this Quality Account, please contact:

Mandy Rayani
Chief Nurse,
Solent NHS Trust

Solent NHS Trust
Highpoint Venue (Previously Known as Eastpoint)
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Southampton
SO19 8BR

Phone Number
023 8060 8900

Appendix 1:
Full Accounts

Solent NHS Trust - Annual Accounts 2015-16

Statement of Comprehensive Income for year ended

31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	8.1	**(118,911)**	(124,709)
Other operating costs	6	**(71,662)**	(65,455)
Revenue from patient care activities	4	**161,968**	165,152
Other operating revenue	5	**16,886**	22,088
Operating surplus/(deficit)		**(11,719)**	(2,924)
Investment revenue	10	**21**	29
Other gains and (losses)	11	**(94)**	(189)
Finance costs	12	**(133)**	(40)
Surplus/(deficit) for the financial year		**(11,925)**	(3,124)
Public dividend capital dividends payable		**(3,239)**	(3,376)
Retained surplus/(deficit) for the year		**(15,164)**	(6,500)

Other Comprehensive Income	**2015-16 £000s**	**2014-15 £000s**
Impairments and reversals taken to the revaluation reserve	**(17,207)**	(557)
Net gain/(loss) on revaluation of property, plant & equipment	**419**	13,027
Total comprehensive income for the year	**(31,952)**	5,970

Financial performance for the year	**2015-16 £000s**	**2014-15 £000s**
Retained surplus/(deficit) for the year	**(15,164)**	(6,500)
Impairments (excluding IFRIC 12 impairments)	**10,165**	423
Adjustments in respect of donated asset reserve elimination	**(63)**	(197)
Adjusted retained surplus/(deficit)	**(5,062)**	(6,274)

The notes on pages 146 to 167 form part of this account

Statement of Financial Position as at

31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	13	**84,031**	112,124
Intangible assets	14	**2,930**	1,153
Investment property	16	**0**	0
Other financial assets		**0**	0
Trade and other receivables	20.1	**1,760**	1,936
Total non-current assets		**88,721**	115,213
Current assets:			
Inventories	19	**458**	713
Trade and other receivables	20.1	**11,005**	15,474
Other financial assets	22	**0**	0
Other current assets	23	**0**	0
Cash and cash equivalents	24	**5,575**	785
Sub-total current assets		**17,038**	16,972
Non-current assets held for sale	25	**0**	0
Total current assets		**17,038**	16,972
Total assets		**105,759**	132,185
Current liabilities			
Trade and other payables	26	**(17,713)**	(16,178)
Other liabilities	27	**0**	0
Provisions	33	**0**	0
Borrowings	28	**(306)**	(317)
Other financial liabilities	29	**0**	0
Total current liabilities		**(18,019)**	(16,495)
Net current assets/(liabilities)		**(981)**	477
Total assets less current liabilities		**87,740**	115,690
Non-current liabilities			
Trade and other payables	26	**(167)**	(188)
Other liabilities	27	**0**	0
Provisions	33	**0**	0
Borrowings	28	**(839)**	(1,120)
Other financial liabilities	29	**0**	0

DH revenue support loan	28	**(4,304)**	0
Total non-current liabilities		**(5,310)**	(1,308)
Total assets employed:		**82,430**	114,382

FINANCED BY:

Public Dividend Capital		**6,435**	6,435
Retained earnings		**63,438**	77,690
Revaluation reserve		**12,557**	30,257
Other reserves		**0**	0
Total Taxpayers' Equity:		**82,430**	114,382

The notes on pages 146 to 167 form part of this account

The financial statements on pages 142 to 145 were approved by he board on 31 May 2016 and signed on its behalf by

Chief Executive: *SJHann.* Date: 31 May 2016

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	6,435	77,690	30,257	114,382
Changes in taxpayers' equity for 2015-16				
Retained surplus/(deficit) for the year		(15,164)		(15,164)
Net gain / (loss) on revaluation of property, plant, equipment			419	419
Impairments and reversals			(17,207)	(17,207)
Transfers between reserves		912	(912)	0
Net recognised revenue/(expense) for the year	0	(14,252)	(17,700)	(31,952)
Balance at 31 March 2016	6,435	63,438	12,557	82,430
Balance at 1 April 2014	213	83,753	18,224	102,190
Changes in taxpayers' equity for the year ended 31 March 2015				
Retained surplus/(deficit) for the year		(6,500)		(6,500)
Net gain / (loss) on revaluation of property, plant, equipment			13,027	13,027
Impairments and reversals			(557)	(557)
Transfers between reserves		437	(437)	0
Reclassification Adjustments				
New temporary and permanent PDC received - cash	11,222			11,222
New temporary and permanent PDC repaid in year	(5,000)			(5,000)
Net recognised revenue/(expense) for the year	6,222	(6,063)	12,033	12,192

Statement of Cash Flows for the Year ended 31 March 2016

	2015-16	2014-15
	£000s	£000s
Cash Flows from Operating Activities		
Operating surplus/(deficit)	(11,719)	(2,924)
Depreciation and amortisation	4,172	3,569
Impairments and reversals	10,165	423
Interest paid	(133)	(40)
PDC Dividend (paid)/refunded	(3,358)	(3,360)
(Increase)/Decrease in Inventories	255	(460)
(Increase)/Decrease in Trade and Other Receivables	4,645	2,464
Increase/(Decrease) in Trade and Other Payables	2,982	(11,554)
Net Cash Inflow/(Outflow) from Operating Activities	7,009	(11,882)
Cash Flows from Investing Activities		
Interest Received	21	29
(Payments) for Property, Plant and Equipment	(5,050)	(3,685)
(Payments) for Intangible Assets	(2,208)	(7)
Proceeds of disposal of assets held for sale (PPE)	714	0
Net Cash Inflow/(Outflow) from Investing Activities	(6,523)	(3,663)
Net Cash Inform / (outflow) before Financing	486	(15,545)
Cash Flows from Financing Activities		
Gross Temporary (2014/15 only) and Permanent PDC Received	0	11,222
Gross Temporary (2014/15 only) and Permanent PDC Repaid	0	(5,000)
Loans received from DH - New Revenue Support Loans	8,604	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans	(4,300)	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	0	(192)
Net Cash Inflow/(Outflow) from Financing Activities	4,304	6,030
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	4,790	(9,515)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	785	10,300
Cash and Cash Equivalents (and Bank Overdraft) at year end	5,575	785

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations
Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group
Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds
Under the provisions of IAS 27 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements*, restated prior period accounts are presented where the adoption of the new policy has a material impact.

As the corporate trustee of Solent NHS Charity, the Trust has the power to exercise control. However the transactions of the charity are immaterial and have not been consolidated. Details of the transactions with the charity are included in note 37, Related Party Transactions.

1.5 Pooled Budgets
The Trust does not have any Pooled Budget arrangements.

1.6 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies
The Trust has made critical judgements in applying accounting policies. Any critical judgements made are detailed in the relevant accounting policy.

1.6.2 Key sources of estimation uncertainty
Other than the valuation of non current assets the Trust has made no assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period which may cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Non current assets have been revalued using indices relevant to the asset class and the exercise has been carried out by District Valuers who are RICS qualified.

1.7 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient treatment plans that are part-completed at the year end are apportioned across the financial years on the basis of percentage of treatment completed at the end of the reporting period compared to expected total treatment planned.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit.

1.8 Employee Benefits

Short-term employee benefits
Salaries, wages and employment related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred, unless it meets the specific conditions as detailed in note 1.35.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

The Trust has no PFI transactions.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 0.7% in real terms (1.37% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 33.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

The Trust is not part of the Carbon Reduction Commitment Scheme.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss
The Trust has no financial assets at fair value through profit and loss.

Held to maturity investments
The Trust has no maturity investments.

Available for sale financial assets
The Trust has no available for sale financial assets.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment.

1.26 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
The Trust has no financial guarantee contract liabilities.

Financial liabilities at fair value through profit and loss
The Trust has no financial liabilities at fair value through profit and loss.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.29 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 40 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and Special Payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries
Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.33 Associates
The Trust has no associates.

1.34 Joint arrangements
The Trust has no joint arrangements.

1.35 Research and Development
Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNI on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.36 Accounting Standards that have been issued but have not yet been adopted
The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

• IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2010, but not yet adopted by the FReM: early adoption is not therefore permitted
• IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
• IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

In 2014-15 Trust activity was organised into eight service lines. In 2015-16 the Substance Misuse service moved into the Adult Mental Health service line. Details of the seven service line are as follows;

Child & Family Health Services	children's nursing: child and adolescent mental health; health visiting, paediatric medical , paediatric therapies and school nursing
Sexual Health Services	chlamydia screening, HIV outpatient services, sexual health promotion, termination of pregnancies, vasectomy services, sexual assault referral centre
Dental	specialist dental care referrals
Adults Southampton	physiotherapy, community nursing, cardiac nurse service, speech therapy, stoma care, palliative care, learning disabilities.
Primary Care & LTC	health promotion, community diabetes service, podiatry, minor injuries, homeless healthcare, dermatology, phlebotomy service, GP services, MSK services, physiotherapy
Adults Portsmouth	Specialist Palliative Care, Rehab and re-ablement, community nursing, end of life and continuing healthcare inpatient unit, elderly frail inpatient unit, occupational therapy, physiotherapy, speech and language therapy, pulmonary rehab and home oxygen, learning disabilities, care home support, heart failure, admission avoidance and supported discharge services
Adult Mental Health	Inpatient and Community Mental Health and Substance Misuse services for people who require specialist assessment, care and treatment by a dedicated multidisciplinary team

Each service has its own senior management team. The Chief Operating Decision Maker (COMD) of the Trust is the Trust Board which is required to approve the budget and all major operating decisions.

The monthly performance report to the COMD reports the performance of each services operating contribution towards infrastructure and overhead costs against approved budgets. The financial information below is consistent with the monthly reporting.

	2015-16			
	Revenue £000s	Employee Benefits £000s	Other Operating Costs £000s	Operating surplus / (deficit) £000s
Child & Family Health Services	38,908	(27,260)	(2,061)	9,587
Sexual Health Services	28,148	(6,856)	(14,251)	7,041
Dental	8,843	(4,661)	(1,416)	2,766
Adults Southampton	27,060	(18,776)	(2,865)	5,419
Primary Care & LTC	16,677	(11,546)	(1,928)	3,203
Adults Portsmouth	24,637	(17,269)	(1,851)	5,517
Adult Mental Health	23,071	(14,576)	(4,526)	3,969
Discontinued Operations	48		(17)	31
Total Services	**167,392**	**(100,944)**	**(28,915)**	**37,533**
Infrastructure	7,843	(8,716)	(23,675)	(24,548)
Corporate Costs	3,640	(9,251)	(4,758)	(10,369)
Depreciation, amortisation, impairment			(17,780)	(17,780)
Operating surplus/(deficit)	**178,875**	**(118,911)**	**(75,128)**	**(15,164)**

	2014-15			
	Revenue £000s	Employee Benefits £000s	Other Operating Costs £000s	Operating surplus / (deficit) £000s
Child & Family Health Services	38,911	(28,789)	(2,048)	8,074
Sexual Health Services	27,398	(6,906)	(13,361)	7,131
Dental	8,023	(4,706)	(1,454)	1,863
Adults Southampton	26,342	(18,341)	(3,037)	4,964
Primary Care & LTC	18,411	(13,176)	(2,236)	2,999
Adults Portsmouth	24,751	(17,867)	(2,323)	4,561
Adult Mental Health *	24,485	(14,400)	(5,584)	4,501
Discontinued Operations	650	(455)	(50)	145
Total Services	**168,971**	**(104,640)**	**(30,093)**	**34,238**
Infrastructure	7,967	(7,320)	(24,215)	(23,568)
Corporate Costs	10,331	(12,749)	(10,738)	(13,156)
Depreciation, amortisation, impairment			(4,014)	(4,014)
Operating surplus/(deficit)	**187,269**	**(124,709)**	**(69,060)**	**(6,500)**

* Adult Mental Health restated to include Substance Misuse service line.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. None of the activities which generate income had full costs which exceeded £1m.

4. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	28	0
NHS England	26,258	28,040
Clinical Commissioning Groups	106,241	105,532
Foundation Trusts	455	293
Department of Health	0	0
NHS Other (including Public Health England and Prop Co)	33	0
Non-NHS:		
Local Authorities	28,294	30,811
Private patients	392	357
Injury costs recovery	77	0
Other	190	119
Total Revenue from patient care activities	**161,968**	**165,152**

5. Other operating revenue

	2015-16 £000s	2014-15 £000s
Education, training and research	7,335	8,305
Receipt of donations for capital acquisitions	97	197
Non-patient care services to other bodies	2,007	5,197
Income generation	2,075	2,424
Rental revenue from operating leases	1,823	1,696
Other revenue	3,549	4,269
Total Other Operating Revenue	**16,886**	**22,088**
Total operating revenue	**178,854**	**187,240**

6. Operating expenses

				2015-16 £000s	2014-15 £000s
Services from other NHS Trusts				2,809	3,077
Services from CCGs/NHS England				0	25
Services from other NHS bodies				0	1
Services from NHS Foundation Trusts				2,629	2,348
Total Services from NHS bodies*				**5,438**	**5,451**
Purchase of healthcare from non NHS bodies				1,756	2,012
Trust Chair and Non-executive Directors				47	55
Supplies and services - clinical				19,293	18,926
Supplies and services - general				1,948	2,237
Consultancy services				719	2,084
Establishment				4,511	4,405
Transport				642	586
Business rates paid to local authorities				448	740
Premises				19,002	19,440
Legal Fees				375	484
Impairments and Reversals of Receivables				(250)	830
Depreciation				3,741	3,229
Amortisation				431	340
Impairments and reversals of property, plant and equipment				10,165	423
Internal Audit Fees				46	79
Audit fees				73	109
Clinical negligence				357	379
Research and development (excluding staff costs)				1,679	2,598
Education and Training				928	847
Other				313	201
Total Operating expenses (excluding employee benefits)				**71,662**	**65,455**
Employee Benefits					
Employee benefits excluding Board members				117,975	123,617
Board members				936	1,092
Total Employee Benefits				**118,911**	**124,709**
Total Operating Expenses				**190,573**	**190,164**

*Services from NHS bodies does not include expenditure which falls into a category below

7. Operating Leases

The Trust occupies properties using operating lease arrangements with NHS and non NHS organisations.

7.1 Trust as lessee

	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 Total £000s
Payments recognised as an expense				
Minimum lease payments			5,029	7,587
Total			5,029	7,587
Payable:				
No later than one year	4,969	260	5,229	6,142
Between one and five years	10,001	185	10,186	11,143
After five years	8,443	0	8,443	11,673
Total	23,413	445	23,858	28,958

Total future sublease payments expected to be received: £nil

7.2 Trust as lessor

The Trust receives rental income from a number of tenants for rental of properties.

			2015-16 £000	2014-15 £000
Recognised as revenue				
Rental revenue			1,823	1,696
Total			1,823	1,696
Receivable:				
No later than one year			1,211	1,535
Between one and five years			2,298	2,296
After five years			3,431	4,579
Total			6,940	8,410

2014-15 has been restated following a review of rental income leases.

8.0 Employee benefits and staff numbers

8.1 Employee benefits

	2015-16		
	Total £000s	Permanently £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	100,360	94,594	5,766
Social security costs	6,875	6,875	0
Employer Contributions to NHS BSA - Pensions Division	12,090	12,090	0
Termination benefits	558	558	0
Total employee benefits	**119,883**	**114,117**	**5,766**
Employee costs capitalised	972	551	421
Gross Employee Benefits excluding capitalised costs	**118,911**	**113,566**	**5,345**

	Total £000s	Permanently £000s	Other £000s
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	104,459	99,162	5,297
Social security costs	7,214	7,214	0
Employer Contributions to NHS BSA - Pensions Division	12,241	12,241	0
Other pension costs	1	1	0
Termination benefits	1,076	1,076	0
TOTAL - including capitalised costs	124,991	119,694	5,297
Employee costs capitalised	282	94	188
Gross Employee Benefits excluding capitalised costs	**124,709**	**119,600**	**5,109**

8.2 Staff Numbers

	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	149	142	7	162
Administration and estates	730	718	12	761
Healthcare assistants and other support staff	767	756	11	777
Nursing, midwifery and health visiting staff	875	853	22	883
Nursing, midwifery and health visiting learners	0	0	0	30
Scientific, therapeutic and technical staff	564	560	4	613
Social Care Staff	0	0	0	0
Other	1	1	0	0
TOTAL	**3,086**	**3,030**	**56**	**3,226**
Of the above - staff engaged on capital projects	16	14	2	11

8.3 Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	29,397	32,566
Total Staff Years	2,954	3,152
Average working Days Lost	9.95	10.33

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	8	7

	£000s	£000s
Total additional pensions liabilities accrued in the year	644	391

8.4 Exit Packages agreed in 2014-15

Exit package cost band (including any special payment element)	2015-16			2014-15		
	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	5	9	14	13	12	25
£10,000-£25,000	5	6	11	14	6	20
£25,001-£50,000	7	0	7	2	9	11
£50,001-£100,000	1	0	1	1	4	5
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	18	15	33	30	31	61
Total resource cost (£000s)	422	136	558	403	704	1,107

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. 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.

8.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

9. Better Payment Practice Code

9.1 Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	26,399	51,159	28,684	46,274
Total Non-NHS Trade Invoices Paid Within Target	24,109	46,770	23,961	37,341
Percentage of NHS Trade Invoices Paid Within Target	91%	91%	84%	81%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,395	18,376	1,560	38,627
Total NHS Trade Invoices Paid Within Target	1,196	14,778	1,224	28,820
Percentage of NHS Trade Invoices Paid Within Target	86%	80%	78%	75%

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

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust had no claims made under this legislation and paid no compensation.

10. Investment Revenue

	2015-16 £000s	2014-15 £000s
Bank interest	21	29
Total investment revenue	21	29

11. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	(126)	(189)
Gain (Loss) on disposal of assets held for sale	32	0
Total	(94)	(189)

12. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	81	0
Interest on obligations under finance leases	52	40
Total interest expense	133	40
Total	133	40

13.1 Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2015	25,855	79,822	3,243	3,236	70	3,723	435	116,384
Additions of Assets Under Construction			5,524					5,524
Additions Purchased	0	0	0	0	0	0	0	0
Additions - Purchases from Cash Donations & Government Grants	0	0	35	62	0	0	0	97
Reclassifications	0	3,244	(7,467)	27	0	1,988	0	(2,208)
Reclassifications as Held for Sale and reversals	(240)	(460)	0	0	0	0	0	(700)
Disposals other than for sale	0	(134)	0	0	0	(348)	0	(482)
Upward revaluation/positive indexation	50	369	0	0	0	0	0	419
Impairments/negative indexation	(13,165)	(14,207)	0	0	0	0	0	(27,372)
At 31 March 2016	12,500	68,634	1,335	3,325	70	5,363	435	91,662
Depreciation								
At 1 April 2015	0	399	0	2,102	22	1,344	393	4,260
Reclassifications as Held for Sale and reversals	0	(15)	0	0	0	0	0	(15)
Disposals other than for sale	0	(37)	0	(14)	0	(304)	0	(355)
Charged During the Year	0	2,512	0	269	11	929	20	3,741
At 31 March 2016	0	2,859	0	2,357	33	1,969	413	7,631
Net Book Value at 31 March 2016	12,500	65,775	1,335	968	37	3,394	22	84,031
Asset financing:								
Owned - Purchased	12,500	65,734	1,335	819	37	1,974	22	82,421
Owned - Donated	0	41	0	149	0	0	0	190
Held on finance lease	0	0	0	0	0	1,420	0	1,420
Total at 31 March 2016	12,500	65,775	1,335	968	37	3,394	22	84,031

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	5,447	24,810	0	0	0	0	0	30,257
Movements (specify)	(5,111)	(12,589)	0	0	0	0	0	(17,700)
At 31 March 2016	336	12,221	0	0	0	0	0	12,557

Additions to Assets Under Construction in 2015-16

	£000's
Land	0
Buildings excl Dwellings	1,950
Plant & Machinery	2,028
IT - in-house & 3rd party software	1,546
Balance as at YTD	5,524

13.2 Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2014	24,168	72,088	131	2,897	97	2,753	435	102,569
Additions of Assets Under Construction	0	0	5,068	0	0	0	0	5,068
Additions Purchased	0	0	0	162	0	0	0	162
Additions - Purchases from Cash Donations & Government Grants	0	0	0	16	0	0	0	16
Additions Leased	0	0	0	0	0	810	0	810
Reclassifications	0	1,348	(1,956)	195	0	189	0	(224)
Disposals other than for sale	0	(36)	0	(34)	(27)	(29)	0	(126)
Upward revaluation/positive indexation	1,982	6,684	0	0	0	0	0	8,666
Impairments/negative indexation	(295)	(262)	0	0	0	0	0	(557)
At 31 March 2015	25,855	79,822	3,243	3,236	70	3,723	435	116,384
Depreciation								
At 1 April 2014	0	2,077	0	1,807	13	700	381	4,978
Disposals other than for sale	0	0	0	(9)	0	0	0	(9)
Upward revaluation/positive indexation	(70)	(4,291)	0	0	0	0	0	(4,361)
Impairments	70	353	0	0	0	0	0	423
Charged During the Year	0	2,260	0	304	9	644	12	3,229
At 31 March 2015	0	399	0	2,102	22	1,344	393	4,260
Net Book Value at 31 March 2015	25,855	79,423	3,243	1,134	48	2,379	42	112,124
Asset financing:								
Owned - Purchased	25,855	79,374	3,243	1,024	48	960	42	110,546
Owned - Donated	0	49	0	110	0	0	0	159
Held on finance lease	0	0	0	0	0	1,419	0	1,419
Total at 31 March 2015	25,855	79,423	3,243	1,134	48	2,379	42	112,124

13.3 Property, plant and equipment

The Trust received donated assets from Solent NHS Charity, Southampton Clinical Commissioning Group, SCA and League of Friends in the year.

Land and buildings are held at revalued amounts. These assets were revalued as at 31 March 2016 using optimisation methodology (delivery of services from modern facilities) and indices relevant to the asset class. The exercise was carried out by District Valuers who are RICS qualified. The impact of the revaluation is:

	Land £000's	Buildings £000's	Total £000's
Increase to revaluation reserve	50	369	419
Decrease to revaluation reserve	(5,036)	(12,171)	(17,207)
Impairment charged to SOCNI	(8,129)	(2,036)	(10,165)
	(13,115)	(13,838)	(26,953)

The economic lives of the property, plant and equipment range from:

	Min Life (yrs)	Max Life (yrs)
Buildings excluding dwellings	1	92
Plant & machinery	1	25
Transport equipment	4	10
Information technology	1	7
Furniture & fittings	1	10

14.1 Intangible non-current assets

2015-16	IT - in-house & 3rd party software £000's	Total £000's
At 1 April 2015	1,784	1,784
Additions Purchased	0	0
Reclassifications	2,208	2,208
At 31 March 2016	3,992	3,992
Amortisation		
At 1 April 2015	631	631
Charged during the year	431	431
At 31 March 2016	1,062	1,062
Net Book Value at 31 March 2016	2,930	2,930
Asset Financing: Net book value at 31 March 2016 comprises:		
Purchased	2,930	2,930
Total at 31 March 2016	2,930	2,930

Revaluation reserve balance for intangible non-current assets

The Trust does not hold any revaluation reserves for intangible non-current assets. No revaluation of intangible assets was carried out in the period.

14.2 Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software £000's	Total £000's
At 1 April 2014	1,635	1,635
Additions Purchased	7	7
Reclassifications	224	224
Disposals other than by sale	(82)	(82)
At 31 March 2015	1,784	1,784
Amortisation		
At 1 April 2014	303	303
Disposals other than by sale	(12)	(12)
Charged during the year	340	340
At 31 March 2015	631	631
Net Book Value at 31 March 2015	1,153	1,153
Asset Financing: Net book value at 31 March 2015 comprises:		
Purchased	1,153	1,153
Total at 31 March 2015	1,153	1,153

14.3 Intangible non-current assets

The Trust received no donated intangible assets in the year.

The economic lives of the intangible assets range from:

	Min Life (yrs)	Max Life (yrs)
IT - in-house & 3rd party software	2	7

15. Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment £000s	Total £000s
Other	10,165	10,165
Total charged to Annually Managed Expenditure	10,165	10,165
Total Impairments of Property, Plant and Equipment changed to SoCI	10,165	10,165

No impairment losses on Donated and Government Granted Assets is included above.

16. Investment property
The Trust has no investment property.

17. Commitments

17.1 Capital commitments
Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016 £000s	31 March 2015 £000s
Property, plant and equipment	1,205	1,955
Intangible assets	51	145
Total	1,256	2,100

17.2 Other financial commitments
The Trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for ICT services. The payments to which the Trust is committed are as follows:

	31 March 2016 £000s	31 March 2015 £000s
Not later than one year	8,158	8,246
Later than one year and not later than five year	1,093	10,338
Later than five years	0	0
Total	9,251	18,584

18. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	347	0	3,497	0
Balances with Local Authorities	3,811	0	0	0
Balances with NHS bodies inside the Departmental Group	6,636	0	4,524	4,304
Balances with Bodies External to Government	211	1,760	9,998	1,006
At 31 March 2016	11,005	1,760	18,019	5,310
prior period:				
Balances with Other Central Government Bodies	1,207	0	2,045	0
Balances with Local Authorities	3,459	0	978	0
Balances with NHS Trusts and FTs	9,951	0	4,265	0
Balances with Bodies External to Government	857	1,936	9,207	1,308
At 31 March 2015	15,474	1,936	16,495	1,308

19. Inventories

	Drugs £000s	Consumables £000s	Total £000s
Balance at 1 April 2015	397	316	713
Additions	9,901	2,788	12,689
Inventories recognised as an expense in the period	(10,050)	(2,894)	(12,944)
Balance at 31 March 2016	248	210	458

20.1 Trade and other receivables

	Current 31 March 2016 £000s	Current 31 March 2015 £000s	Non-current 31 March 2016 £000s	Non-current 31 March 2015 £000s
NHS receivables - revenue	4,850	7,272	0	0
NHS prepayments and accrued income	1,685	2,679	0	0
Non-NHS receivables - revenue	3,726	4,807	0	0
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	1,482	989	1,760	1,936
PDC Dividend prepaid to DH	103	0		
Provision for the impairment of receivables	(1,471)	(1,721)	0	0
VAT	347	1,207	0	0
Other receivables	283	241	0	0
Total	11,005	15,474	1,760	1,936
Total current and non current	12,765	17,410		

Included in NHS receivables are prepaid pension contributions: | 0 |

The great majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As Clinical Commissioning Groups and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other trade receivables are reviewed on a regular basis with the person responsible. Provisions are established if debtors exceed the following time intervals past their agreed terms - after 90 days 100%. Any overdue debts are actively pursued by specialised teams.

20.2 Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	5,038	4,091
By three to six months	633	1,607
By more than six months	564	1,002
Total	6,235	6,700

20.3 Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2014	(1,721)	(891)
Amount recovered during the year	1,209	510
(Increase)/decrease in receivables impaired	(959)	(1,340)
Balance at 31 March 2015	(1,471)	(1,721)

No collateral is held against these debts.

21. NHS LIFT investments
The Trust has no NHS LIFT investments.

22. Other Financial Assets
The Trust has no other financial assets.

23. Other current assets
The Trust has no other current assets.

24. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	785	10,300
Net change in year	4,790	(9,515)
Closing balance	5,575	785
Made up of		
Cash with Government Banking Service	5,551	752
Commercial banks	0	12
Cash in hand	24	21
Cash and cash equivalents as in statement of financial position	5,575	785
Cash and cash equivalents as in statement of cash flows	5,575	785
Patients' money held by the Trust, not included above	5	5

25. Non-current assets held for sale
The Trust has no non-current assets held for sale.

26. Trade and other payables

	Current 31 March 2016 £000s	Current 31 March 2015 £000s	Non-current 31 March 2016 £000s	Non-current 31 March 2015 £000s
NHS payables - revenue	310	807	0	0
NHS payables - capital	106	0	0	0
NHS accruals and deferred income	4,108	3,442	0	0
Non-NHS payables - revenue	1,785	1,373	0	0
Non NHS payables - capital	264	1,838	0	0
Non-NHS accruals and deferred income	7,397	6,608	167	188
Social security costs	992	1,053	0	0
PDC Dividend payable to DH	0	16	0	0
Accrued Interest on DH Loans	3	0	0	0
VAT	0	0	0	0
Tax	904	992	0	0
Other	1,844	49	0	0
Total	17,713	16,178	167	188
Total payables (current and non-current)	17,880	16,366		

Included above:

to Buy Out the Liability for Early Retirements Over 5 Years	0	0
number of Cases Involved (number)	0	0
outstanding Pension Contributions at the year end	1,601	6

27. Other liabilities
The Trust has no other liabilities.

28. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Loans from Department of Health	0	0	4,304	0
Finance lease liabilities	306	317	839	1,120
Total	306	317	5,143	1,120
Total borrowings (current and non-current)	5,449	1,437		

The loan from Department of Health is a Revenue Support Loan, repayment is due February 2018 and attracts interest at 1.5%.

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016	
	Other £000s	Total £000s
0-1 Years	306	306
1 - 2 Years	5,143	5,143
TOTAL	5,449	5,449

29. Other financial liabilities
The Trust has no other financial liabilities.

30. Deferred revenue

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	1,440	1,861	187	208
Deferred revenue addition	1,433	1,461	0	0
Transfer of deferred revenue	(2,255)	(1,882)	(21)	(21)
Current deferred income at 31 March 2016	618	1,440	166	187
Total deferred income (current and non current)	784	1,627		

31. Finance lease obligations as lessee
Amounts payable under finance leases (Other)

	Minimum lease payments		Present value of minimum	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Within one year	345	345	306	317
Between one and five years	881	1,176	839	1,069
After five years	0	50	0	51
Less future finance charges	(81)	(134)		
Minimum Lease Payments / Present value of minimum lease payments	1,145	1,437	1,145	1,437
Included in:				
Current borrowings			306	317
Non-current borrowings			839	1,120
			1,145	1,437

32. Finance lease receivables as lessor
The Trust has no finance lease receivables as lessor.

33. Provisions
The Trust has no provisions

£2,034,981 is included in the provisions of the NHS Litigation Authority at 31 March 2016 (£916,265 at 31 March 2015) in respect of clinical negligence liabilities of the Trust.

34. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authorty legal claims	16	9
Net value of contingent liabilities	16	9
Contingent assets		

The Trust has no contingent assets.

35. Financial Instruments

35.1 Financial risk management
Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and NHS England and the way those Clinical Commissioning Groups and NHS England are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Agency. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

35.2 Financial Assets

	Loans and receivables £000s	Total £000s
Receivables - NHS	6,137	6,137
Receivables - non-NHS	3,711	3,711
Cash at bank and in hand	5,575	5,575
Total at 31 March 2016	15,423	15,423
Receivables - NHS	9,951	9,951
Receivables - non-NHS	5,016	5,016
Cash at bank and in hand	785	785
Total at 31 March 2015	15,752	15,752

35.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	4,307	4,307
Non-NHS payables	10,894	10,894
Other borrowings	4,304	4,304
Total at 31 March 2016	19,505	19,505
NHS payables	3,891	3,891
Non-NHS payables	8,801	8,801
Total at 31 March 2015	12,692	12,692

36. Events after the end of the reporting period
There have been no events after the end of the reporting period.

37. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
NHS England	30	27,010	750	1,915
Clinical Commissioning Groups				
NHS Southampton	15	32,237	0	648
NHS Portsmouth	0	52,173	0	710
NHS West Hampshire	0	7,818	56	297
NHS South Eastern Hampshire	0	5,592	0	105
NHS Fareham & Gosport	0	5,180	0	55
NHS North East Hampshire & Farnham	0	1,407	53	120
NHS North Hampshire	29	2,018	0	27
NHS Trust and Foundation Trust				
Hampshire Hospitals Foundation Trust	1,280	17	34	1
Portsmouth Hospitals NHS Trust	3,419	1,401	284	331
University of Southampton NHS Foundation Trust	2,163	1,571	645	529
Southern Health NHS Foundation Trust	1,418	2,014	442	591
NHS Business Services Authority	1,589	0	239	0
NHS Litigation Authority	358	0	0	0
NHS Property Services Ltd	5,315	876	737	411
Community Health Partnerships	2,295	0	1,005	0
Solent NHS Charity	2	51	0	1

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HM Revenue and Customs, NHS Pensions Agency, Portsmouth City Council, Southampton City Council and Hampshire County Council.

The Trust has also received revenue from Solent NHS Charity of which the NHS Trust Board is the Corporate Trustee.

38. Losses and special payments

There were 3 cases of losses and special payments totalling £4,301 accrued during 2015-16 (10 cases totalling £39,000 during 2014-15).

39. Financial performance targets

The Trust has a duty to achieve breakeven or a surplus in each accounting period.

39.1 Breakeven performance

	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	193,935	192,146	187,756	187,240	178,854
Retained surplus/(deficit) for the year	1,863	776	1,858	(6,500)	(15,164)
Adjustment for					
Adjustments for impairments	0	0	0	423	10,165
Adjustments for impact of policy change re donated/government grants assets	0	0	0	(197)	(63)
Break-even in-year position	1,863	776	1,858	(6,274)	(5,062)
Break-even cumulative position	1,863	2,639	4,497	(1,777)	(6,839)

	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%)					
Break-even in-year position as a percentage of turnover	0.96	0.40	0.99	-3.35	-2.83
Break-even cumulative position as a percentage of turnover	0.96	1.37	2.40	-0.95	-3.82

39.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

39.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	3,897	16,884
Cash flow financing	(486)	15,545
Unwinding of Discount Adjustment		
Finance leases taken out in the year	0	810
External financing requirement	(486)	16,355
Under/(over) spend against EFL	4,383	529

39.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	5,623	6,054
Less: book value of assets disposed of	(811)	(63)
Less: donations towards the acquisition of non-current assets	(100)	(17)
Charge against the capital resource limit	4,712	5,974
Capital resource limit	4,740	6,793
(Over)/underspend against the capital resource limit	28	819

40. Third party assets

The Trust held £5,359 cash and cash equivalents at 31 March 2016 (£4,970 at 31 March 2015) which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

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