Agenda
Solent NHS Trust Extra Ordinary In Public Board Meeting

Friday 24th May 2019 1pm – 1:30pm

Kestrel 1&2, 2nd Floor, Highpoint Venue, Southampton, Hampshire, SO19 8BR.

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Well Led Domains
1	1pm	----	**Chairman's Welcome and apologies to receive**	Chair	-
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
2		30mins	**Audit Results Report** *To receive (as presented to and recommended by the Audit & Risk Committee, 24th May) - to follow*	Director of Finance and Performance	W6-W8
			Letter of Representation *To approve (as presented to and recommended by the Audit & Risk Committee, 24th May) - to follow*		W6-W8
			Audit Opinion *To receive (as presented to and recommended by the Audit & Risk Committee, 24th May) - to follow*		W6-W8
3			**Annual Accounts** *To approve (as presented to and recommended by the Audit & Risk Committee, 24th May)*	Director of Finance and Performance	W5, W6
4			**Annual Report – including the Annual Governance Statement** *To approve (as presented to and recommended by the Audit & Risk Committee, 24th May)*	AD Corporate Affairs and Co. Sec	W1-W7
5			**Quality Account** *To approve (as presented to and recommended by the Audit & Risk Committee, 24th May)*	Chief Nurse	W5-W8
6			**Governance Update – including:** • **Declarations of Interest** • **Board Self – Certification NHSI Provider Licence Compliance – annual declaration** *To approve*	AD Corporate Affairs and Co. Sec	W1 W4, W5, W6
7	1:30pm	-----	**Close** **Date of next In Public meeting:** • **3rd June 2019 Mary Rose Room, Haven Community Centre, The Salvation Army, Lake Road, Portsmouth, PO1 4HA**		

Suresh Patel
Ernst & Young
Wessex House
19 Threefield Lane
Southampton
SO14 3QB

Solent NHS Trust Headquarters
Highpoint Venue
Bursledon Road
Southampton
Hampshire
SO19 8BR

Tel: 0300 123 3390
www.solent.nhs.uk

Dear Suresh,

24th May 2019

Letter of Representation

This letter of representations is provided in connection with your audit of the financial statements of Solent NHS Trust ("the Trust") for the year ended 31 March 2019. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to form an opinion as to whether the financial statements give a true and fair view of the financial position of the Trust as of 31 March 2019 and of its financial performance and its cash flows for the year then ended in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM)**.**

We understand that the purpose of your audit of our financial statements is to express an opinion thereon and that your audit was conducted in accordance with International Standards on Auditing (UK and Ireland), which involves an examination of the accounting system, internal control and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose - all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves.

A. Financial Statements and Financial Records

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 18 December 2018, for the preparation of the financial statements in accordance with the Secretary of State Directions and the DHSC GAM.

2. We acknowledge, as members of management of the Trust, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Trust in accordance with the Secretary of State Directions and the DHSC GAM, and are free of material misstatements, including omissions. We have approved the financial statements.

3. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

4. As members of management of the Trust, we believe that the Trust has a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with the Secretary of State Directions and the DHSC GAM that are free from material misstatement, whether due to fraud or error.

5. We believe that the effects of any unadjusted audit differences, summarised in appendix A, accumulated by you during the current audit and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

6. We have not corrected these differences identified by and brought to your attention by EY because although the Group Accounting Manual states that the provision for bad debts should not be made for organisations within the Department of Health accounting boundaries, i.e. NHS organisations, the Trust has taken a prudent approach. It is aware of outstanding debt with NHS organisations that is unlikely to result in future cash flows and as a result has fully provided for this debt.

B. Non-compliance with law and regulations, including fraud

1. We acknowledge that we are responsible for determining that the Trust's activities are conducted in accordance with laws and regulations and that we are responsible for identifying and addressing any non-compliance with applicable laws and regulations, including fraud.

2. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Trust's (regardless of the source or form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters involving financial statements, related to laws and regulations that have a direct effect on the determination of material amounts and disclosures in the Trust's financial statements, related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Trust's activities, its ability to continue to operate, or to avoid material penalties, involving management, or employees who have significant roles in internal controls, or others or in relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others or in relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

- Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- Additional information that you have requested from us for the purpose of the audit; and
- Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

3. We have made available to you all minutes of the meetings of the Trust Board, and committees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the year to the most recent meeting on the following date: 4th February 2019 (Trust Board meeting).

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Trust's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We believe that the significant assumptions we used in making accounting estimates, including those measured at fair value, are reasonable.

6. We have disclosed to you, and the Trust has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

D. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have disclosed in the financial statements all guarantees that we have given to third parties.

E. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

F. Agreement of Balances and key judgments

1. We have disclosed to you details of all transactions and judgments we have made on income and expenditure, payable and receivable balances with counter-parties irrespective of whether or not they have been included in the 2018/19 Agreement of Balances Exercise.

2. We have agreed balances, disputes and claims with all NHS bodies via the Agreement of Balances process and where not agreed, we have reported the matter to you.

3. We have disclosed to you all of the risks and judgments we have made in arriving at the Trust's reported financial outturn for financial year ended 31 March 2019.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises financial and non-financial information (other than the financial statements and the auditor's report thereon) included in the Trust's annual report.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Segmental reporting

1. We have reviewed the operating segments reported internally to the Board and we are satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8:Operating Segments, they are similar in each of the following respects:

- The nature of the products and services
- The nature of the production processes
- The type or class of customer for their products and services
- The methods used to distribute their products

I. Use of the Work of a Specialist

1. We agree with the findings of the specialists that we engaged to evaluate the valuation of Property, Plant and Equipment and have adequately considered the qualifications of the specialists in determining the amounts and disclosures included in the financial statements and the underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an effect on the independence or objectivity of the specialists.

J. Accounting Estimates

1. We believe that the measurement processes, including related assumptions and models, used to determine the accounting estimates have been consistently applied and are appropriate in the context of DHSC GAM.

2. We confirm that the significant assumptions used in making the accounting estimates appropriately reflect our intent and ability to carry out specific courses of action on behalf of the entity.

3. We confirm that the disclosures made in the financial statements with respect to the accounting estimates are complete and made in accordance with DHSC GAM.

4. We confirm that no adjustments are required to the accounting estimates and disclosures in the financial statements due to subsequent events.

Yours sincerely,

_____ _____

Andrew Strevens

Director of Finance and Performance

Jon Pittam

Chair of the Audit and Risk Committee

Appendix A

-	Assets Current	Assets Non-current	Liabilities Current	Liabilities Non- current	CIES
Uncorrected misstatements	Debit/ (Credit)	Debit/ (Credit)	Debit/ (Credit)	Debit/ (Credit)	Debit/ (Credit) Current period
Known differences:					
► **NHS debt provided for against DHSC GAM guidance**	685,948				(685,948)
Total	685,948				(685,948)

Independent auditors report to the Accountable Officer of Solent NHS Trust

(As taken from the Audit Results Report from EY presented to the Audit & Risk Committee, 24th May 2019, complete with cross referenced pg number as highlighted blue. Matters awaiting confirmation/finalisation highlighted yellow.)

Opinion

We have audited the financial statements of Solent NHS Trust for the year ended 31 March 2019 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 43. 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 2018/19 HM Treasury's Financial Reporting Manual (the 2018/19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 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).

In our opinion the financial statements:

- give a true and fair view of the financial position of Solent NHS Trust as at 31 March 2019 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.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below.

We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion

thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; 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; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in these respects.

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

- Referral to the Secretary of State [SUBJECT TO COMPLETION]

We refer a matter to the Secretary of State under section 30(1)(b) 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.

At 31 March 2019 Solent NHS Trust has achieved an in-year surplus of £1.25 million per the 2018/19 draft accounts against its incoming resources for the financial year. However, it has a cumulative deficit of £6.936 million which has resulted in a failure to meet the break-even duty over a rolling 3 year period. The Trust has now incurred a deficit of £2.084 million in 2016/17 and a surplus of £757,000 in 2017/18. Based on the 2018/19 draft accounts the Trust's cumulative deficit position is £97,000 over the rolling 3 year period. However, the Trust has bettered its agreed control total each year over the same period.

On XX May 2019 we made a referral to the Secretary of State under Section 30(1)(b) to confirm that the Trust is still in breach of its breakeven duty.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 76, the Directors are responsible for the preparation of the financial statements and for

being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

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.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs
(UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.
A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's 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 2017, 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 2019.

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.

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.

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.

Use of our report

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 for no other purpose. 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.

Suresh Patel
Ernst & Young LLP (Local Auditor), Southampton
2X May 2019

Solent NHS Trust

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income for year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	4	171,897	167,059
Other operating income	5	21,222	20,160
Operating expenses	7	(189,949)	(179,726)
Operating surplus from continuing operations		**3,170**	**7,493**
Finance income	10	94	24
Finance expenses	11	(152)	(151)
PDC dividends payable		(2,240)	(2,305)
Net finance costs		**(2,298)**	**(2,432)**
Other (losses)	12	(1)	(4)
Surplus for the year		**871**	**5,057**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	14.3	(191)	(630)
Revaluations	14.3	419	351
Total comprehensive income for the period		**1,099**	**4,778**
Adjusted financial performance (control total basis):			
Surplus for the period		871	5,057
Impairments (excluding IFRIC 12 impairments)		753	(4,310)
Remove I&E impact of capital grants and donations		(254)	(10)
Adjusted financial performance surplus		**1,370**	**737**

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	2,102	2,422
Property, plant and equipment	14	86,869	81,276
Receivables	20	1,837	2,653
Total non-current assets		**90,808**	**86,351**
Current assets			
Inventories	19	346	394
Receivables	20	15,670	13,533
Non-current assets held for sale / assets in disposal groups	25	0	1,100
Cash and cash equivalents	24	15,665	9,601
Total current assets		**31,681**	**24,628**
Current liabilities			
Trade and other payables	26	(25,770)	(20,338)
Borrowings	28	(7,985)	(4,792)
Other liabilities	27	(918)	(1,320)
Total current liabilities		**(34,673)**	**(26,450)**
Total assets less current liabilities		**87,816**	**84,529**
Non-current liabilities			
Trade and other payables	26	0	0
Borrowings	28	(1,410)	(5,098)
Other liabilities	27	(104)	(125)
Total non-current liabilities		**(1,514)**	**(5,223)**
Total assets employed		**86,302**	**79,306**
Financed by			
Public dividend capital		12,337	6,435
Revaluation reserve		7,622	7,625
Income and expenditure reserve		66,343	65,246
Total taxpayers' equity		**86,302**	**79,306**

The notes on pages 5 to 25 form part of these accounts.

The financial statements on pages 1 to 4 were approved by the Board on 24 May 2019 and signed on it's behalf by:

Chief Executive: Date:

Statement of Changes in Equity for the year ending 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**6,435**	**7,625**	**65,246**	**79,306**
Impact of implementing IFRS 9 on 1 April 2018	0	0	(5)	**(5)**
Surplus for the year	0	0	871	**871**
Other transfers between reserves	0	(231)	231	**0**
Impairments	0	(191)	0	**(191)**
Revaluations	0	419	0	**419**
Public dividend capital received	5,902	0	0	**5,902**
Taxpayers' equity at 31 March 2019	**12,337**	**7,622**	**66,343**	**86,302**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**6,435**	**8,163**	**59,930**	**74,528**
Surplus for the year	0	0	5,057	**5,057**
Other transfers between reserves	0	(259)	259	**0**
Impairments	0	(630)	0	**(630)**
Revaluations	0	351	0	**351**
Taxpayers' equity at 31 March 2018	**6,435**	**7,625**	**65,246**	**79,306**

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		3,170	7,493
Non-cash income and expense:			
Depreciation and amortisation	7	4,084	3,954
Net impairments	14.3	753	(4,310)
Income recognised in respect of capital donations	5	(310)	(56)
(Increase) in receivables and other assets		(1,151)	(1,436)
Decrease in inventories		48	13
Increase in payables and other liabilities		3,347	1,965
Net cash generated from operating activities		**9,941**	**7,623**
Cash flows from investing activities			
Interest received		94	24
Purchase of intangible assets		(231)	(141)
Purchase of property, plant, equipment and investment property		(7,874)	(3,406)
Sales of property, plant, equipment and investment property		1,100	0
Receipt of cash donations to purchase capital assets		291	0
Net cash generated (used in) investing activities		**(6,620)**	**(3,523)**
Cash flows from financing activities			
Public dividend capital received		5,902	0
Movement on loans from the Department of Health and Social Care		(250)	1,595
Capital element of finance lease rental payments		(267)	(393)
Interest on loans		(137)	(106)
Interest paid on finance lease liabilities		(15)	(38)
PDC dividend (paid)		(2,490)	(1,848)
Net cash generated from financing activities		**2,743**	**(790)**
Increase in cash and cash equivalents		**6,064**	**3,310**
Cash and cash equivalents at 1 April - brought forward		**9,601**	**6,291**
Cash and cash equivalents at 31 March	24	**15,665**	**9,601**

Notes to the Accounts

1 Accounting policies and other information

1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 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 Going concern

These accounts have been prepared on a going concern basis. This is supported by the recent contract negations with NHS and Local Authority organisations to provide continuing services throughout 2019/20. Having considered the challenges the Trust face, particularly with reference to the operating plan for the next twelve months, and having reviewed with the 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.

1.3 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.

1.4 Interests in other entities

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 NHS Trust or where the subsidiary's accounting date is not co-terminus.

The Trust has no subsidiaries.

Associates

The Trust has no associates.

Joint arrangements

The Trust has no joint arrangements.

1.5 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.

1.6 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.

1.7 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.

1.8 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.

1.9 Revenue

Income 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 income for the Trust is contracts with commissioners in respect of health care services. Income 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 which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.10 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Employees that are not eligible to join the NHS Pensions Scheme can join the National Employment Savings Scheme (NEST). NEST is a defined contribution workplace pension scheme and the expense is recognised in the SOCI. The expenditure recognised in SOCI for the financial year to 31 March 2019 was £8,974 (financial year to 31 March 2018 £4,680).

1.11 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.12 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- 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 be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs 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 valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.13 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where 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 cost. Software that is integral to the operation 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. 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; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Where no intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

1.14 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. 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 the shorter of the lease term and the estimated useful lives.

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

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 are 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.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

1.15 Donated assets

Donated and grant funded property, plant and equipment and intangible non-current assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment and intangible non-current assets.

1.16 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.

1.17 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust has no PFI or LIFT 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 Investment properties

The Trust has no investment properties.

1.20 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. Cash, bank and overdraft balances are recorded at current values.

1.21 Carbon Reduction Commitment scheme (CRC)

The Trust is not part of the Carbon Reduction Commitment Scheme.

1.22 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.

1.23 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 of 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.

1.24 The 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 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 as an expense on a straight-line basis over the lease term.

1.25 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

1.26 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 32 but is not recognised in the Trust's accounts.

1.27 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 NHS Resolution 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 when the liability arises.

1.28 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.

1.29 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.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset and recognised in the Statement of Comprehensive Income as a financing income.

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 held to 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. Interest is recognised using the effective interest method.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

Allowances for trade receivables and lease receivables are calculated at the Expected Credit Loss on day 1. This approach means the provision is calculated as the percentage risk that the debtor will not pay, multiplied by the best estimate of how much will not be paid. From historical data the number of days from invoice date to payment date and non-payments is converted to a percentage of total invoices raised for a period (month). The historical default rate is then applied to all invoices raised and as they age resulting in the amortised cost. A review of aged debt is then carried out and, where a debt is not fully provided for, a judgment is made based on internal knowledge which may result in the debt being provided for in full.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.30 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 and Social Care are recognised at historic 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 and Social Care, 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.

Financial liabilities in respect of assets acquired through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

1.31 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.32 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.33 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.

1.34 Foreign exchange

The Trust's functional 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.

1.35 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. However, they are disclosed in Note 36 to the accounts in accordance with the requirements of HM Treasury's *FReM* .

1.36 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 the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.37 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.38 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 SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.39 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.40 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019/20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● 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.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Operating Segments

In 2018/19 Trust activity was organised into eight service lines. Details of the eight service line are as follows;

Mental Health Services	Inpatient and Community Mental Health and Substance Misuse services for people who require specialist assessment, care and treatment by a dedicated multidisciplinary team, learning disabilities.
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, care home support, heart failure, admission avoidance and supported discharge services.
Children's East	Children's nursing, child and adolescent mental health, health visiting, paediatric medical, paediatric therapies and school nursing.
Children's West	Children's nursing, child and adolescent mental health, health visiting, paediatric medical, paediatric therapies and school nursing.
Adults Southampton	Neuro rehab services, specialist palliative care, rehab and re-ablement, community nursing, neuro inpatient unit, elderly frail inpatient unit, occupational therapy, physiotherapy, speech and language therapy, care home support, heart failure, admission avoidance, stoma care and supported discharge services.
Primary Care & LTC	TB, homeless healthcare, GP services, pain, rheumatology, physiotherapy, specialist physiotherapy, translation and interpretation services, behaviour change services, podiatry and podiatric surgery.
Sexual Health Services	Gum, reproductive health, HIV outpatient services, sexual health promotion, termination of pregnancies, vasectomy services, sexual assault referral centre.
Dental	Specialist dental care, GA's, Prisons and Oral Health.

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.

	2018/19			
	Revenue	Employee Benefits	Other Operating Costs	**Operating surplus / (deficit)**
	£000s	£000s	£000s	**£000s**
Mental Health Services	30,421	(19,151)	(3,242)	**8,028**
Adults Portsmouth	20,452	(15,350)	(2,212)	**2,890**
Children's East	16,131	(12,156)	(813)	**3,162**
Children's West	23,326	(15,879)	(1,486)	**5,961**
Adults Southampton	30,818	(20,157)	(3,128)	**7,533**
Primary Care & LTC	16,199	(11,493)	(1,274)	**3,432**
Sexual Health Services	26,409	(6,976)	(13,967)	**5,466**
Dental	10,664	(5,975)	(2,047)	**2,642**
Total Services	**174,420**	**(107,137)**	**(28,169)**	**39,114**
Infrastructure	7,167	(7,094)	(22,557)	**(22,484)**
Corporate Costs	11,530	(12,141)	(8,012)	**(8,623)**
Depreciation, amortisation, impairment	0	0	(7,256)	**(7,256)**
Operating surplus/(deficit)	**193,117**	**(126,372)**	**(65,994)**	**751**

	2017/18			
	Revenue	Employee Benefits	Other Operating Costs	**Operating surplus / (deficit)**
	£000s	£000s	£000s	**£000s**
Mental Health Services	29,457	(19,374)	(3,518)	6,565
Adults Portsmouth	20,280	(13,883)	(1,832)	4,565
Children's East	16,015	(11,651)	(627)	3,737
Children's West	22,363	(15,041)	(1,408)	5,914
Adults Southampton	28,197	(19,853)	(2,872)	5,472
Primary Care & LTC	16,247	(11,256)	(2,218)	2,773
Sexual Health Services	27,374	(6,898)	(14,614)	5,862
Dental	8,926	(5,161)	(1,537)	2,228
Total Services	**168,859**	**(103,117)**	**(28,626)**	**37,116**
Infrastructure	6,462	(8,013)	(22,572)	(24,123)
Corporate Costs	11,922	(10,012)	(7,741)	(5,831)
Depreciation, amortisation, impairment	0	0	(2,105)	(2,105)
Operating surplus/(deficit)	**187,243**	**(121,142)**	**(61,044)**	**5,057**

The two financial years are not directly comparable due to movement of costs between service lines, infrastructure and overhead costs.

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 Operating income from patient care activities

4.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Mental health services		
Block contract income	35,222	35,478
Community services		
Community services income from CCGs and NHS England	109,851	105,783
Income from other sources (e.g. local authorities)	24,361	25,355
All services		
Private patient income	310	251
Agenda for Change pay award central funding	1,939	0
Other clinical income	214	192
Total income from activities	**171,897**	**167,059**

4.2 Income from patient care activities (by source)

	2018/19 £000	2017/18 £000
NHS England	23,184	22,372
Clinical commissioning groups	121,877	118,881
Department of Health and Social Care	1,941	0
Other NHS providers	943	962
Local authorities	23,428	24,392
Non-NHS: private patients	225	251
Injury cost recovery scheme	85	20
Non NHS: other	214	181
Total income from activities	**171,897**	**167,059**
Of which:		
Related to continuing operations	171,897	167,059

5 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	2,219	3,028
Education and training (excluding notional apprenticeship levy income)	3,913	4,147
Non-patient care services to other bodies	2,061	2,605
Provider sustainability / sustainability and transformation fund income (PSF / STF)	3,621	3,027
Other contract income	8,156	6,327
Other non-contract operating income		
Receipt of capital grants and donations	310	56
Rental revenue from operating leases	942	970
Total other operating income	**21,222**	**20,160**
Of which:		
Related to continuing operations	21,222	20,160

Other contract income includes sessional room hire, car parking and catering.

6 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,477
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

6.1 Transaction price allocated to remaining performance obligations

	31 March 2019 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	494
Total revenue allocated to remaining performance obligations	**494**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

7 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	4,929	4,782
Purchase of healthcare from non-NHS and non-DHSC bodies	1,172	1,337
Staff and executive directors costs	126,333	121,142
Remuneration of non-executive directors	70	67
Supplies and services - clinical (excluding drugs costs)	9,239	9,024
Supplies and services - general	1,709	1,842
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	9,299	10,203
Consultancy costs	319	101
Establishment	5,384	5,463
Premises	15,273	13,977
Transport (including patient travel)	465	702
Depreciation on property, plant and equipment	3,469	3,391
Amortisation on intangible assets	615	563
Net impairments	753	(4,310)
Movement in credit loss allowance: contract receivables / contract assets	(201)	0
Movement in credit loss allowance: all other receivables and investments	0	(272)
Audit fees payable to the external auditor		
audit services- statutory audit	53	65
Internal audit costs	69	59
Clinical negligence	465	449
Legal fees	91	71
Insurance	5	5
Research and development	1,391	2,024
Education and training	730	1,015
Rentals under operating leases	5,713	5,458
Redundancy	544	148
Car parking & security	79	83
Hospitality	6	5
Losses, ex gratia & special payments	206	138
Other	1,769	2,194
Total	**189,949**	**179,726**
Of which:		
Related to continuing operations	189,949	179,726

Other expenditure includes external contractor costs and VAT partial exemption liability.

8 Operating leases

The Trust occupies properties using operating lease arrangements with NHS and non NHS organisations.

8.1 Trust as a lessee

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	5,713	5,458
Total	**5,713**	**5,458**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	5,613	5,596
- later than one year and not later than five years;	8,555	1,668
- later than five years.	2,301	691
Total	**16,469**	**7,955**

Future minimum sublease payments to be received: £nil

8.2 Trust as a lessor

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	942	970
Total	**942**	**970**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	955	976
- later than one year and not later than five years;	1,731	2,244
- later than five years.	1,991	2,893
Total	**4,677**	**6,113**

9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	99,867	94,812
Social security costs	9,177	8,784
Apprenticeship levy	489	465
Employer's contributions to NHS pensions	12,842	12,211
Pension cost - other	8	5
Termination benefits	544	148
Temporary staff (including agency)	4,240	4,960
Total gross staff costs	**127,167**	**121,385**
Recoveries in respect of seconded staff	**0**	0
Total staff costs	**127,167**	**121,385**
Of which		
Costs capitalised as part of assets	290	95

9.1 Retirements due to ill-health

During 2018/19 there were 3 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £112k (£348k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

9.2 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 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 employee and employer representatives as deemed appropriate.

Employees that are not eligible to join the NHS Pensions Scheme can join the National Employment Savings Scheme (NEST). NEST is a defined contribution workplace pension scheme and the expense is recognised in the SOCI. The expenditure recognised in SOCI for the financial year to 31 March 2019 was £8,974 (financial year to 31 March 2018 £4,680).

10 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	94	24
Total finance income	**94**	**24**

11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	137	113
Finance leases	15	38
Total interest expense	**152**	**151**
Total finance costs	**152**	**151**

12 Other gains / (losses)

	2018/19 £000	2017/18 £000
Losses on disposal of assets	(1)	(4)
Total (losses) on disposal of assets	**(1)**	**(4)**
Total other (losses)	**(1)**	**(4)**

13 Auditor disclosures

13.1 Other auditor remuneration

The Trust has no other auditor remuneration.

13.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

14.1 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**14,665**	**69,620**	**1,184**	**3,816**	**70**	**4,969**	**451**	**94,775**
Additions	0	7	9,315	154	0	27	85	**9,588**
Impairments	(1,350)	(692)	0	0	0	0	0	**(2,042)**
Reversals of impairments	345	753	0	0	0	0	0	**1,098**
Revaluations	55	364	0	0	0	0	0	**419**
Reclassifications	0	2,331	(2,331)	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	0	(1)	0	**(1)**
Valuation/gross cost at 31 March 2019	**13,715**	**72,383**	**8,168**	**3,970**	**70**	**4,995**	**536**	**103,837**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**7,013**	**0**	**2,821**	**55**	**3,183**	**427**	**13,499**
Provided during the year	0	2,365	0	253	3	842	6	**3,469**
Accumulated depreciation at 31 March 2019	**0**	**9,378**	**0**	**3,074**	**58**	**4,025**	**433**	**16,968**
Net book value at 31 March 2019	**13,715**	**63,005**	**8,168**	**896**	**12**	**970**	**103**	**86,869**
Net book value at 1 April 2018	**14,665**	**62,607**	**1,184**	**995**	**15**	**1,786**	**24**	**81,276**

Asset financing:	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	13,715	62,973	8,168	655	12	766	103	**86,392**
Finance leased	0	0	0	156	0	204	0	**360**
Owned - donated	0	32	0	85	0	0	0	**117**
NBV total at 31 March 2019	**13,715**	**63,005**	**8,168**	**896**	**12**	**970**	**103**	**86,869**

Revaluation reserve balance for Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
At 1 April 2018	470	7,155	0	0	0	0	0	7,625
Movements	55	(58)	0	0	0	0	0	(3)
At 31 March 2019	**525**	**7,097**	**0**	**0**	**0**	**0**	**0**	**7,622**

Additions to assets under construction in 2018/19

	£000
Buildings excluding dwellings purchased	8,823
Plant & machinery purchased	43
Information technology purchased	205
Buildings excluding dwellings donated	244
Total	**9,315**

14.2 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**12,115**	**65,070**	**1,076**	**3,446**	**70**	**5,858**	**451**	**88,086**
Additions	0	0	3,149	370	0	135	0	**3,654**
Impairments	0	(657)	0	0	0	0	0	**(657)**
Reversals of impairments	2,460	1,977	0	0	0	0	0	**4,437**
Revaluations	90	261	0	0	0	0	0	**351**
Reclassifications	0	2,969	(3,041)	0	0	72	0	**0**
Disposals / derecognition	0	0	0	0	0	(1,096)	0	**(1,096)**
Valuation/gross cost at 31 March 2018	**14,665**	**69,620**	**1,184**	**3,816**	**70**	**4,969**	**451**	**94,775**
Accumulated depreciation at 1 April 2017 - brought forward	**0**	**4,915**	**0**	**2,587**	**44**	**3,117**	**422**	**11,085**
Provided during the year	0	2,098	0	234	11	1,043	5	**3,391**
Disposals / derecognition	0	0	0	0	0	(977)	0	**(977)**
Accumulated depreciation at 31 March 2018	**0**	**7,013**	**0**	**2,821**	**55**	**3,183**	**427**	**13,499**
Net book value at 31 March 2018	**14,665**	**62,607**	**1,184**	**995**	**15**	**1,786**	**24**	**81,276**
Net book value at 1 April 2017	**12,115**	**60,155**	**1,076**	**859**	**26**	**2,741**	**29**	**77,001**

Asset financing:

Net book value at 31 March 2017	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	14,665	62,558	1,184	703	15	1,407	24	**80,556**
Finance leased	0	0	0	186	0	379	0	**565**
Owned - donated	0	49	0	106	0	0	0	**155**
NBV total at 31 March 2018	**14,665**	**62,607**	**1,184**	**995**	**15**	**1,786**	**24**	**81,276**

14.3 Property, plant and equipment

The Trust received donated assets from NHS England and Solent NHS Charity in the year.

Land and buildings are held at revalued amounts. A desktop revaluation exercise was carried out on these assets as at 31 March 2019 using optimisation methodology (delivery of services from modern facilities) and indices relevant to the asset class. The exercise was carried out by the District Valuers who are RICS qualified. The impact of the exercise is:

	Land £000	Buildings excluding dwellings £000	Total £000
Increase to revaluation reserve	55	364	419
Decrease to revaluation reserve	0	(191)	(191)
Impairment charge to SOCI	(1,350)	(501)	(1,851)
Reversal of impairment charge to SOCI	345	753	1,098
	(950)	**425**	**(525)**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	95
Plant & machinery	5	25
Transport equipment	10	10
Information technology	2	10
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

15 Intangible non-current assets

15.1 Intangible non-current assets - 2018/19

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**4,701**	**33**	**4,734**
Additions	0	295	**295**
Reclassifications	117	(117)	**0**
Valuation / gross cost at 31 March 2019	**4,818**	**211**	**5,029**
Amortisation at 1 April 2018 - brought forward	**2,312**	**0**	**2,312**
Provided during the year	615	0	**615**
Amortisation at 31 March 2019	**2,927**	**0**	**2,927**
Net book value at 31 March 2019	**1,891**	**211**	**2,102**
Net book value at 1 April 2018	**2,389**	**33**	**2,422**

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.

15.2 Intangible non-current assets - 2017/18

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**3,952**	**641**	**4,593**
Additions	0	141	**141**
Reclassifications	749	(749)	**0**
Valuation / gross cost at 31 March 2018	**4,701**	**33**	**4,734**
Amortisation at 1 April 2017 - brought forward	**1,749**	**0**	**1,749**
Provided during the year	563	0	**563**
Amortisation at 31 March 2018	**2,312**	**0**	**2,312**
Net book value at 31 March 2018	**2,389**	**33**	**2,422**
Net book value at 1 April 2017	**2,203**	**641**	**2,844**

15.3 Intangible non-current assets
The Trust received donated intangible assets from Hampshire County Council in the year.

The economic lives of the intangible assets range from:	Min Life (yrs)	Max Life (yrs)
Internally generated information technology	5	10

16 Analysis of impairments and reversals

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	753	(4,310)
Total net impairments charged to operating surplus / deficit	**753**	**(4,310)**
Impairments charged to the revaluation reserve	191	630
Total net impairments	**944**	**(3,680)**

No impairment on donated assets included above.

17 Investment property
The Trust has no investment property.

18 Commitments

18.1 Capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	3,566	494
Intangible assets	7	80
Total	**3,573**	**574**

18.2 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement) for ICT services. The payments to which the Trust is committed are as follows:

	31 March 2019 £000	31 March 2018 £000
Not later than 1 year	4,867	5,078
After 1 year and not later than 5 years	1,618	1,976
Paid thereafter	0	0
Total	**6,485**	**7,054**

19 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	169	202
Consumables	177	192
Total inventories	**346**	**394**

Inventories recognised in expenses for the year were £11,736k (2017/18: £11,863k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

20.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	13,851	
Trade receivables*		7,595
Accrued income*		3,961
Allowance for impaired contract receivables / assets*	(1,150)	
Allowance for other impaired receivables	0	(1,346)
Prepayments (non-PFI)	1,313	2,156
PDC dividend receivable	175	0
VAT receivable	1,216	986
Other receivables	265	181
Total current trade and other receivables	**15,670**	**13,533**
Non-current		
Prepayments (non-PFI)	1,837	2,653
Total non-current trade and other receivables	**1,837**	**2,653**
Of which receivables from NHS and DHSC group bodies:		
Current	11,114	7,886

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

20.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2018 - brought forward	**0**	**1,346**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,351	(1,346)
New allowances arising	818	0
Reversals of allowances	(1,019)	0
Allowances as at 31 March 2019	**1,150**	**0**

Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
Allowances as at 1 April 2017 - brought forward	**1,480**
Increase in provision	(272)
Amounts utilised	138
Unused amounts reversed	0
Allowances as at 31 March 2018	**1,346**

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 movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19 £000	2017/18 £000
At 1 April	**9,601**	**6,291**
Net change in year	6,064	3,310
At 31 March	**15,665**	**9,601**
Broken down into:		
Cash at commercial banks and in hand	20	10
Cash with the Government Banking Service	15,645	9,591
Total cash and cash equivalents as in SoFP	**15,665**	**9,601**
Total cash and cash equivalents as in SoCF	**15,665**	**9,601**
Patients' money held by the Trust, not included in above.	**3**	3

25 Non-current assets held for sale

	2018/19 £000	2017/18 £000
Balance at 1 April	**1,100**	**1,200**
Assets sold in year	(1,100)	**0**
Impairment of assets held for sale	0	**(100)**
Balance at 31 March	**0**	**1,100**

The assets held for sale were the land and buildings of the area at St James Hospital, Portsmouth, know as Oakdene. The sale completed in 2018/19 financial year.

26 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	6,111	3,455
Capital payables	1,999	240
Accruals	13,897	12,995
Social security costs	1,311	1,267
Other taxes payable	671	581
PDC dividend payable	8	83
Accrued interest on loans*	0	22
Other payables	1,773	1,695
Total current trade and other payables	**25,770**	**20,338**
Of which payables from NHS and DHSC group bodies:		
Current	6,143	4,266

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within Note 28. IFRS 9 is applied without restatement therefore comparatives have not been restated.

27 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	918	1,320
Total other current liabilities	**918**	**1,320**
Non-current		
Deferred income: contract liabilities	104	125
Total other non-current liabilities	**104**	**125**

28 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	7,786	4,554
Obligations under finance leases	199	238
Total current borrowings	**7,985**	**4,792**
Non-current		
Loans from the Department of Health and Social Care	1,345	4,805
Obligations under finance leases	65	293
Total non-current borrowings	**1,410**	**5,098**

29 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2018	**9,359**	**531**	**9,890**
Cash movements:			
Financing cash flows - payments and receipts of principal	(250)	(267)	**(517)**
Financing cash flows - payments of interest	(137)	(15)	**(152)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	22	0	**22**
Application of effective interest rate	137	15	**152**
Carrying value at 31 March 2019	**9,131**	**264**	**9,395**

30 Other financial liabilities

The Trust has no other financial liabilities.

31 Finance leases

31.1 Finance lease obligations as lessor

The Trust has no finance lease receivables as lessor.

31.2 Finance lease obligations as lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**298**	**551**
of which liabilities are due:		
- not later than one year;	233	282
- later than one year and not later than five years;	65	269
Finance charges allocated to future periods	(34)	(20)
Net lease liabilities	**264**	**531**
of which payable:		
- not later than one year;	199	238
- later than one year and not later than five years;	65	293

32 Provisions

The Trust has no provisions.

At 31 March 2019, £9,703k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Solent NHS Trust (31 March 2018: £894k).

33 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Contingent liabilities		
NHS Resolution legal claims	(16)	(23)
Net value of contingent liabilities	**(16)**	**(23)**

Contingent assets
The Trust has no contingent assets.

34 Financial Instruments

34.1 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, Local Authorities and NHS England and the way those Clinical Commissioning Groups, Local Authorities 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. The Trust's 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 NHS Improvement. 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. The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. 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 2019 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.

34.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	12,966	**12,966**
Cash and cash equivalents at bank and in hand	15,665	**15,665**
Total at 31 March 2019	**28,631**	**28,631**
Carrying values of financial assets as at 31 March 2018 under IFRS 39		
Trade and other receivables excluding non financial assets	7,595	**7,595**
Cash and cash equivalents at bank and in hand	9,601	**9,601**
Total at 31 March 2018	**17,196**	**17,196**

34.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	9,131	**9,131**
Obligations under finance leases	264	**264**
Trade and other payables excluding non financial liabilities	23,780	**23,780**
Total at 31 March 2019	**33,175**	**33,175**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	9,359	**9,359**
Obligations under finance leases	531	**531**
Trade and other payables excluding non financial liabilities	18,491	**18,491**
Total at 31 March 2018	**28,381**	**28,381**

34.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	31,765	23,312
In more than one year but not more than two years	1,396	213
In more than two years but not more than five years	14	4,856
Total	**33,175**	**28,381**

35 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	0	0	158	128
Stores losses and damage to property	2	206	0	0
Ex-gratia payments	0	0	1	10
Total losses and special payments	**2**	**206**	**159**	**138**

The Trust received no gifts in 2018/19.

36 Third party assets

The Trust held £3,289 cash and cash equivalents at 31 March 2019 (£2,728 at 31 March 2018) 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.

37 Related party transactions

During the year none of the Department of Health and Social Care 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 and Social Care 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 £000s	Receipts from Related Party £000s	Amounts owed to Related Party £000s	Amounts due from Related Party £000s
NHS England	21	26,987	24	5,973
Clinical Commissioning Groups				
NHS Portsmouth	48	58,722	2	767
NHS Southampton	0	38,798	28	1,030
NHS West Hampshire	26	9,441	32	299
NHS South Eastern Hampshire	0	6,248	0	261
NHS Fareham & Gosport	0	5,320	0	161
NHS North East Hampshire & Farnham	0	1,434	0	32
NHS North Hampshire	37	2,209	0	43
NHS Trust and Foundation Trust				
Hampshire Hospitals Foundation Trust	1,376	90	226	7
Portsmouth Hospitals NHS Trust	2,878	1,640	652	274
University of Southampton NHS Foundation Trust	2,163	1,593	864	373
Southern Health NHS Foundation Trust	1,888	2,613	497	555
Local Authorities				
Hampshire County Council	34	6,990	835	192
Portsmouth City Council	675	7,452	148	869
Southampton City Council	86	8,742	167	1,127
NHS Business Services Authority	167	0	16	0
NHS Resolution	470	607	0	730
NHS Property Services Ltd	5,976	51	3,881	66
Community Health Partnerships	2,384	0	83	0
Solent NHS Charity	0	20	0	0

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 and NHS Pensions Agency.

The income from NHS Resolution is related to insurance claims for loss of income and damage to properties owned by the Trust.

The Trust has also received revenue from Solent NHS Charity of which the NHS Trust Board is the Corporate Trustee.

38 Events after the reporting date

There have been no events after the end of the reporting period.

39 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	27,822	54,799	24,989	50,562
Total non-NHS trade invoices paid within target	25,115	45,438	23,479	47,509
Percentage of non-NHS trade invoices paid within target	90.3%	82.9%	94.0%	94.0%
NHS Payables				
Total NHS trade invoices paid in the year	1,381	14,880	1,230	17,446
Total NHS trade invoices paid within target	1,139	13,971	1,067	16,514
Percentage of NHS trade invoices paid within target	82.5%	93.9%	86.7%	94.7%

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

40 Breakeven duty rolling assessment

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Operating income	193,935	192,146	187,756	187,240	178,854	180,675	187,219	193,119
Breakeven duty in-year financial	1,863	776	1,858	(6,274)	(5,062)	(2,084)	737	1,370
Breakeven duty cumulative position	**1,863**	**2,639**	**4,497**	**(1,777)**	**(6,839)**	**(8,923)**	**(8,186)**	**(6,816)**
Cumulative breakeven position as a percentage of operating income	1.0%	1.4%	2.4%	(0.9%)	(3.8%)	(4.9%)	(4.4%)	(3.5%)

41 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

42 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
External financing limit (EFL)	11,122	6,518
Cash flow financing	(679)	(2,108)
External financing requirement	**(679)**	**(2,108)**
Under spend against EFL	**11,801**	**8,626**

43 Capital Resource Limit

The Trust is given a capital resource limit which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Gross capital expenditure	9,883	3,795
Less: Disposals	(1,101)	(119)
Less: Donated and granted capital additions	(310)	(56)
Charge against Capital Resource Limit	**8,472**	**3,620**
Capital Resource Limit	10,015	3,944
Under spend against CRL	**1,543**	**324**

Item 4.1

Presentation to	X	In Public Board Meeting		Confidential Board Meeting				
Title of Paper	Annual Report (including the Annual Governance Statement)							
Author(s)	Rachel Cheal, AD Corporate Affairs & Company Secretary		**Executive Sponsor**		Sue Harriman, CEO			
Date of Paper	17th May 2019		**Committees presented**		• Reviewed by executive team • Annual Governance Statement presented to May Assurance Committee • Annual Report and AGS presented to May Audit & Risk Committee			
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy	X	**W3** Culture	X	**W4** Roles & Responsibilities	X
	W5 Risks and Performance	X	**W6** Information		**W7** Engagement	X	**W8** Learning, Improvt & innovation	X
Action requested of the Board		To receive	X	For decision				
Link to BAF risk	N/A	X						

Every year we are required to produce an **Annual Report** and **Annual Governance Statement (AGS),** in accordance with Department of Health & Social Care Group Accounting Manual (2018-19) and guidance from NHS Improvement.
The draft annual report has been shared with and scrutinised by External Auditors as part of the annual auditing process.

At the time of drafting and paper submission to the Audit & Risk Committee, matters still outstanding are highlighted[1] within the document – these include:

- confirmation of the External Auditor Opinion within the Annual Governance Statement,
- Section 3 The Auditors Report, and;
- insertion of the Quality Account and Full Accounts (which will be presented separately to the Board, following presentation to the Audit & Risk Committee).

Contemporary updates in relation to the outstanding sections, and any other matters will be provided verbally at the meeting itself.

Since shared with the Audit & Risk Committee, the Annual Report has been amended as follows; the statement referencing referral to the Secretary of State in accordance with Section 30 of the Local Audit and Accountability Act 2014 has been deleted under the 'Going Concern' section, pg 108, as it is understood that this no longer applies to the Trust in light of the year end positions for both this financial year (18/19) and the prior year (17/18) being a surplus.

The Annual Report and AGS have been presented to the Audit & Risk Committee directly prior to the Board meeting.

Board Recommendation

The Board is asked to;

- Approve the Annual Report
- Approve the Annual Governance Statement (pg 57-74). The Chief Executive will be asked to separately sign the AGS following the Board meeting which is submitted to the Auditor and NHSI.

The final consolidated Annual Report (to include the Quality Account and Full Accounts) must be made available on the Trusts' public website by 31 July 2019, in accordance with NHSI requirements.

[1] Also highlighted in blue within the document are place-markers for signatures/confirmation of dates – a clean version will be presented for 'signature' at the Board meeting.

NHS
Solent
NHS Trust

Solent NHS Trust
Annual Report and Accounts 2018/19
incorporating the Quality Account 2018/19

Solent NHS Trust

Annual Report and Accounts 2018/19

incorporating the Quality Account 2018/19

Contents

Statement from the Chief Executive Officer and former Chair

Welcome to our Annual Report and Quality Account for the 2018/19 financial year. The report gives an overview of what we do, the challenges we face, our performance, as well as a detailed analysis of our activities and accounts.

2018/19 has been an incredibly positive year for Solent NHS Trust. In October, many of our services were visited by a team of inspectors from the Care Quality Commission (CQC) and during November we had our well-led inspection. The CQC rated us as 'Good' overall and the care we provide as 'Outstanding'. Every one of our fifteen core services is now rated 'Good' or 'Outstanding' which shows great consistency in the way that we plan and deliver services. The CQC praised our workforce for the commitment they show to the people we provide services to, and their families.

We would like to begin this report by saying 'thank you' to all of our teams for their on-going dedication. They are the people, at the heart of Solent, who carry out their work with tremendous skill and passion. It is a real pleasure to lead an organisation full of inspiring people who continually go above and beyond to provide outstanding care. We hope that throughout this report, you will see the golden thread; the difference they make to the people who use our services.

As with the rest of the Health and Social Care system, we face the challenge of rising demand. Despite the huge pressures placed on our staff and our system, we have continued to improve the quality of care we provide. Our Patient Friends & Family Test (FFT) results showed that 96% of people would recommend Solent as a place to receive treatment. Our Quality Improvement Programme, which you can read more about in the Quality Account, is testament to our strong improvement culture and a tribute to our teams who consistently give great care, create a great place to work and keep people safe and well at, or close to, home.

As well as resounding support from people within Solent, we are incredibly fortunate to have support from local people; through feedback and through their involvement in the development of our services. We ask people to tell us when things go well and when we don't quite get it right, we also continue to ask people to help us develop our services. In 2017/18, we continued to engage with our Young Shapers, a group of young people who work with our Children's service line. They have helped us to see our services through the eyes of a service user, and through the eyes of a young person. Their involvement in our services has been invaluable, and we look forward to involving even more people, from the communities we serve, in the development of our services as we continue to embed our Community Engagement Strategy during 2019/20.

We continue to invest in Solent, creating an environment in which people feel engaged in their work and motivated to deliver the very best care, embedding our HEART values throughout. For three years in a row we have seen an improvement in our NHS Staff Survey results, and our 2018 results made us best in class for combined Community, Mental Health and Learning Disability trusts in the Listening into Action results published in the Health Service Journal (HSJ). We were thrilled to see that our engagement score, which tells us how people feel about work, has increased for the third year in a row. The 2018 results tell us that feedback is making a difference, and that we are realising our strategic priority of Solent being a great place to work. Our commitment is to ensure that leaders keep listening, learning and improving. To help us do this, we have invested in new senior roles for Diversity & Inclusion, Independent Freedom to Speak Up Guardian and Community Engagement and Patient Experience. Within our

Annual Report you will find a summary of our survey results and the work we are doing to continue to make changes to improve the Trust for everybody.

We believe in the future of local, integrated services. During 2018/19, we placed even greater emphasis on working with other organisations in joining up, and shaping, future care. We continue to play an active role in the development of the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP), and in the development of local integrated care partnerships. Our communities need to be empowered to stay well, and where possible, be cared for at home. By working as a care system, and leading where possible, we believe we can shape that future care system.

In addition to delivering outstanding care, we continue to excel in the area of community health research working together with Side by Side, our well established patient and carer leadership group. Research gives access to new treatments and opportunities to learn new techniques. It is well recognised that being a research active organisation increases the overall quality of care and patient outcomes. And so, being named as the top performing Trust for research activity in the category of 'care trusts', by the National Institute for Health Research, is an accolade of which we are tremendously proud.

For the people who use our services, it is crucial that we provide welcoming and spacious environments, with up-to-date facilities. This year we have seen significant investment in our buildings which will continue into the next year. During 2018/19, NHS England announced that we have been awarded £15.8million to extend the Western Community Hospital site in Southampton, and we started work on the £10 million project to redevelop St Mary's Community Health Campus, bringing even more services in the heart of the community. These significant investments will allow us to care for even more people, throughout more stages of their lives, in purpose-built, state of the art facilities.

Each year provides more challenges than the last, with increasing financial constraints and ever-growing demand for services. Despite these challenges, we achieved a £1.4m surplus (having received £3.5m of Provider Sustainability Funding, awarded by NHS Improvement). You can read more about our financial position in the Performance Report and Summary Accounts sections.

Looking to the future, we enter the next year with optimism. We will continue to focus on delivering our vision; to keep *more* people safe and well at, or close to, home, whilst striving to be an 'outstanding' organisation. To help us achieve our plans, we will continue to include our diverse communities, commissioners and partner organisations, invest in, and develop, our workforce and keep learning and improving.

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

and on behalf of
Alistair Stokes
Chair (until 31st March 2019)

Statement from our new Chair

It is a privilege to Chair an organisation and it is my particular privilege to Chair Solent at this time. Following extensive scrutiny by the Care Quality Committee (our regulator) we have been awarded 'Good' - this is no easy task to achieve and, which is particularly gratifying, we have been awarded 'Outstanding' for caring. Everyone can take pride in their work to deliver this excellent result - front line and support staff, clinical and non-clinical, it takes the whole team.

Additionally our staff survey results are most heartening. We have performed extremely well against other Trusts and our results are good in their own right and improving.

This does not make us complacent but it does give us cause to celebrate, and to identify ways in which we can be better - in line with our priorities of giving great care and being a great place to work.

We have also had a good outcome for our third priority - being good value for money. This is down to good stewardship alongside innovation in delivering better care, cost effectively that we have delivered a small surplus this year. Having our finances on an even keel will be helpful to us in achieving our ambitions for next year.

The healthcare environment continues to be a tough one and there are many challenges ahead however I am confident that we have the people in Solent and the partnerships in place to continue to keep more people healthy, safe and independent at, or close to, home.

I would like to thank my Board colleagues for their diligence and leadership over the last year and to recognise our retiring Chair Alistair Stokes. He has been at Solent for 8 years and we thank him for his contribution to the Board and helping to deliver our great outcomes.

Insert signature

Catherine Mason
Chair, from 1st April 2019
Date: 24th May 2019

Section one:
Performance report

Overview

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

Consideration of the going concern basis can be found within Section 4.

Our staff with a patient at Snowdon Ward

Statement from the Chief Executive

2018/19 has been a year of learning and continuous improvement for us. We take pride in our focus on quality and our strong improvement culture, as evidenced by our recent CQC inspection report.
I am proud that the people who work at the heart of Solent, continue to inspire each other every day and whose incredible commitment seems to increase year on year. Our clear, ambitious vision to make a difference by keeping more people safe and well in the community, and the active role we take in joining up, and shaping, future care were cited by the inspection team as examples of 'outstanding practice'. They were also complementary to the holistic approach we take to ensuring that both physical and mental health are considered equally, the strong leadership and development within the organisation, and our learning and quality improvement culture. The CQC recognised areas where we perform amongst the best in the country: the take up for the National Child Monitoring Programme, our results in the National Institute of Health Research's annual league tables, and our compliance with Information Governance. The work of our Children's Team, to involve young people in the development of services through Young Shapers, was mentioned as exemplary.

We continue to make a positive difference to the people who use our services, but we always want to learn and sometimes we don't quite get it right. The feedback we receive from people helps us to understand what we are doing well and where we need to make improvements. In 2018/19, we received our highest ever number of Patient Friends and Family responses, 25,108 for the year, an increase by a third on the previous year. Where possible, we encourage our services to work in a responsive way, and face-to-face, with people to resolve concerns and problems quickly. You can read more about our performance and achievements in quality, safety and patient experience in our Quality Account, Section 5.

We rely on the expertise and dedication of our staff to deliver high quality services and therefore want to ensure that we attract and retain the best staff. This year, we have focused on improving recruitment and retention and were part of an NHS Improvement programme to reduce turnover in clinical staff. Thanks to this programme, we have utilised new, and innovative ways, of recruiting people, established a new recognition programme, The Solent Awards, and we have established a new career progression framework. I am delighted that our NHS Staff Survey results have improved again. Our people said that they feel more valued and recognised for the work they do, and there is a significant increase in the number of our people who would recommend Solent as a place to work. We strive to be even better; doing more of more of what works and making changes in response to employee feedback. As an executive team and as a board we regularly take time out to visit our services and listen to our staff – we recognise how important this is. We know our people feel they work too hard and we appreciate the pressures and difficult circumstances that our people work under. During the year ahead we will continue our CuriosiTea events where staff share stories about how they made a difference in their role and intend to expand and strengthen our health and wellbeing offer, aimed at improving our people's experience of working in Solent.

There is no doubt that 2018/19 represented significant financial challenges for the NHS. Our finances are deeply impacted by sustained efficiency expectations, coupled with continued increasing demand whilst being required to maintain and improve the quality of care delivered. We finished the year in a positive financial position; performing better than our stretch deficit plan of £0.4m and receiving £3.5m of Provider Sustainability Funding awarded by NHSI (£1.5m as per the original Control Total plan and an additional £2.0m for performing marginally better than plan) meaning we achieved a £1.4m surplus. This would not have been possible without the commitment of everyone across all areas of the organisation. 2019/20 will bring increased financial challenges as we are required to make further recurrent savings. In order to achieve these we need to continue to think differently, transforming services and working with partners to deliver major system transformations when it makes sense to do so.

This year we have seen a consistent growth in the demand of our services, with the Trust making nearly 1.15 million patient contacts in one year, nearly an 8% rise on the previous year. Increasing demand can cause additional pressures on our workforce. With this in mind, we keep a close eye on our workforce performance indicators to identify any areas of concern that we need to address. Our performance measures for employee absence and turnover rate provide us with a good indication about the health and wellbeing of our staff.

To ensure we maintain safe staffing levels we have needed to use agency staff within some of our services. This has meant that we have consistently spent more than our monthly target on agency expenditure. A combination of factors has led to higher spend, including hard to fill vacancies, across a range of services, and the acuity of patients, particularly in our mental health wards. To help decrease the use of agency, we have robust processes in place to approve requests and we hope to see an improved position next year. Our absence rate has been positive this year. For half the year, our absence rate has been at, or below, our 4% target, and has not been above 5% during 2018/19, even during winter when pressures are increased. Our employee turnover rate has remained consistent, at around 14%. Thanks to our positive working environment, our vacancy rate is comparatively lower than the national median of other Trusts as a whole. We remain committed to creating a workplace where people feel motivated and able to deliver, and we will continue to value, engage and empower our employees.

We have faced some operational performance challenges over the year; including longer than acceptable waiting lists in some of our services such as Domiciliary Phlebotomy Service, Podiatric Services and Pulmonary Rehabilitation in the east, for dental General Anaesthesia, our Child and Adolescent Mental Health Services (CAMHS), Paediatric Medical Service and Musculoskeletal Service (MSK). We recognise the impact this has on the people who use our services and their families and work to ensure that we have escalation processes in place for individuals waiting if their needs become more urgent. We also continue to work with our commissioners and partners in the health and social care systems to ensure that we appropriately design services to meet current population need and to actively reduce waits. During the year we have been liaising closely with the third party organisation who provide wheelchairs to help improve delivery to ensure improvements in patient outcomes and experience.
When our performance is below expected standards, we work with our commissioners, people who use our services and regulatory bodies transparently, openly and collaboratively. Together, we resolve issues as quickly and safely as possible and we learn so that we can do things differently in the future.

I hope as you read the rest of our Annual Report that you will see that we are an organisation that prides itself on being open and honest and always striving for continuous improvement by reflecting and learning. Our Quality Improvement Programme continues to grow in strength and impact aiming to equip those that work with us (the people who use our services and our colleagues) with both the skills and confidence to identify, deliver and sustain improvements across our services. You can read more about our Quality Improvement approaches and the difference it has made within the Quality Account and within our Academy of Research and Improvement Annual Report.

What remains clear, and I hope is evident to everyone who uses our services, is the enthusiasm and commitment of the people who work at the heart of Solent. I'm hugely proud to be the Chief Executive of 'Team Solent', where everyone counts and contributes. I look forward to building on the foundations of 2018/19 – we have an exciting future ahead of us, working as a team, to make a difference by keeping even more people healthy, safe and independent at, or close to, home.

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

About us

Who we are

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

We are a specialist community and mental health provider with an annual income of over £193m for 2018/19.

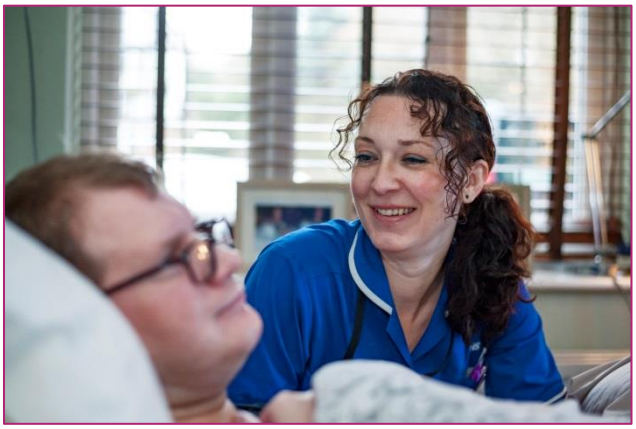
Last year, we employed 4,932 clinical and non-clinical members of staff (including part time and bank staff) which equates to 2,943 full-time equivalents (FTE), and delivered nearly 1.14 million service user contacts, nearly an 8% rise on the previous year.

What we do

We specialise in providing high quality, best value, community and mental health services to people living in Portsmouth, Southampton and in some parts of Hampshire.

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. On 1st October 2018 we commenced our specialist dentistry service on the Isle of Wight and since then have successfully integrated the service into our wider county offer. Our team of talented staff work from over 100 locations.

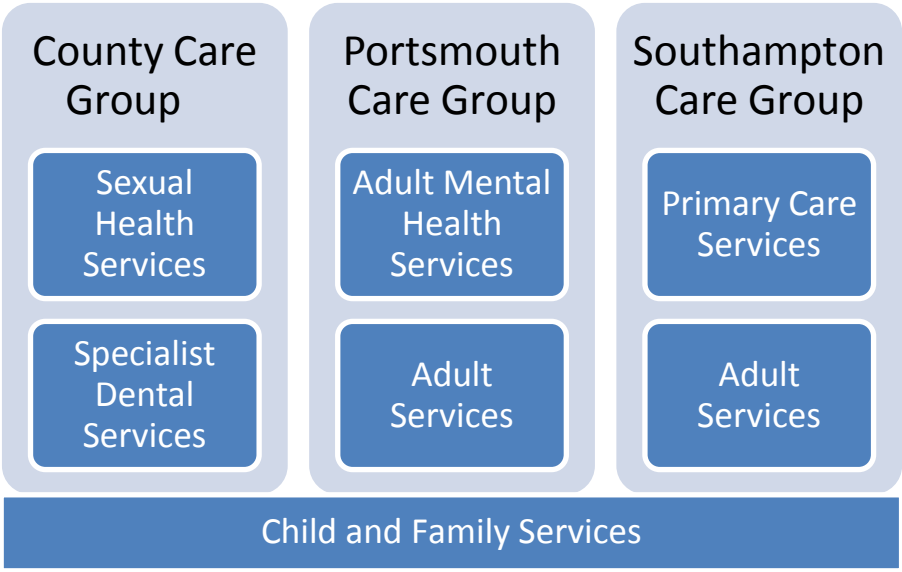
We support families to ensure children get the best start in life, provide services for people with complex care needs and help older people keep their independence. We also provide screening and health promotion services, which support people to lead a healthier lifestyle.



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

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

The following diagram illustrates our Care Group Structure:



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

Our vision and goals

Our Story – why we exist

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

People, values and culture drive us. The best people, doing their best work, in pursuit of our vision.

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

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

Our business priorities: How we deliver our vision

We know our vision is ambitious, but we have excellent foundations. Every year we focus on a small number of priorities. These guide the work of our teams and are used to set individual staff objectives.

Deliver great care

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

Make Solent a great place to work

- Supporting people to look after their health and wellbeing
- Improving the workplace by listening to ideas and acting on feedback
- Supporting and developing leaders who enable people to be at their best

Deliver the best value for money

- Working with partners to spend money wisely
- Involving people in decisions about spending money
- Enabling services to have more time to provide care

Our values

Our shared HEART values reflect the deep belief that we are caring organisation at the centre of our community. They support the development of a strong working culture. They breathe life into our organisation – guiding and inspiring all of our actions and decisions. They enable us to be better at what we do and create a great place for our employees to work, whilst ensuring we provide the highest quality of care to the people who use our services.

How we work together as a values-based organisation

Our values create the foundation for everything we do – for our employees and people in our communities.

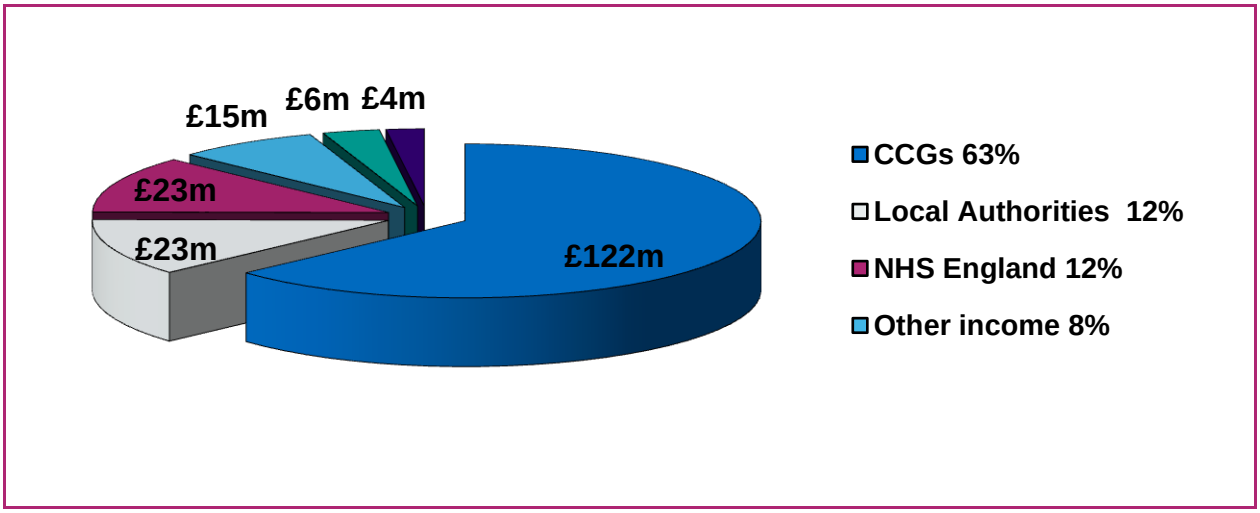
During the annual appraisal process, we asked people to reflect on what the values mean to them personally and how they bring them to work. We have also reshaped our recruitment and leadership practices to make HEART a part of our daily culture.

We will continue to develop ways of working that draws our values into all that we do, creating a great place to work and a great experience for our service users.

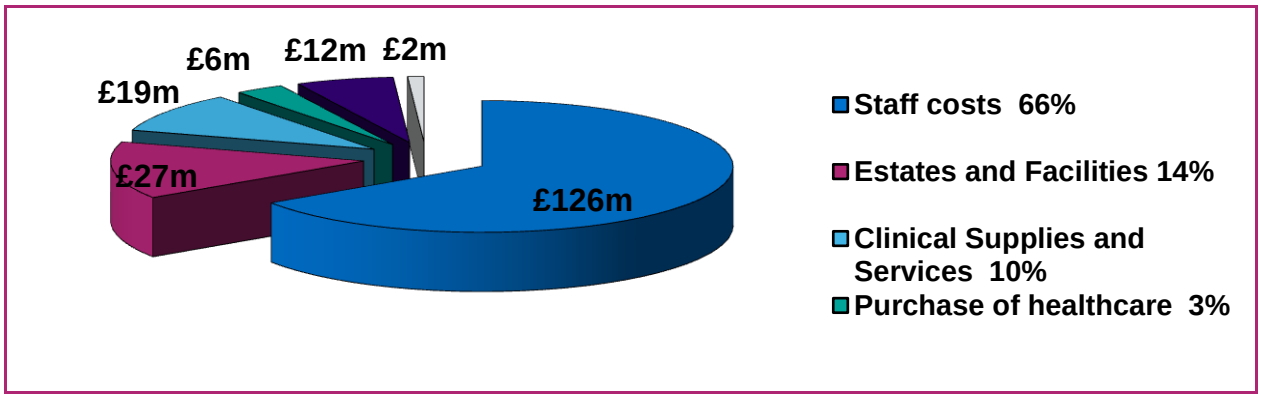
Our finances

During 2018/19 we had an income of over £193m.

Our income is illustrated below:



Our expenditure is illustrated below:



Staff from our Community Independence Service

The year in review

Summary of financial performance

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

Principle risks and uncertainties facing the organisation

Our focus during 2018/19, like previous years, has been on maintaining service quality and sustaining financial recovery. Despite the financial challenges, service performance generally held up well throughout the year.

We achieved a £1.4m surplus, against a stretch deficit plan of £0.4m; the original plan had a deficit of £1.0m. During 2018/19, Solent received £3.5m of Provider Sustainability Funding, as awarded from NHSI (£1.5m as per the original plan and an additional £2.0m for performing marginally better than plan). Our efficiency target (Cost Improvement Plan) was £7.7m, of which £6.1m was delivered; the balance was achieved by other measures.

Our Control Total, for 2019/20 is a breakeven position, including an efficiency target of £8.1m – however we recognise that this will be extremely challenging. We continue to actively engage with NHS Improvement to deliver efficiencies identified in Lord Carter of Coles report.

Our business risks

The great majority of our business is with Clinical Commissioning Groups (CCGs), NHS England, and local authorities, as commissioners for NHS patient care services and preventative services. As CCGs, NHS England and local authorities are funded by Government to buy NHS patient care and preventative services; the Trust is not exposed to the degree of financial risk faced by business entities, apart from the normal contract negotiation/renewal that is expected in any organisation. Deficits were incurred in 2014/15, 2015/16 and 2016/17 and as at 31st March 2019, the cumulative deficit stands at £6.8m, which have been funded by Department of Health loans with differing repayment dates. It is anticipated that these are rolled over until the Trust returns to making in-year surpluses.

In 2018/19 we have continued to respond to tender opportunities aligned to our core business and remain committed to exploring innovative models of integration and contract extension mechanisms to provide continuity for organisations and people who use our services.

With regards to our financial forecasts and modelling for the year ahead in order to achieve the Control Total, a number of risks exist as reflected below and in the following sections.

We are currently waiting for formal confirmation from NHSI regarding the mechanism by which the funding for the Agenda for Change uplifts associated with local authority contracts, agreed during 2018/19 and being paid by the Trust, will be received.

We have notified our regulator of assumptions made concerning contracting income, the allocation of Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF) on assumptions that financial milestones are met as well as expectations concerning pay and non-pay expenditure.

Funding pressures

The financial constraints within local government are such that significant savings will be required, which will require difficult choices to be made. We welcome the pledge within the NHS Long Term Plan that investment in community and mental health services will grow faster than the overall NHS budget over the coming years. Long-term investment plans are not currently well-developed at a local level however, and commissioners acknowledge that some Trust services are underfunded. Risks exist in relation to securing growth funding across our geography for 2019/20 and we are already seeing significant pressures in meeting demand.

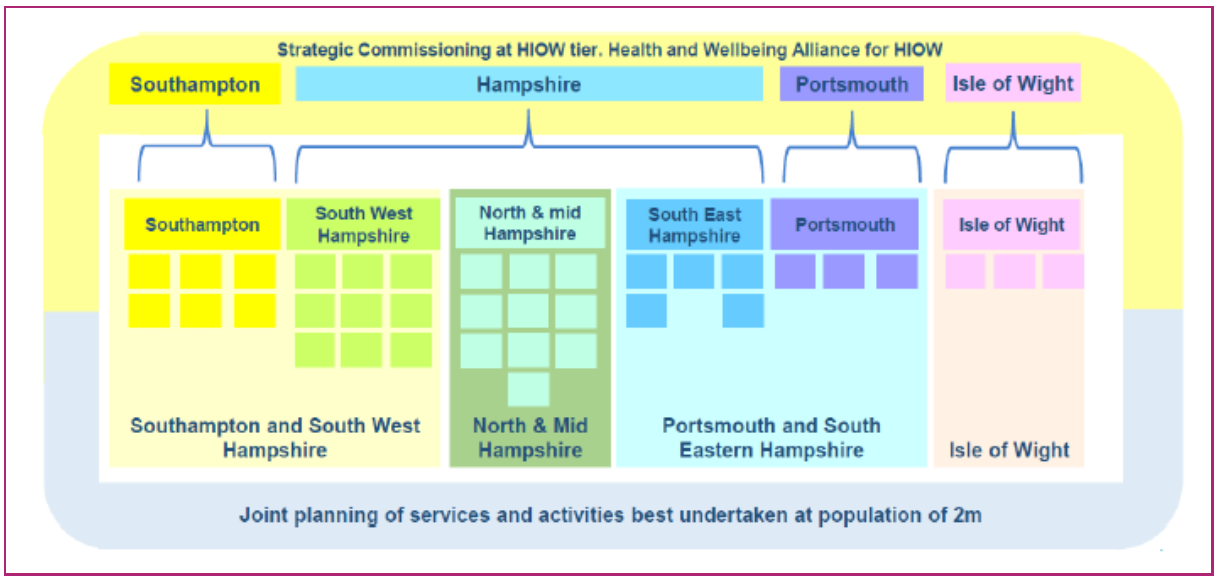
The risks are such that solutions that are more radical in nature will be required over the next few years, which may mean that we will have to reduce, or stop, the provision of some services due to insufficient funds to deliver them safely and effectively. In addition, we will need to continue to work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

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

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

We continue to see the commercial environment evolving and we remain committed to working in collaboration with our health and social care partners within the Hampshire and Isle of Wight Sustainability and Transformation Partnership (HIOW STP) to develop and implement system wide plans, aligned to the NHS Long Term Plan, which will ensure the future sustainability of local health and care delivery systems to meet population need.

The HIOW STP Executive Delivery Group oversee pan-HIOW plans (for example for cancer activity and demand), whereas plans for smaller geographical footprints are developed and managed via Integrated Care Partnerships (ICPs). The following diagram illustrates the current ICPs within the HIOW footprint:



Contracting principles have been established at a HIOW level to assist with ICPs in their approaches, ensuring these are aligned to NHS Operational Planning and Contracting Guidelines for 2019/20.

Portsmouth and South East Hampshire (PSEH) Integrated Care Partnership (ICP)

All organisations with responsibility for health and care in PSEH have come together to deliver a shared set of objectives, which includes commitment to a single system improvement plan to restore and improve service quality, performance and financial health. We have established new ways of working together, with providers and commissioners increasingly taking collective responsibility for population health and resources.

Our Chief Executive, Sue Harriman, is the System Convener for the PSEH ICP and all of the Executive Team and many of the Senior Leadership Team have key roles.

The system has established a supporting governance infrastructure, including;

- an Unified Executive Group, which meets monthly, responsible for the leadership, management and support of the ICP ,
- a Clinical Executive Group, which meets monthly, bringing together the senior clinical leaders from partner organisations and Programme Clinical Leads, and;
- an Operational and Programme Delivery Group, which meets monthly, focusing on system performance and the delivery of clinical and corporate service transformation against the ICP Plan. Additional advisory groups have also been established, including a Non-executive Director and Lay Member Network.

Priority transformation programmes have been identified as follows:

Transformation programme	Focus
Children and Families	• Outpatient avoidance
Mental Health	• Acute Beds Transformation • New Emergency front door
Urgent Care	• Urgent Care Capacity (including Winter Resilience and sustainability) • Emergency Department redesign
Community Health and Care	• Admission Avoidance • Urgent Care Charter
Planned Care	• Outpatient Transformation

The immediate priority is to deliver significant improvements in urgent and emergency care performance. The priorities for mental health are to create a new emergency front door alongside the physical health emergency services at Portsmouth Hospitals NHS Trust, and a collaborative approach to the management of service users needing acute bed admission.

We continue to be engaged in a Multi-speciality Community Provider (MCP) transformation programme within Portsmouth, underpinned by a partnership agreement between the Trust, the Portsmouth Primary Care Alliance, the

local authority and Clinical Commissioning Group (CCG). The programme builds on work already started to integrate community health and social care services at locality level, centred around primary care.

Southampton and South West (SW) Hampshire

Similar work is underway in Southampton, where, as a key partner in the Better Care Southampton transformation programme we are working with partner organisations to formulate a more robust out of hospital operating model that seeks to underpin the STP strategy.

By delivering better integrated out of hospital services we will be able to deliver even better patient outcomes, while also operating more efficiently, establishing a new way of working together with common objectives and accepting collective responsibility for the health and care of the people in the areas we serve.

We remain in discussion with commissioners to ensure that local delivery plans for the Southampton and SW geography are developed in partnership; ensuring investment reflects the commitments made in the NHS Long Term Plan to increase funding in community and mental health services and ensure greater prevention and self-management of illness within the community. You can read about the work we have been undertaking with our partners and alliances in the following section.

The future

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

We also know that during times of change we are open to risk. These include risks concerning ensuring we are able to maintain 'business as usual', attract and retain an engaged workforce, remain a credible partner and continue to strive to achieve excellence in all we do. We must not get distracted. The Board has oversight of our strategic risks, many of which are interdependent, via our Board Assurance Framework and also ensures we have appropriate mitigations in place to manage these, particularly during periods of such significant transformation. Ensuring that Solent provides great care, is a great place to work and provides great value for money remain our priorities.

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

Working with our partners

Southampton and County Services

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

The programme aims to:

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

Within social care

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

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

Within primary care

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

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

Within the secondary sector

We work as a key system partner, supporting colleagues in University Hospital Southampton NHS Foundation Trust (UHS). By establishing strong relationships and transparent partnership working, as well as working in a more integrated way with social care colleagues, we have contributed to the improving position with regards to delayed transfers of care. Our In- Reach Coordinator, based in the hospital actively seeks out service users for discharge and our Community Emergency Department Team works closely with the emergency department and frailty partners to prevent admission through advice and information.

Within our community hospital wards based at the Royal South Hants Hospital, we have implemented a weekly Care

Act compliance meeting, which includes colleagues from social care. Together, by sharing information, we evaluate delays to facilitate discharge. We have also helped to develop the Southampton Integrated Discharge Bureau to become a hub for discharges across the community and acute sector.
We continue to work with our partners to deliver our Homeless Healthcare team, a multi-disciplinary primary care team providing care to homeless people in Southampton.

Portsmouth and South East Hampshire

Solent NHS Trust, via the Portsmouth and South East Hampshire Care Group, continue to engage in strong effective partnerships with the following:

- Clinical Commissioning Group - We have a mature relationship and have invested in a number of joint posts. Together, we have developed a four year plan for transformation and financial planning purpose. This has created an environment of strategic change rather than tactical savings.
- Portsmouth City Council - We now have co-located and integrated services in all key areas of the care group with some joint appointments. We are in active discussion about how to take this further forward to enable full scale integration around neighbourhood teams.
- Portsmouth Primary Care Alliance (PPCA) - We have supported the PPCA in their business development, including providing corporate service support to enable them to be successful in their bid to run 24 services. We have a partnership agreement between the organisations which flags our on-going commitment to improve the capacity and capability of primary care.
- MCP stands for 'Multi-Speciality Community Provider' one of several models of care in the NHS Five Year Forward View. The Portsmouth MCP Programme is a partnership between the Portsmouth Primary Care Alliance, Solent NHS Trust, Portsmouth CCG and Portsmouth City Council. MCP partners have committed to work together to meet the challenges facing health and care services in the city by jointly developing new ways of working and delivering new services, dissolving traditional boundaries between primary, community, and social care.

  Key Drivers include:
  - Portsmouth people wanting "joined up", "co-ordinated" care
  - The need to provide quality services
  - Workforce shortages mean we need to make efficient use of increasingly scarce professionals
  - The need to ensure that services are affordable and sustainable in the future
  - The need to create strength through partnerships in order to support out of hospital delivery for the benefits of those that use our services

  We are:
  - Building an integrated health and care team serving each neighbourhood (Primary Care Network)
  - Supporting people to stay at home
  - Reviewing and integrating urgent and enhanced support services which are better organised across the City or wider area

By March 2019 we achieved the following:

Working in the community

We are committed to involving people, from the full diversity of communities we serve in the development of the Trust and our services.

Community engagement

Community engagement is a core part of how we operate so that it becomes embedded in the culture and practice of the organisation at all levels.

You can find details of our Community Engagement Strategy within the Equality, Diversity and Inclusion section of the Staff Report, and within our Quality Account, Section 5.

Engagement with our Membership

Back in late 2015 we stepped off the Foundation Trust (FT) application pipeline. Since that time we have not actively recruited members, instead concentrating on engaging the registered membership.

In September 2018, we wrote to registered members to share the Trust's future plans for membership and the Trust's formal decision to disband the Members Council, and the role of governors. We confirmed our continued commitment to communicating with, and involving, people who live in the wide range of communities we serve and explained that we want to fully engage local people in shaping and developing our services. We also shared that, as a Trust, we have a renewed commitment to community engagement and that we will be developing our membership, aligned to our Community Engagement Strategy.

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

- published Shine, our newsletter for both staff and public members
- invited members to attend our Community Engagement Event and AGM
- shared information on key topics, including our Care Quality Commission inspection
- offered members the opportunity to volunteer with us
- shared information about various health campaigns.

Our volunteers

You can read more about our volunteers within the Quality Account, Section 5.

Engagement with Health Overview and Scrutiny Forums

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

Southampton (Health Overview and Scrutiny Panel)

- Quality Account
- The closure of Woolston Clinic and the move of Podiatry to Bitterne Health Centre and other locations
- The proposed redevelopment of the Western Community Hospital (via Southampton City CCG)

Portsmouth (Health Overview and Scrutiny Panel)

- Quality Account
- Phase 2 works at St James' Hospital and St Mary's Community Health Campus
- Solent update (July 2018) including: Care Quality Commission inspection, mental health transformation, integrated services in Portsmouth, Solent financial position and forecast, parking, catering and adults services

Hampshire (Health and Adult Social Care Select Committee)

- Quality Account

Charitable funds

Beacon, Solent NHS Charity, raises money for areas not covered or fully supported by NHS funds and aims to make a difference to the experience of service users and staff. This can be anything from improving a waiting area, staff development and recognition, or creating a multi-use outdoor sports area for those staying with us on a longer term basis. Sometimes it is the smallest things that can make the biggest difference.

Whilst we are a relatively small and unknown charity, we are immensely grateful to everyone who has donated money. The donations we received during 2018/19 amounted to £7k. During the year ahead we will be considering how the charity can make linkages with 'in kind' support opportunities to maximise the social impact and outcomes.

Whole system response and emergency preparedness

To ensure that we can continue to provide our priority services should there be an incident, Emergency Preparedness, Resilience and Response (EPRR) for Solent NHS Trust continues as an identified work stream.

During 2018/19, we carried out a number of exercises that facilitated the validation of plans and preparedness; these included:

- Comprehensive winter planning exercises across the key service lines
- Preparation and planning for the possible impacts of a 'no deal' or disruptive exit from the European Union (EU)

Staff were invited to attend scenario based exercises and training was provided by the Emergency Planning Practitioner. Any lessons identified, following these exercises and after incidents, were shared with the wider Trust and any necessary actions taken.

During the year, we also continued to play an active role, and work in partnership with other organisations, to prepare for a critical or major incident including the Local Resilience Forum (LRF). Our Chief Operating Officer for Southampton and County Wide continued to represent us at the Local Health Resilience Partnership (LHRP), whilst our Emergency Planning Practitioner (EPP) regularly attended local health resilience meetings, sharing information with our Emergency Planning Group which meets regularly.

During 2018/19 we have:

- carried out an audit of business continuity plans
- held business continuity exercises to test service business continuity plans especially prior to winter
- participated in a number of exercises, involving the acute trust and partners
- providing regular training for on call staff
- participated in system wide task and finish groups for the psychosocial response to a mass casualty.

We also completed a training needs assessment, and a new training plan has been put in place for the coming year. The plan, which has been built around the training needs of strategic on call participants, is robust and diverse to cover the necessary information. In preparation for a difficult winter, we reviewed and updated our winter plan, ensuring that contingency plans for increased capacity were updated and tested to reflect the possible capacity system challenges.

Each year NHS England (NHSE) assesses us for assurance against the EPRR core standards. In 2018/19, NHSE concluded that we had submitted evidence to demonstrate that we were 'substantially compliant' with the EPRR assurance assessment. NHSE acknowledged the work we had undertaken during the year, this indicates that we have the capability to continue to deliver products and services at predefined levels in the event of a disruptive incident.

Since the Autumn of 2018, we have also been assessing and preparing for the possible impacts of leaving the EU with a 'no deal'. We have been working with managers and staff to ensure that they are aware, and able to mitigate, should the EU exit have any adverse effects on the delivery of our services.

Technology and the digital agenda

We recognise how important the technology agenda is in supporting a digitally fit NHS for the future, in accordance with the NHS Long Term Plan. In year we have invested in a number of initiatives in accordance with our IT Strategy, including:

- Smart Phones Project - which deployed 1496 new smart phones to staff allowing them to use the latest app technologies
- Unified Communications Project - which moved the majority of staff away from physical desk phones, providing significant savings by cancelling legacy phone lines
- Patient Wi-Fi Project - allowing patients to access a safe Wi-Fi solution within our premises
- Windows Advanced Threat Protection Deployment Project - which further protects our IT assets from external cyber threats
- Isle of Wight Dental Service IT Provision Project – we commenced our service provision on the IOW in October last year and since then have successfully migrated our dental services IT infrastructure.

Our services continue to progress innovative working practices using technology, examples include:

- the use of Solent Pulse, a text messaging service used by our School Nursing and Health Visiting Teams
- the establishment of the Healthier Together www.what0-18.nhs.uk website, providing advice for parents, young people and pregnant women as well as clinical resources for professionals, and
- the expansion of our webchat offer for our Contraception and Genitourinary Services, which will be expanded further during 2019/20.

Looking ahead, we will be progressing the following projects;

- Managed Print Project – due for completion summer 2019 which will introduce a more efficient, modern and flexible printing solution across the Trust's estate
- Remote Patient Consultations Project – with our first user due to go live summer 2019. This will allow clinicians to communicate with patients in their own homes via video teleconferencing technology (if both parties feel that is appropriate). This project will be piloted and evaluated over the summer of 2019 and then further rollouts will commence over the next two years.
- Windows 10 Operating System Deployment – due for completion by February 2020, which will move the Trust away from the Windows 7 Operating System before it is obsolete.

We are continuing to work with the STP Digital Transformation Board to enhance interoperability across the wider geographic area and we are working with the Wessex Care Record to allow clinicians to view one clinical record when patients span primary, acute and community care.

Solent news

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

Western Community Hospital £16m investment

In December, the Health Secretary Matt Hancock announced funds for over 70 new estates schemes across the country. We were ear marked £15.8m to develop a 50-bed rehabilitation wing for older inpatients at the Western Community Hospital in Millbrook, Southampton. This investment will enable us to relocate services currently based at the Royal South Hants hospital in Southampton, adding significant value for the Health & Care System, whilst collocating services and enabling a hub of clinical excellence in future proofed, state-of-the-art facilities in the heart of their community. The building work is expected to begin in mid-2020.

Beth Kelly, Diabetes Specialist Nurse; winner of the QiC (Quality in Care) Award for Diabetes Healthcare Professional of the Year 2018

Beth Kelly, Diabetes Nurse, who works as part of a team of fellow Diabetes Nurse Specialists (DSNs), won the QiC Award for Diabetes Healthcare Professional of the Year. She was awarded for her work in establishing the DSN Forum UK. The forum allows diabetes specialist nurses to network at the click of a button, share best practice and to also ask for advice and support.

Launch of the Solent Veterans Programme

In April, Chief Executive, Sue Harriman, pledged our support to the ExForcesNet's Forces4Change Charter and officially launched our Veterans Programme. The programme, which provides support to those from the Armed Forces community who would like to work, gain work experience or to volunteer in our services, brings together our passion to supporting veterans, with the deep commitment in Solent NHS Trust for adding value to individual's lives. Building on our programme we are leading a Portsmouth Military Mental Health Alliance to deliver new services to Armed Forces, Veterans and families. The Alliance which includes Solent Mind, Society of St James, Princess of Wales Rifle Regiment, Portsmouth CCG and ExForcesNet has been awarded £697,188 over two years from the Armed Forces Covenant Trust fund for the provision of 3 services; a veterans service in the Wellbeing Centre, an armed forces curriculum in the Recovery College and a Quick Reaction Force to respond to individuals in crisis.

£10.3m investment at St Mary's

Work on the 'Phase 2' refurbishment of St Mary's Community Hospital Campus (SMCHC), which was one of 40 NHS hospitals and community services that were selected to receive capital funding, began during

2018/19. Sue Harriman, Chief Executive, and Andrew Strevens, Director of Finance, Performance and Estates, 'broke the ground' at SMCHC. The boost in funding is targeted to deliver new consultation rooms, therapy rooms, a wholesale scale pharmacy, a large phlebotomy service, and extended physiotherapy and podiatry services. In recognition of our aging population, our Estates Team are developing dementia friendly and fully accessible environments. Our refurbishment is due to conclude at the end of October 2019.

Launch of Solent Awards

At the beginning of July we launched the Solent Awards, our new recognition scheme. People, including employees and those that use our services, are asked to nominate colleagues/ teams across three categories: Manager of the month, Colleague of the month, Team of the month. The winners are then voted for by Solent employees. In addition, the Executive Team review all nominations and choose two colleagues for a Directors' Choice Award. The winners of a Directors' Choice Award are chosen for the creativity or innovation they have shown, or the difference they have made. Since its launch and inception, The Solent Awards has seen almost 600 nominations come in from colleagues and people who use our services. We have had 27 winners of the Solent Colleague, Manager and Team of the Month Awards and 19 winners of the esteemed Solent Directors' Choice Award respectively and are due to hold our inaugural celebration event in June 2019.

Portsmouth nurse gets Queen's Nurse Award

Kathryn Hammond joined an elite band of healthcare professionals donning the title 'Queen's Nurse' (QN). Kathryn, Child and Adolescent Mental Health Service Modern Matron, was given her title at an invitation-only ceremony event in London last June.

Co-production of animated bedtime routine support for children with learning difficulties

A series of accessible multi- media resources were developed with families of children with learning disabilities and mental distress. The resources aim to help families get access to interim support at home for issues that affect many children but can be made more complicated by learning disabilities. Dr Clare Mander, Allied Health Professional Lead and Clinical Lead for Accessible Information, worked with parents, children and siblings, who have lived experience, to develop and evaluate accessible resources to support and promote self-management whilst families await specialist interventions.

Dedication to supporting young people recognised

Kim Nesbitt, a Young Person's Independent Sexual Violence Advisor (ISVA) received an award for her commendable dedication to helping those who are vulnerable, traumatised or in crisis, following sexual abuse. The award was presented by the Serious Sexual Offences (SSO) Silver Group.

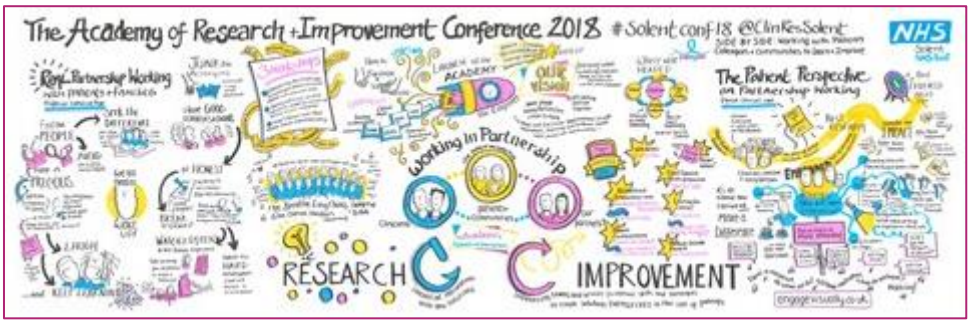
Winter health and care event, Portsmouth Cascades

In January we joined local health and care organisations in the Portsmouth area to host a winter health and care event. The informal event, which took place in the Cascades shopping centre in central Portsmouth, was open to anyone who wanted to drop-in for information about a number of health and care services and new initiatives. There were also opportunities for people to talk with stall holders about a wide range of issues to do with local healthcare and find out more about how they can help people to stay well during the colder months.

Research league tables

In August, we were named as the top performing Trust for both the number of active participations and the volume of research projects, with over 2,000 participants taking part in 55 studies via our Academy of Research. This impressive portfolio increased by 55%, reflecting both the quality and variety of research.

Research and Improvement (R&I) Conference



Our 8th Research and Improvement conference was held in July, in conjunction with 'Side-by-Side' – a dedicated group of individuals that give a patient and public perspective to our work. For the second year, the conference was accredited as 'Patients Included'. This means that the conference was planned and delivered in partnership with patients. Around 180 people attended the event with a number of stands, keynote talks, presentations, workshops and delegates showcasing a number of improvement projects covering research, quality improvement, audit and innovation.

Two nurses scoop prestigious awards

Two of Solent's nurses picked up awards at the Nursing Times Awards during October.

Debbie Fudge, Tuberculosis (TB) Liaison Nurse, won the Infection Prevention Award, and Sharon Simpson, Older Person's Mental Health (OPMH) Research Nurse, won the Clinical Research Nursing Award.

The Nursing Times Awards brings together nurses and organisations from across the profession to celebrate and honour achievements in the field.

Digital innovation for children and families

Parents and young people can now text the School Nursing and Health Visiting Team to get a response from a qualified nurse, thanks to Solent Pulse, a text messaging service. The service gives more choice about how children

and families can contact health professionals and saves people from needing to request additional home visits or attend a drop-in clinic.

In addition, our Children's Services have worked with partners from across Hampshire and the Isle of Wight to create Solent NHS Trust webpages on the established 'what0-18' website. The website, which focuses on improving the health of children and young people, is available to people in Dorset, Hampshire and the Isle of Wight. The resources on the website have been developed by healthcare professionals to provide reliable information and to help people decide if their children need to be seen by a healthcare professional and if so, how urgently.

Care at Christmas

During the run-up to Christmas, last year, we focused heavily on communicating #CareAtChristmas, reiterating our commitment to keeping more people healthy, safe, and independent in or close to their own home. As part of this focus, we worked with local media outlets to tell the story of Solent nurses who would be working in the community, on and over, the festive period. BBC South interviewed Children's Community Nurse, Lorraine Bishop, and one of her patients, George. A truly inspirational service user and his mum talked about his four year experience of Cancer and excellent treatment he received from Lorraine. This interview was particularly poignant, as it talked about keeping children at home at Christmas, wherever possible. In a similar vein, the interview with Crisis Clinical Manager, Kylie Witkowski and a Peer Mentor for Solent NHS Trust and our partners, Solent Mind, talked about the urgent care that may be required at Christmas and how lived experience can create a recovery journey.

Celebrating NHS70

In July the NHS celebrated its 70 birthday. Solent colleagues, service users and volunteers took part in a range of celebratory events. A garden party was held for long service colleagues and for people who had won a special award, and Solent's Big70tea parties were very well attended. We also launched a series of

NHS70 films to demonstrate some of the many roles in our Trust and the difference our team make, we visited West Quay Shopping Centre with NHS partners, and the Chief Nurse paid a special visit to year 2 children at a local school to talk about all the different people who keep the NHS running. The children also learnt about the importance of hand washing and took part in an NHS themed craft.

As well the many events, we were pleased to be able to celebrate some of our long serving colleagues who were nominated to attend celebratory services at Westminster Abbey, Winchester Cathedral and York Minster.

We were incredibly proud of Rose Bennett, a domestic assistant at St James' Hospital, who won the Lifetime Achievement Award at the NHS70 Parliamentary Awards. Rose's success and the Awards were covered by the local and national media.

Going concern

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

Performance Analysis

Performance Measurement

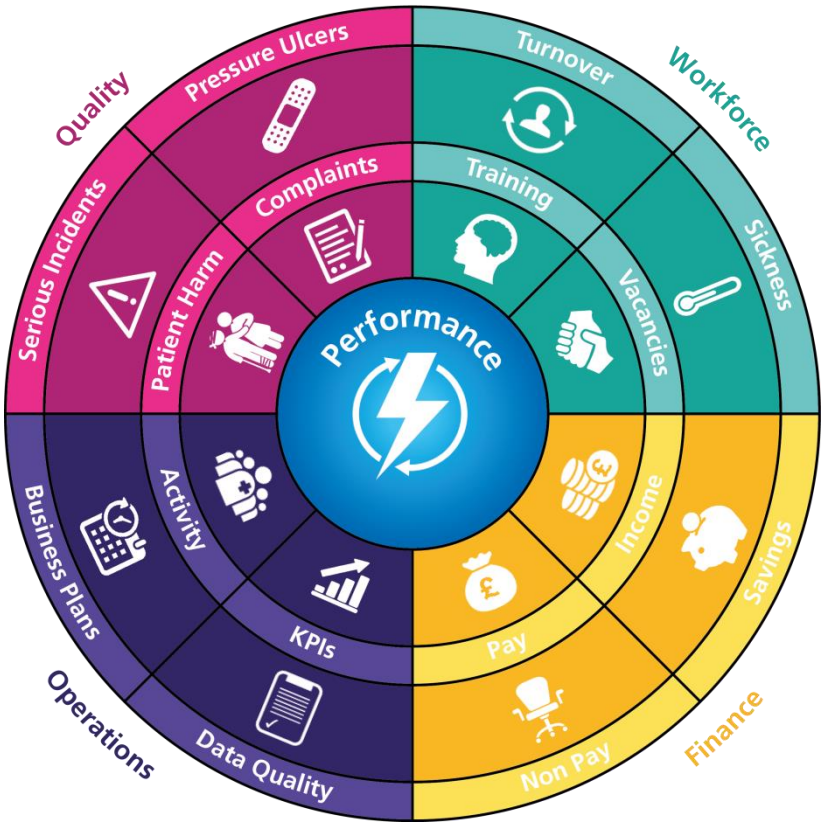
We record and report a range of data on a monthly basis for all of our services. The information is used to help us provide internal intelligence and assurance that our services are delivering safe, effective and efficient care as well as to our commissioners, regulators and the public.

During 2018/19, we increased our reporting to 586 external Key Performance Indicators (KPIs), 1133 individual reporting indicators and 46 audits, across 12 commissioning organisations – together these help services and commissioners monitor our performance against the standards of care expected and services commissioned.

Throughout the year, we have maintained the performance governance structure which has been in place for the last two years. This consists of Performance Review Meetings with each clinical service line where exceptions are escalated to executives for oversight, assurance and discussion. The Performance Review Meetings scrutinise service level performance against a range of operational, financial, quality and workforce metrics, as well as monitoring identified hotspot areas where performance concerns have been raised.

In addition to the above for our clinical services, performance reviews of corporate services (our non-clinical support services) have also continued throughout 2018/19. The meetings review and discuss a range of data detailing financial and workforce performance of each corporate team. This year has seen the addition of deep-dives onto the Corporate Review Meeting agenda. This provides an opportunity for each team to present their priorities and workload to the group, and gives the other corporate teams a forum to discuss and feedback. The performance meetings are held monthly with formal exception reports submitted to the Trust Management Team (an executive committee).

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



Activity Review

A breakdown of patient contacts and occupied bed days by service line is illustrated in the following table:

Service Line	Contacts	Inpatient Occupied Bed Days	Total
Adult Mental Health	35,581	20,522	56,103
Adult Services, Portsmouth	207,306	13,756	221,062
Adult Services, Southampton	290,028	21,707	311,735
Child and Family Services	196,285	0	196,285
Special Care Dental Services	51,715	0	51,715
Primary Care and Long Term Conditions Services	194,578	0	194,578
Sexual Health Services	106,478	0	106,478
	1,081,971	**55,985**	**1,137,956**

We have seen an increase of 8% in activity compared to 2017/18, predominantly within our community based services. This growth is reflective of the NHS Long Term Plan's ambition to shift activity out of hospital and into community based care settings. The largest areas of growth have been seen within our Adults Services in both Portsmouth and Southampton, demonstrating the burden placed upon services such as community & district nursing as a result of the aging and growing population.

We successfully achieved the national standards for Referral to Treatment (RTT) within 18 weeks for another year. Due to the community nature of services provided by us, there are only a few services which are applicable to the national RTT standards. A breakdown of related performance for 2018/19 is illustrated in the following table:

RTT standard	Number of compliant referrals	Total number of referrals	Performance
Part 1B – Complete Outpatient	7,685	7,720	**99.5%**
Part 2 – Incomplete	12,785	12,856	**99.4%**

NHS Improvement Single Oversight Framework

The NHS Improvement Single Oversight Framework (SOF) provides the framework for overseeing organisations and identifying potential performance concerns by NHS Improvement (NHSI). We continued to assess ourselves against the standards set out, regularly utilising the national Model Hospital tool for benchmarks. We have maintained our 'Level 2' organisational grading, where Level 1 is the best and Level 4 indicates an organisation that is most challenged. We believe this is a positive position for us and our inability to achieve a Level 1 rating to date has predominately been caused by our previously forecasted in-year financial deficit, however, in light of our year end position our regulator may wish to consider our organisational grading moving forward.

The Single Oversight Framework covers five themes:

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

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

Overall, we have performed well against the majority of metrics included within the NHSI SOF. The following commentaries provide detail on areas of exception.

Quality of Care Metrics:

The measure of 'Quality of Care' includes the CQC's most recent assessment of whether our care is safe, effective, caring and responsive as well as in-year information where available. NHSI have also set some indicators under this domain and our performance is summarised as follows;

Organisational Health

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Staff sickness (in month)	4%	4.2%	3.7%	3.6%	3.7%	3.7%	3.9%	4.3%	4.6%	4.5%	4.9%	4.5%	4.3%
Staff turnover (rolling 12 months)	12%	14.2%	13.9%	13.9%	14.0%	14.1%	14.1%	14.0%	14.0%	14.1%	14.1%	14.4%	14.2%
Staff Friends & Family Test - % Recommended - Employer	80%			69.0%			71.2%						69.0%
Proportion of Temporary Staff (in month)	6%	5.6%	4.9%	5.7%	5.9%	5.9%	5.8%	5.7%	6.1%	6.2%	5.7%	5.9%	5.9%

Although in some months we have not met the aspirational target of 4% for sickness, compared to the national Community Trust Indicator benchmark average of 5%, we have achieved below this all year and have achieved the second lowest rate of all participating Trusts over the past 6 months of the year.

The Trust turnover rate has remained between 13%-15% all year, averaging at 14.1%, which is marginally below the national Community Trust Indicator benchmark average of 14.2%.

You can read more about our staff retention programme and our health and wellbeing improvement plan within the Staff Report section of the Annual Report.

Caring

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Written Complaints		19	27	17	20	17	12	23	17	14	17	15	18
Staff Friends & Family Test - % Recommended - Care	80%			84.0%			84.7%						86.6%
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Friends & Family Test - % positive	95%	95.4%	96.4%	96.4%	96.0%	96.1%	95.9%	96.6%	96.4%	96.0%	97.1%	97.2%	96.0%
Mental Health Friends & Family Test - % positive	95%	74.7%	71.2%	88.3%	89.0%	85.7%	100.0%	90.6%	91.0%	88.0%	84.7%	90.9%	92.1%

Compliance against the Caring domain is positive overall with no significant concerns. Due to the nature of our

Mental Health Services, the Friends and Family Test (FFT) scores are generally lower than Community services FFT scores. The NHS Benchmarking Network's most recent mental health FFT benchmark was 88% (2017/18). After targeted work by the service line during the year to increase FFT responses, we achieved above this for two thirds of the year.

Effective

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	100%	100%	98%	100%	100%	97%	100%	100%	100%	100%
% clients in settled accommodation		74%	75%	80%	79%	79%	82%	83%	84%	85%	84%	84%	84%
% clients in employment	5.0%	4.4%	5.0%	5.8%	6.0%	5.9%	6.7%	6.2%	5.5%	4.8%	5.2%	5.0%	5.1%

The standards required to meet the metrics under the Effective domain were met in most months throughout the year.

Safe

The only area of concern within the Safe domain is VTE Risk Assessments for our Inpatient Wards. Our mental health wards and service line are reviewing their processes to ensure compliance is improved during 2019/20.

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Occurrence of any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
NHS England/ NHS Improvement Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE Risk Assessment	95%	91.0%	99.0%		91.0%	98.0%	96.0%	93.0%	94.0%	92.0%	91.0%	93.0%	90.0%
Clostridium Difficile - variance from plan	0	0	0	0	0	0	0	1	0	1	0	0	0
Clostridium Difficile - infection rate	0	0	0	0	0	0	0	1	0	1	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E.coli) bacteraemia bloodstream infection	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	0
Admissions to adult facilities of patients who are under 16 yrs old	0	0	0	0	0	0	0	0	0	0	0	0	0

Operational Performance Metrics:

NHSI have determined a number of key metrics in accordance with NHS Constitutional standards. Our performance against these are summarised as follows;

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	99.5%	99.8%	99.4%	99.7%	99.1%	99.4%	99.6%	99.7%	99.6%	99.3%	99.0%	98.8%
Maximum 6-week wait for diagnostic procedures	99%	99%	99%	100%	100%	100%	97%	99%	96%	98%	97%	99%	98%
Inappropriate out-of-area placements for adult mental health - services - Number of Bed Days	0	0	21	71	122	116	19	0	0	0	0	0	0
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	75.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	60.0%	50.0%	100.0%	67.0%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%			97.2%			97.2%			TBC			TBC
Improving Access to Psychological Therapies (IAPT)													
- Proportion of people completing treatment moving to recovery	50%	51.1%	56.1%	60.4%	61.9%	58.7%	61.2%	55.9%	59.7%	55.3%	62.3%	50.2%	58.1%
- Waiting time to begin treatment - within 6 weeks	75%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	99.7%	98.0%
- Waiting time to begin treatment - within 18 weeks	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Overall, compliance against the Operational Performance theme is positive with the only exceptions outlined below.

We have faced some performance challenges over the year with a third party supplier in relation to the 6 week waiting time target for diagnostic procedures for our MSK services. We are continuing to work closely with the provider to minimise delays and improve performance moving forward.

Earlier in the year we had to temporarily reduce out capacity on the Maples Ward (our Psychiatric Intesive Care Unit) due to remedial works after a patient incident which caused damage to the estate. Consequently, this led to a number of people who use our services at the Unit being placed out of area between May and September whilst the work was undertaken.

The 'Operational Performance' metrics outlined within the table do not provide an overall performance assessment for the Trust, however based on our performance against these metrics and defined thresholds, NHSI consider whether support or intervention is required. During 2018/19 we did not receive any support from NHSI in relation to our performance against these metrics.

Strategic Objectives Achievement

We began the year with 61 strategic objectives planned for delivery against our second year of our Operating Plan (2017-19). These objectives were further split into 375 respective milestones managed locally by service lines and corporate teams - progress is monitored against agreed objectives monthly at performance meetings.

Solent NHS Trust Priorities and the Solent Story

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

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

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

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

Our key successes

The following section illustrates a few examples where we can demonstrate we have delivered against our strategy.

Service line: Adults Southampton
Objective: We will work with system partners to reduce admissions and Delayed Transfers of Care (DTOCs) by supporting system integration and cluster development by March 2019

The Adults Southampton team have worked closely with system partners to support the drive to reduce DTOCs in order to support patient pathways and release system pressures. Services were reviewed in 2018-19 and new processes and models of care introduced. Success of this has been widely received and also resulted in Adults Southampton achieving positive feedback in the Partner Organisation report for UHS Complex Patient Discharges.

Service line: Sexual Health
Objective: We will control the demand for our clinical face to face services by expanding our Webchat offer for our contraception and Genitourinary services by March 19

To help manage the increased demand within Sexual Health Services, a Webchat facility was created, which went live in October 2018 in order to provide a safe and secure platform for users to access live chat as well as a 24/7 'need help' function. This functionality has shown that patients are accessing the 'need help' function at a variety of times and 10-12% of patients are opting to chat to an operator. This service enables harder to reach groups to contact us via Webchat, as many communities still attach stigma to sexual health and therefore may not readily access mainstream services that are available. Due to the success of this objective, this facility will be expanded further throughout the service in 2019-20.

Service line: Child & Family
Objective: Patient experience will improve where services are delivered by more than one provider at the same time by March 2019

As a way of improving patient experience where services are delivered by more than one provider at the same time, the Child and Family Service successfully delivered the Enhanced Child Health Visiting Offer (ECHO) programme which enables a more intensive home visiting programme for children up to the age of 5 for our most vulnerable families. Positive feedback has been received from families and staff as well as commissioners for this programme. The service has also made progress through engaging external researchers to support evaluation and research into the success of this programme.

2019/20 – A Look Forward

After successfully being awarded funding from NHS Digital, we are undertaking a trust wide project to optimise our main clinical record system which will improve data quality, provide a foundation for standardised reporting and introduce a business intelligence portal for the first time. This will enable our services to manage their business through self-service and a restructured Performance Team to meet their needs.

Our CQC Inspection Results

You can read about our CQC inspection results in the Quality Account, Section 5.

Environmental Reporting

We developed a Sustainable Development Management Plan that aligns with the NHS Standard Contract, specifically the 'Service Contract item SC18 – Sustainable Development' and this was reviewed and updated in July 2018.
We are committed to being a leading sustainable healthcare organisation, and to carrying out our business with the minimum impact on the environment. Our Sustainable Development Management Plan (SDMP) priorities are:

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

During 2018/19, across the Trust we:

- Reduced total waste volumes compared with 2017/18. Our waste to landfill volumes decreased during 2018/19 and our target for 2019/20 is to achieve zero waste to landfill
- Improved our mixed waste recycling; our target for 2019/20 is to separate out our waste streams where possible to enable independent recycling of waste paper and cardboard
- Invested over £142K in energy efficiency measures
- Involved staff in a Green Impact campaign to raise awareness and generate environmental improvement actions; and
- Introduced initiatives to make our procurement more sustainable.

We will be implementing our refreshed Access & Transport Policy during the year ahead which will assist us in our aspiration to reduce single occupancy car travel and increasing cycling in conjunction with our Sustainable Travel Plan. We are working closely with the 'My Journey' programme across Hampshire, Portsmouth and Southampton to raise awareness of alternative transport options and to secure grant funding to support the implementation of new initiatives. Behavioural change remains one of the main challenges to this being successfully implemented.

On an annual basis we complete the Sustainable Development Unit report, supported by ERIC returns (Estates Return Information Collection) and from data provided through our energy bureau. This is in line with our Carbon Reduction Action Plan, to meet our mandatory sustainability reporting requirements. We use the Model Hospital reports to review our performance against published benchmark information and our peer groups.

In addition, on a monthly basis, we monitor our waste disposals and utilities consumption. Our utilities consumption is compared with previous year's usage and adjusted using degree day data[1] to ensure economic efficiencies and to track consumption in line with our carbon reduction targets. Our waste disposal locations are monitored to ensure minimal waste to landfill, and to track increasing recycling rates. We work with our waste contractor to increase segregation to improve recycling rates, and with their subcontractors to increase clinical waste residues to R1[2] recovery facilities, instead of previous landfill sites. Changes to our cleaning methodology will further support improvements in waste segregation and recycling rates in 2019/20. With the agreement of the Environment Agency, the waste contractors permit was enhanced allowing offensive waste to also be disposed of and recovered, via R1 facilities. We will be reviewing our waste contract during the year ahead to explore opportunities with our partners and will also be considering our utilities contract to ensure we achieve best value for money and ensure continued improvement with accuracy in monitoring our consumption. This will inform future capital investment decisions to reduce energy consumption and delivery of a sustainable estate.

Artists' impression of St Mary's Community Health Campus Phase 2 development

Artists' impression of St Mary's Community Health Campus Phase 2 development

In accordance with the HM Treasury Sustainability Reporting Guidance, our Carbon Reduction Action Plan addresses the minimum requirements concerning Green House Gases (GHG) including Scope 1, (direct GHG emissions), Scope 2 (energy indirect GHG emissions), and Scope 3 (Other Indirect GHG emissions) as well as Finite Resource Consumption including estates water consumption, via our ERIC return (measured in cubic meters).

We are committed to sustainable procurement practices and all new contracts are issued in accordance with NHS Terms and Conditions. By ordering our goods via a supply chain we minimise fleet mileage, deliveries, congestion and associated pollutants.

The Performance Report is signed by

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

[1] Degree day data enables an accurate assessment and comparison of energy consumption to be made making due allowance for weather conditions in any given period.
[2] R1 recovery facilities use waste to generate energy

Section two:

Accountability and Corporate Governance Report

Directors' report

Governing our services

Our Board of Directors

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

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

- 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, and
- ensuring the management of staff welfare and patient safety.

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

The Board meets formally every other month In-Public. Additional meetings with Board members and invited attendees are held following In-Public meetings to discuss confidential matters. The Board also holds confidential seminar (briefing) meetings /workshops 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 are the Chief Executive Officer, the Director of Finance, Performance and Estates, the Chief Medical Officer, the Chief Nurse and the Chief People Officer. Together with the Chief Operating Officer for Portsmouth and Commercial Director and the Chief Operating Officer for Southampton and County Services, they bring a wide range of skills and experience to the Trust enabling us to achieve balance at the highest level. The structure is statutorily compliant and considered to be appropriate. The composition, balance of skills and experience of the Board is reviewed annually by the Governance and Nominations Committee.

Appointments

Executive director appointments

In December 2017 Jackie Ardley was appointed as Interim Chief Nurse and following a substantive recruitment process which commenced in Quarter 4 2017/18, Jackie was appointed permanently into the role of Chief Nurse, from 1st May 2018.

Non-executive director appointment

During 2018/19 there were no new NED appointments. However, Alistair Stokes, Chair, informed us of his intention to retire at the natural end of his tenure, 31st March 2018, following 8 years of Chairmanship of Solent NHS Trust and prior to that as Chair of our predecessor organisation. As such a recruitment progress supported by Odgers Berndston was initiated in Quarter 3 2018/19 with NHS Improvement appointing to the position in January 2019. Our new Chair Catherine Mason, joined on 1st April 2019.

Our Directors

Our Non-executive Directors

Dr Alistair Stokes, Chair (retired 31st March 2019)

Alistair was appointed to the Trust in April 2011. He has had a wide ranging career in marketing, business development and administration in the chemical and pharmaceutical industries including working as Commercial Director with Monsanto Company and as Managing Director for UK operations and subsequently Regional Director for the Far East and South East Asia for Glaxo PLC. From 2007, Alistair served as Chairman of the Ipsen Group's UK companies, retiring from that role in 2010. Alistair also served as Regional General Manager for the NHS in Yorkshire and for several years as a member and Vice Chairman of a District Health Authority and from 1992 until 1998 as Chairman of an NHS Trust. He is a Fellow of the Institute of Directors and a Chartered Director. Alistair was the lead NED for Health & Safety (including Local Security Management). Alistair retired on 31st March 2019, at the natural end of his tenure.

We would like to thank Alistair for his dedication and commitment to the Trust over the years. Alistair is one of the longest serving members of the Board, and together with the Board and wider Executive Team, has lead the Trust through a number of significant changes, including establishing Solent NHS Trust as a standalone organisation in 2011, and more recently supporting our continued journey of transformation; joining up care when it makes sense to do so. Alistair retires from the Trust at a time when we are in a strong position; rated 'Good' by the Care Quality Commission with 'Outstanding' care and with a positive working culture, reflected in our NHS Staff Survey results. The Trust also has strengthened financial governance and stability, all of which are a testament to Alistair's leadership of the Board and steadfast support.

Mick Tutt, Deputy Chair and Non-executive Director

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

Jon Pittam, Senior Independent Director and Non-executive Director

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

Mike Watts, Non-executive Director

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

Professor Francis Davis, Non-executive Director

Francis was appointed to the Trust in October 2016. Francis grew up and volunteers in Portsmouth where has been an employer for thirty years, a Visiting Fellow in the Business School and on the Portsmouth (Church of England) Diocesan Board for Social Responsibility. He lives in central Southampton where his family attend city schools and GP practices, and he is a governor of Southampton City Further Education College. He is currently Professor of Communities and Public Policy at the University of Birmingham and is internationally recognised as an expert on aspects of disability, the social inclusion impacts of faith and migrant communities, civic innovation and anchor institutions. He has lived experience as a carer and of mental ill health and a strong personal interest in the health needs of survivors of crime, veterans, health inequalities and how the county's natural, marine and open space resources can contribute to recovery of body and mind. Formerly a private sector CEO Francis has chaired industry bodies for the South and South East, worked as a senior civil servant at Cabinet level and is a regular advisor to Chartered Institute of Public Finance and Accountancy (CIPFA), ComRes, Whitehall, Westminster, City Mayors, local government and international bodies. Francis chairs the Finance Committee and the Charitable Funds Committee and is also an Associate Hospital Manager.

Stephanie Elsy, Non-executive Director

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

Looking forward - our new Chair

Catherine Mason, Chair (from 1st April 2019)

Catherine joined us as Chair from 1st April 2019. Prior to this Catherine was a Non-executive Director of University Hospital Southampton NHS Foundation Trust between March 2018 - March 2019.
Catherine has experience of working in the transport, consumer goods and healthcare sectors. She held senior roles within marketing for blue chip companies, was the Group Chief Executive of Translink, a public transport organisation in Northern Ireland and was Managing Director of NATS (National Air Traffic Services) Services division, the leading provider of air traffic control services. Catherine moved into healthcare in 2016 when she was appointed as Chief Executive for Allied Healthcare, the UK's largest provider of care at home, and then joined Spire Healthcare as Chief Operating Officer. Living locally, Catherine is committed to improving the healthcare of local communities and believes there are many opportunities for community and mental health services to drive system transformation.

We look forward to working with Catherine and warmly welcome her to Solent.

Our Executive Directors

Sue Harriman, Chief Executive

Sue trained as a nurse in the Royal Navy. During her 16 year military career, she worked in both primary and secondary care, including spending five months on board a hospital ship during the 1990 Gulf War conflict.
Sue was a trained critical care nurse for a number of years, and after completing a BSc in Infection Prevention at the University of Hertfordshire, joined the NHS in 2002 to become a Nurse Consultant in Infection Prevention. Sue has developed a management and leadership portfolio that includes attending Britannia Royal Naval College, Dartmouth, and gaining Masters level Management and Leadership qualifications at the University of Southampton.
Sue has been an Executive Board Director for 10 years. Her executive roles have included Director of Nursing and Allied Health Professions, Chief Operating Officer and Managing Director. Sue was appointed to lead Solent NHS Trust as Chief Executive in September 2014.
Sue has lived and worked, locally, in Hampshire since her military career brought her here nearly 30 years ago. She is committed to bringing health and care services together so they work in partnership with the community, and those who use and work with them.
As the Chief Executive, Sue believes her role is to empower the Trust to provide the best care possible, for its team of staff to feel supported and happy at work, whilst ensuring the Trust always offers best value for money.
Sue says, "I feel very privileged to be leading Solent NHS Trust at this time, I will never forget my roots as a nurse, caring for people and their families and friends at such important times in their lives. I became a nurse because I cared deeply about helping others, now as a Chief Executive I will do everything I can to make sure our team at

Solent can always continue to care with compassion, and be the best they can whilst providing the care their service users want and need."
Sue is also the nominated System Convener for the Portsmouth & South East Hampshire Integrated Care Partnership.

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

Andrew is the Director of Finance, Performance and Estates and joined the Trust in August 2015. His formative years were in Southampton, being educated in local state schools.
He has worked within the health service since 2009 and brings a whole system view, having worked in senior positions for providers (Hampshire Community Health Care and Southern Health) and as a commissioner (NHS England South Region). He also has a commercial background, having worked for KPMG and B&Q Plc. Andrew is passionate about ensuring the maximum benefit from the resources available.

Dr Daniel Meron, Chief Medical Officer

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

Sarah Austin, Chief Operating Officer Portsmouth and Commercial Director

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

Jackie Ardley, Chief Nurse

Jackie has over 40 years experience in the NHS as a nurse. She commenced her career in Critical Care, working across the health system in General Nursing, Primary Care and Mental Health and Community Services. In 2001 Jackie spent seven years working on national service redesign programmes, leading a number of successful initiatives within a number of roles including Director of Service Improvement and a Regional Director post in Improvement Partnerships. Jackie has worked as Chief Nurse in Leicestershire Partnership NHS Trust. She is passionate about improving service users and their families experience across health and social care. Jackie joined us in December 2017 as Interim Chief Nurse and was substantively appointed in May 2018.

David Noyes, Chief Operating Officer Southampton and County Wide Services

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

Helen Ives, Chief People Officer

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

difference to the communities we serve and deliver great care. She is also the executive lead for workforce planning, ensuring we have a sustainable workforce plan that enables us to deliver our services.

Board development and performance evaluation

The Board of Directors keeps its performance and effectiveness under on-going review.

The Board holds seminar and workshops every two months to focus on educational, developmental and strategic topics. Educational sessions in year have included Lord Carter recommendations and demonstrations of the Model Hospital, a briefing on Quality Improvement from NHS Elect, a session on understanding the external context by NHS Confederation and a session on the Social Value Act, as well as receiving training in Safeguarding.

Board members have continued to embed the agreed outcomes of the board development programme and have invested workshop time on key topics such as Diversity and Inclusion. The Board will be reviewing skills and competencies in the year ahead to inform a new developmental programme. External expertise will be used to support delivery.

The Trust also conducted regular self- assessments in year against the NHSI and CQC 'Developmental reviews of leadership and governance using the Well- Led Framework: guidance for NHS Trusts and NHS Foundation Trusts' consequently a robust action plan has been developed to address any areas requiring attention. The Board acknowledges the requirements of the guidance to conduct an independent assessment and will do so within the prescribed timeframe, and in consideration of our new Chair appointment.

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.

Individual Board members are appraised annually.

Declaration of interests and Non-executive Director Independence

The Board of Directors is satisfied that the Non-executive Directors, who serve on the Board for the period under review, are independent, with each Non-executive Director self-declaring against a 'test of independence'.
The Board of Directors are also satisfied that there are no relationships of circumstances likely to affect independence and all Board members are required to update their declarations in relation to their interests held in accordance with public interest, openness and transparency.

Name	Interest registered
Dr Alistair Stokes Chairman	No interests to declare
Jon Pittam Non-executive director	No interests to declare
Mick Tutt Non-executive director	Pelican Consulting – sole trader offering management advice and support to health and social care organisations
Francis Davis Non-executive director	Employer: • University of Birmingham – 3 days per week • Advisor to CIPFA Consulting • TEAR FUND Directorships: • Near Neighbours • Power 2 Inspire • Southampton City College Trustee: Cathedral Innovation Centre
Stephanie Elsy Non-executive director	Directorship: • Emsworth Forum Ltd • Community Development Finance Associate Ltd Directorship /Company Ownership: Stephanie Elsy Associates Chair of Emsworth Neighbourhood Forum
Mike Watts Non-executive director	Directorship: • Capability and Performance Improvement Ltd • Trojans Sports Club Project work for various external clients and occasionally other trusts 1 day workshop consultancy with Staff Side Unions at North Hants Hospital
Sue Harriman Chief Executive Officer	No interests to declare
Helen Ives Chief People Officer	Directorship/Company Ownership – Helen Ives Ltd
Andrew Strevens Director of Finance, Performance and Estates	No interests to declare
Dan Meron Chief Medical Officer	• Honorary Deputy Medical Director – University Hospital Southampton • Honorary Consultant Psychiatrist – Southern Health NHS FT • Honorary Clinical Senior Lecturer – University of Southampton • Fellow of Royal College of Psychiatrists • Member of British Medical Association (BMA)
Jackie Ardley Chief Nurse	No interests to declare
Sarah Austin Chief Operating Officer - Portsmouth &Commercial Director	• Co-author of the Forces4Change charter -no personal monetary interest currently. • Friend is owner of ExForcesNet • Daughter is a regular volunteer for Solent MIND with whom Solent holds subcontract • Family friend senior officer at CGI – not dealing with Solent Account • Family friend working at Capticks – not dealing with Solent Account
David Noyes Chief Operating Officer – Southampton	Vice Chair of Southampton Connect

Information Governance

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

Statement of Accountable Officers Responsibilities

The Statement of Accountable Officers Responsibilities is located on page 75.

Modern Slavery Act 2015 – Transparency in Supply Chains

Our modern slavery statement can be found within our Publication Scheme on our Public Website.

The Board's committees

The Board has established the following committees:

Statutory committees

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

Designated committees

- Assurance Committee
- Finance Committee
- Mental Health Act (MHA) Scrutiny Committee
- People and Organisational Development (OD) Committee
- Community Engagement Committee

Composition of Board committees at 31 March 2019

Director	Position	Board	Finance Committee	Remuneration Committee	Assurance Committee	MHA Scrutiny Committee	Governance & Nominations Committee	Audit and Risk Committee	Charitable Funds Committee	People and OD Committee	Community Engagement Committee
Alistair Stokes	Chairman	Chair	-	Member	-	Member (AHM)	Chair	-	-	-	-
Mick Tutt	Deputy Chair/ Non-executive Director	Member	-	Member	Chair	Chair	Member		Member	-	-
Jon Pittam	Senior Ind. Director / Non-executive Director	Member	-	Member	*As appropriate*	Member (AHM)	Member	Chair	-	-	-
Francis Davis	Non-executive Director	Member	Chair	Member	Member	Member (AHM)	-		Chair	Member	Member
Mike Watts	Non-executive Director	Member	Member	Chair	Member	-	-	Member	-	Chair	-
Stephanie Elsy	Non-executive Director	Member	Member	Member	-	-	-	Member	-	Member	Chair
Sue Harriman	Chief Executive	Member	Member	-	Member	-	Member	-	-	-	-
Andrew Strevens	Director of Finance	Member	Member	-	-	-	-	-	-	-	-
Dan Meron	Chief Medical Officer	Member	-	-	Member	Member	-	-	-	-	-
Jackie Ardley	Chief Nurse	Member	-	-	Member	Member	-	-	-	Member[3]	Member
Helen Ives	Chief People Officer	Member	-	-	-	-	-	-	-	Member	-
David Noyes	COO Southampton & County Wide	Non – voting member	-	-	Member	Member	-	-	Member	-	-
Sarah Austin	COO Portsmouth & Commercial Director	Non – voting member	-	-	Member	Member[4]	-	-	-	-	-

[3] Or Head of Professional Standards
[4] Or Deputy COO

Attendance at Board committees at 31 March 2019

Director	Position	Board	Finance Committee	Remuneration Committee[5]	Assurance Committee	MHA Scrutiny Committee	Governance & Nominations Committee	Audit and Risk Committee	Charitable Funds Committee	People and OD Committee	Community Engagement Committee
Alistair Stokes	Chairman	4/5	-	1/1	-	3/4	3/3	-	-	-	-
Mick Tutt	Deputy Chair/ Non-executive Director	5/5	-	1/1	9/9	4/4	3/3	-	2/3	-	-
Jon Pittam	Senior Ind. Director / Non-executive Director	4/5	-	1/1	4/9 *As appropriate	3/4	2/3	3/4	-	-	-
Francis Davis	Non-executive Director	4/5	6/7	1/1	6/9	3/4	-	-	3/3	2/4	3/6
Mike Watts	Non-executive Director	4/5	4/7	1/1	7/9	-	-	3/4	-	4/4	-
Stephanie Elsy	Non-executive Director	4/5	7/7	1/1	-	-	-	4/4	-	3/4	6/6
Sue Harriman	Chief Executive	5/5	4/7	-	6/9	-	3/3	-	-	-	-
Andrew Strevens	Director of Finance	5/5	7/7	-	-	-	-	-	-	-	-
Dan Meron	Chief Medical Officer	5/5	-	-	7/9	2/4	-	-	-	-	-
Jackie Ardley *Started 01/05/2018*	Chief Nurse	5/5	-	-	7/9	1/4	-	-	-	-	6/6
Helen Ives	Chief People Officer	4/5	-	-	-	-	-	-	-	4/4	-
David Noyes	COO Southampton & County Wide	4/5	-	-	9/9	2/4	-	-	3/3	-	-
Sarah Austin	COO Portsmouth & Commercial Director	5/5	-	-	7/9	2/4	-	-	-	-	-
	Total number of meetings in 2018/19 held	5	7	1	9	4	3	4	3	4	6

[5] Two separate virtual meetings were also held to endorse actions

Audit and Risk Committee

Frequency of meeting: At least quarterly (plus private meeting with External Auditor). During 2018/19 the committee met 4 times and separately in private.
The purpose of the Audit & Risk Committee is to provide one of the key means by which the Board of Directors ensures that effective internal control arrangements are in place. The Committee operates in accordance with Terms of Reference set by the Board, which are consistent with the NHS Audit Committee Handbook. All issues and minutes of these meetings are reported to the Board. In order to carry out its duties, Committee meetings are attended by the Chief Executive, the Director of Finance, Performance and Estates 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, Freedom to Speak Up as well as receiving briefings on clinical audit and counter fraud investigations. During the last year, as well as the scheduled items for discussion the Committee also considered reports and updates relating to Brexit Preparedness, Asset Control and conducted a deep dive on one of the Trust's key strategic risks, as detailed within the Board Assurance Framework, concerning Third Party Suppliers.

No significant issues in relation to the financial statements of 2018/19, operations or compliance were raised by the Audit and Risk Committee during the year.

Audit and Risk Committee composition and attendance 2018/19 is previously summarised.

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

Internal audit

Our Internal Auditors during 2018/19 were PricewaterhouseCoopers LLP (PwC).
Internal Audit provides an independent assurance with regards to our 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.

The cost of the internal audit provision for 2018/19 was £68,850 (excluding VAT).

External audit

Our External Auditors are Ernst & Young LLP. 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 National Audit Office.
External Audit is required to review and report on:

- Our financial statements (our accounts) and
- 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 cost of the external audit for 2018/19 was £53,640 (including VAT).
Our external auditors did not conduct any non-audit services in year.

Disclosure of information to auditors

Please refer to the 'Statement of directors' responsibilities in respect of the accounts'.

Countering fraud and corruption

A Local Counter Fraud Specialist (LCFS) is provided by Hampshire and Isle of Wight Fraud and Security Management Service. The role of the LCFS is to assist in creating an anti-fraud, corruption and bribery culture within the Trust, to deter, prevent and detect fraud, to investigate suspicions that arise, to seek to apply appropriate sanctions, and to seek redress in respect of monies obtained through fraud. The Audit and Risk Committee receives regular progress reports from the LCFS during the course of the year and also receives an annual report. Our Counter Fraud provision is recorded with the NHS Counter Fraud Authority as holding and maintaining a Green rating (the highest possible rating) against the 'Standards for NHS Providers 2018-19 for Fraud, bribery and corruption.

We have implemented agreed policies and procedures, such as the Local Counter Fraud, Bribery and Corruption Policy as well as a Freedom to Speak Up Policy and issues of concern are referred to the LCFS for investigation. We also ensure that there are various routes through which staff can raise any concerns or suspicions.

The Director of Finance, Performance and Estates is the executive lead for Counter Fraud and meets regularly with the LCFS to ensure that any learning from incidents and allegations is implemented. The Audit and Risk Committee is also regularly briefed on all allegations / investigations and actions taken.

Freedom to Speak Up

Since the introduction of Freedom to Speak Up in 2015 and as a consequence of recommendations made by Sir Robert Francis, we have implemented processes within the Trust to ensure our staff are able to easily raise concerns and seek confidential advice and support.

Our Quarterly Freedom to Speak Up (FTSU) Steering Group, which is chaired by a Non-executive Director (Chair of the Audit and Risk Committee) is attended by the Chief Executive, Chief People Officer, Chief Nurse and our

Independent Lead FTSU Guardian. At the meeting, the Independent FTSU Lead Guardian and Executives provide assurance to the Lead Non-executive Director for FTSU on behalf of the Board that issues raised are dealt with promptly and appropriately by the Trust. The FTSU Independent Lead Guardian briefs colleagues on:

- Themes, current cases and actions taken taking into account confidentiality and anonymity, and
- regulatory/national requirements from the National Guardian Office

The Chief Nurse and Chief People Officer brief members and provide assurance that appropriate actions are being taken where any matters concern patient and staff safety and /or wellbeing.

In year our guardians dealt with the following cases:

- Quarter 1 – 11 cases
- Quarter 2 – 3 cases
- Quarter 3 – 8 cases
- Quarter 4 – 13 cases

The Group also oversees supporting work programmes associated with FTSU including the development of the strategy and associated implementation plan, the completion of the National Board Self- Assessment and ensuring appropriate promotion and engagement to support an open culture of raising concerns.

Our Independent Lead Guardian is supported currently by five Guardians working across our services.

On an annual basis the Board receives a FTSU Annual Report.

Remuneration

Full details of remuneration are given in the Remuneration Report.

Members Council

We held elections to our Council of Governors back in August 2013 when we were actively pursuing Foundation Trust status. Back in late 2015, in light of changes to the Health and Social Care environment, we took the decision to step off the Foundation Trust pipeline and retained and renamed our council as the 'Members Council' to reflect the strengthened engagement with the membership.

Our governors working with us during the last year were:

Constituency		Name
Staff	Southampton	Debra O'Brien
		Sarah Oborne
	Portsmouth	Jenny Ford
		Vacancy
	Hampshire	Vacancy
Public	Southampton	Clive Clifford
		Jon Clark
		3 x Vacancies
	Portsmouth	Narcisse Kamga
		Michael North
		Sharon Ward
		David Stephen Butler
		Vacancy
	Hampshire	Sharon Collins
		Harry Hellier
		Robert Blackman
		Vacancy
Nominated Governors	Portsmouth City Council	David Williams
	Southampton City Council	Cllr. Warwick Payne
	Hampshire County Council	Cllr. Peter Latham
	NHS Southampton City CCG	Beccy Willis
	University of Southampton *	Vacancy
	NHS Portsmouth City CCG	Vacancy

**(planned rotational seat with University of Portsmouth)*

During 2017/18 we took time to consider the changing external context including the Sustainability and Transformation Partnerships and developing Integrated Care Systems and we embarked on a journey, in collaboration with our governors, to further reconsider their role, the Members Council, as well as that of our wider membership.

Community Engagement Strategy

In July 2018 the Board approved the development of a Community Engagement Strategy, aimed at ensuring that community engagement is recognised as being essential to our shared vision to provide great care, create a great place to work and deliver great value for money and to the fulfilment of its framework for being an organisation that is well led.

We believe that we are ***greater together*** and that only by working in partnership and collaboration can the health and wellbeing of everyone be best achieved.

The strategy has the following aims:

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

We established a new Board Committee in Quarter 3 2018/19, the 'Community Engagement Committee' to further develop the strategy and associated implementation plan. A summary of the Committee's remit and purpose is provided within the Annual Governance Statement.

In light of the development of our Community Engagement Strategy the Board took the decision in consultation with governor colleagues to disband the Council from 30th September 2018 and a celebration event was held in October to thank governors for their support to the Trust.

Governance Statement

Annual Governance Statement 2018/19

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 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 *NHS Trust Accountable Officer Memorandum.*

The Purpose of the System of Internal Control

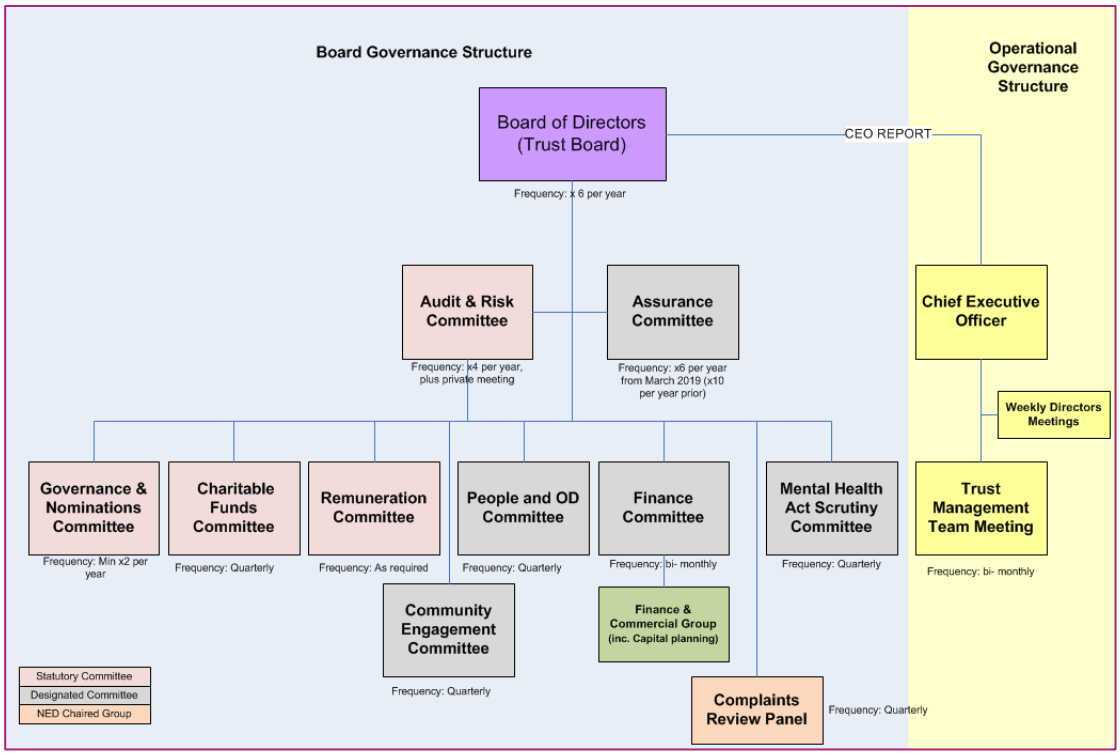
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going 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 2019 and up to the date of approval of the annual report and accounts.

The Governance Framework of the Organisation

Within the Directors Report Section ('Governing our Services') of the Annual Report the following information can be found:

- The individuals who serve on the Board
- Changes in appointments
- Attendance records at Board and Committees meetings

The following diagram illustrates the Board and reporting committees;



A summary of the role of the **Audit & Risk Committee** is found within the Directors Report section of the Annual Report and internal audit opinions for the audits carried out in year are as follows:

Audit title	Report classification
Risk Management – Child and Family Service Line	Medium Risk
Key Financial Systems	
- General ledger	Low Risk
- Cash Collection	Low Risk
- Payroll, HR and expenses	Medium Risk
- Inventory	Low Risk
- Treasury Management	Low Risk
Data Security and Protection Toolkit	Low Risk
Learnings Review	Medium Risk
Mental Health Act Scrutiny Committee Review	Medium Risk
Business Continuity Planning and IT Disaster Recovery	Medium Risk
Demand and Capacity Review	High Risk

Significant progress has been made in respect of responding to recommendations made by our internal auditors, as reflected within their Head of Internal Audit Opinion.

Governance and Nominations Committee

Frequency of meeting: At least twice a year and as required. During 2018-19 the Committee met 3 times (and once virtually).

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

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

Remuneration Committee

Frequency of meeting: At least annually and as required. During 2018-19 the Committee met once (and sought agreement for proposals twice virtually).

The Remuneration Committee is comprised of the Non-executive Directors (and others by invitation). The Committee reports to Confidential Board meetings regarding recommendations and the basis for its decisions. The Committee makes decisions on behalf of the Board about appropriate remuneration (including consideration of performance related pay and to ratify decisions of the Clinical Excellence Awards Panel), allowances and terms of service for the Chief Executive and other Executive Directors.

Charitable Funds Committee

Frequency of meeting: Quarterly (or as required). During 2018-19 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 until Jan 2019, and then bi-monthly thereafter.
During 2018 -19 the Committee met nine times.
The Committee is responsible for providing the Board with assurance on all aspects of quality of care. This includes quality governance systems, ensuring regulatory standards of quality and safety are met and that risk across the organisation is mitigated. In particular the Committee provides assurance to the Board regarding:

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

The Committee also seeks assurance that the development of all clinical governance activities within the service lines improve the quality of care throughout the Trust. The Quality Improvement and Risk Group receive deep dives which are reported to the Assurance Committee via exception as necessary. The Committee may request further scrutiny and information as appropriate. In year, the Committee received additional assurance reports on a variety of matters, including oversight of CQC action plans, wheelchair service, small scale services, quality risks associated with the Board Assurance Framework, and thematic leads' reports on End of Life and the Recovery College.
In year we took the opportunity to welcome continued representation from Clinical Commissioning Groups as a way of enhancing our partnership working. Upon reflection of the progress made to
address the 2017/18 Internal Audit recommendations, and maturing of the Quality Improvement & Risk Group, the Committee adjusted its meeting frequency in year, now meeting every other month.

Finance Committee

Frequency of meeting: Bi -monthly. *During 2018-19 the Committee met seven times.*
The Finance Committee is responsible for ensuring appropriate financial frameworks are in place to drive the financial strategy, and provide assurance to the Board on financial matters as directed. The Committee focuses on the following areas; strategic financial planning, business planning processes, annual budget setting and monitoring, treasury management and financial control, business management as well as conducting in depth reviews of aspects of financial performance as directed by the Board. The Finance Committee has been integral to the Board in providing scrutiny and oversight concerning the delivery of the financial plan.

Mental Health Act Scrutiny Committee (MHAS Committee)

Frequency of meeting: Quarterly. During 2018-19 the Committee met four times.
The central purpose of the Committee is to oversee the implementation of the Mental Health Act (MHA) 1983 (amended 2007) functions within the Trust principally within Adult and Older Persons Mental Health, and Learning Disabilities services. The Committee has primary responsibility for seeking assurance that the requirements of the Act are followed. In particular, to seek assurance that service users are detained only as the Mental Health Act 1983 allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights. In addition, on an annual basis the Trust's external legal advisors provide update training in relation to the Mental Health Act. The Committee also seeks assurance on the appropriate application for Deprivation of Liberties Safeguards (DoLS) as well as seeking assurance regarding adequacy of

training and development opportunities provided for front-line practitioners and of the monitoring of competence regarding the application of the MHA and DoLS.

People and Organisational Development Committee

Frequency of meeting: At least Quarterly. During 2018-19 the Committee met 4 times.
The People and OD Committee oversee all matters relating to workforce planning, talent acquisition, learning & development, employee productivity and workforce performance. It is responsible for ensuring that effective People and OD programmes are developed, which align with organisational strategy and deliver continuous improvement in organisational effectiveness -all within the context of system transformation and organisational change. The Committee has established a number of groups as follows:

- Employee Engagement
- Workforce Planning
- Equality, Diversity & Inclusion
- People Operations Service Delivery
- Occupational Health & Wellbeing

Community Engagement Committee

Frequency of meeting: At least Quarterly. During 2018-19 the Committee met six times.
During 2018/19 a new Committee was established with responsibility for assuring the Board on delivery and development of the Trust's Community Engagement Strategy. The Committee's duties include:

- Providing support, leadership, advice and guidance for staff so that they feel supported and able to make community engagement part of everything they do
- Ensuring that the Trust is accessible to local people and communities who want to be involved in contributing their knowledge, skills and experiences to improving the Trust.
- Ensuring the Trust meets its obligations and duties under equality and human rights legislation
- Providing assurance to the Board that community engagement is becoming part of the culture and practice of the Trust as a 'must do'.

Highlights of Board Committee Reports

The Board has an agreed annual cycle of business and receives exception reports via the relevant Chair in relation to recent meetings of its committees. The Board, as a standing item at each meeting, also considers whether additional assurance is sought from its committees on any items of concern.

The Chief Executive Report to Board includes commentary on significant changes recorded in the Board Assurance Framework (BAF) and Corporate Risk Register and each Board Committee also considers relevant BAF risks at each meeting. Progress on corporate and strategic objectives is reported quarterly within the performance report. In addition, a number of internal audits were completed, as described previously 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 are available via the In-Public Board papers on our website.

Performance Evaluation of Board

Further details of the Board's development activities and performance evaluation can be found within Directors Report section of the Annual Report.

Well Led and NHS Provider Licence

In year we completed self –assessments against the NHSI and CQC *'Developmental reviews of leadership and governance using the Well- Led Framework: guidance for NHS Trusts and NHS Foundation Trusts'* .
We also self-certify against the requirements of the NHS Provider Licence to ensure on-going compliance, in accordance with the NHSI Single Oversight Framework requirements (including Conditions G6 and FT4)– the details of which are incorporated into our Board Performance Report and publicly available. We do not consider there to be any principal risks in relation to compliance with the requirements of the Licence requirements.

Further information about our CQC rating, including our Well-led assessment is found within the Quality Account section of the Annual Report.

Capacity to Handle Risk

Risk management and quality governance arrangements, accountability and leadership

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

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

- Chief Nurse - nominated Executive Lead Director for risk management and quality governance. The Chief Nurse is also responsible for ensuring on-going compliance with CQC registration requirements.
- Chief Medical Officer - Lead director with responsibility for Learning from Deaths (mortality) agenda (Patient Safety Director as defined by national guidance on learning from deaths, National Quality Board 2017)
- Director of Finance, Performance and Estates – nominated Executive Lead Director for health and safety compliance
- Chief Operating Officer for Southampton and County Services - executive lead for emergency planning and disaster recovery, ensuring plans are established and regularly tested.
- Clinical Directors - accountable for risk and clinical governance within their respective service lines, supported by the Operational Directors and Professional Leads for Governance, Quality and Standards .

- Operational Directors and Heads of Service – responsible for managing operational risks originating within their service areas.
- The Head of Risk and Litigation is responsible for ensuring the development and oversight of implementation of the Trust Risk Management Framework, risk procedures and administration of the Trust Risk Register

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

Meetings

- Care Group Meetings , chaired by Chief Operating Officers, general performance of quality and other operational issues
- Service Line Clinical Governance Groups - responsible for the oversight of quality and risks, triangulating performance information to monitor and address service quality. The groups provide exception reporting to the Quality Improvement and Risk Group which is chaired by the Chief Nurse and these are then scrutinised at the Assurance Committee. The service line structure provides high levels of autonomy increasing the effectiveness and accountability of the clinical services.
- Trust Management Team - oversees operational responses to risks contained in the Trust Risk Register. The roles of the Assurance Committee and Audit and Risk Committee are described previously.
- Oversight of performance and risk by the Chief Operating Officers via daily escalation and reporting through to Performance Subcommittees
- Contract, Quality & Risk Management Meeting (CQRM) - monthly monitoring with commissioners
- Care Group and corporate team monthly Performance Reviews Meetings (PRM) are held to seek assurance regarding the management of operational risk. In addition, we monitor quality indicators through service line performance sub-committee meetings.

Governance and reporting processes

- Each service line has a documented local Annual Governance Statement which outlines the internal control and risk management processes under the leadership of each Clinical Director, and underpins the Trust wide Annual Governance Statement with regard to the internal control and clinical governance processes within our clinical services
- Serious Incident requiring investigation (SI) process including Root Cause Analysis (RCA) investigation and SIRI panel arrangement
- Learning from Deaths process for unexpected deaths (mortality reviews)
- An audit programme (Trust wide and service level covering standards and topic specific issues)
- Monthly reporting and publication of safe staffing status (with sign off by matrons and oversight by the Quality and Professional Standards Team)
- The Board is apprised of any key quality and safety matters at the beginning of each Board meeting
- Our Quality Account is produced annually which outlines the progress made and action taken to improve and maintain quality and safety within and across Trust services. The Annual Quality Account is developed in consultation with key stakeholders and serves as an additional validation mechanism for determining the quality of services. More information on the Quality Account is provided in Section 5 of the Annual Report
- Our Patient Experience Strategy was approved following consultation with a wide range of service users and partner agencies. The Trust Patient Experience forum continues to meet quarterly and oversees the delivery and implementation of the strategy
- Any new scheme or change in service provision (including Cost Improvement Plans (CIPs) are formally assessed through an Equality and Quality Impact Assessment (EQIA) process. Within the QIA process, foreseeable or potential risks which could impact on quality, patient safety and experience are considered and key leading indicators are identified to help highlight the realisation of any actual risks. A gateway approach to the

agreement of CIPs and QIAs has been embedded with sign-off by the applicable service line Clinical and Operational Directors in consultation with services prior to review by the Chief Medical Officer and Chief Nurse. The Service Line Clinical Governance Groups are responsible for the management and monitoring of the leading indicators identified within signed off QIAs and for ensuring that in collaboration with the Chief Medical Officer and Chief Nurse, risks associated with QIAs are escalated to the Assurance Committee.

Visits and inspections

- Board to Floor visits (includes executives, non-executives and governors) to engage with frontline staff and service users
- Service review visits by commissioners
- Announced and unannounced visits to clinical areas/teams by the Quality & Professional Standards Team
- Patient-Led Assessments of the care environments

Feedback mechanisms

- Patient and service user feedback (Friends and Family Test and other local mechanisms)
- Patient / carer and staff stories to Board

Risk Management Training

We provide a range of risk management training including;

- All staff complete an online E Learning module, which includes risk management principles, escalation processes, accountability, risk assessment and hazard identification.
- On request face- to- face Risk Management training provided by the Quality and Professional Standards team as an alternative to the E Learning module.
- Risk Register training for all staff who have responsibility in using the Trust's on line risk register.
- A two day training package for SI Investigators provided in collaboration with neighbouring organisations. This training provides in depth training on root cause analysis, identification of hazards and the SI process.
- Formal Incident reporting and reviewers training, and
- Bespoke training provided by the Quality and Professional Standards Team.

Risk Assurance

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

The Risk and Control Framework

I am assured that risk management processes are continuing to be increasingly embedded within the Trust and incident reporting is openly and actively encouraged to ensure a culture of continuous improvement and learning. I am also assured that there are appropriate deterrents in place concerning fraud and corruption. The organisation understands that successful risk management requires participation, commitment and collaboration from all staff.

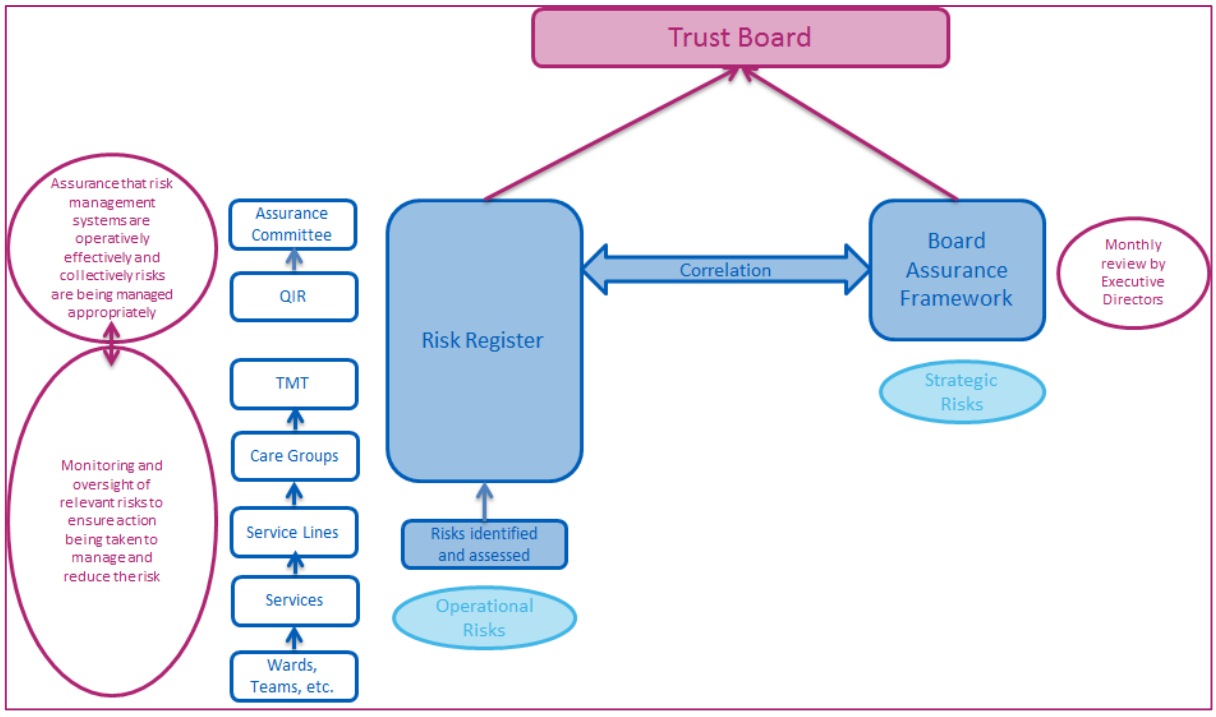
The Board approved the Risk Management Framework in 2018 to replace the former Risk Management Strategy and provides a clear overarching framework for the management of internal and external risk and describes the accountability arrangements, processes and the Trust's risk appetite. The Framework is underpinned by a new step-by-step guide to the Risk Management Process for frontline staff, and revised induction and refresher training for all new and existing staff.

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

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

Risk Assessment Process

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



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

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

Risk identification and measurement

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

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

There is clear alignment between the Board Assurance Framework and operational risk register and our risk pyramid summarises the top risks and most prevalent each month.

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

Strategic Risks

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

- **Indirect Commercial Relationship Risks** - There is a risk to patient safety, contractual performance and reputational damage in relation to partnership/third party supplier arrangements that are not under direct control of Solent)
- **Workforce Sustainability** – There is a risk that we are unable to recruit and / or retain sufficient numbers of clinical staff with the qualifications, skills and experience required. We are already experiencing staffing pressures in a number of our services, as detailed further within the 'significant issues' section of the Annual Governance Statement.
- **Financial Sustainability** - There is a risk that the Trust is unable to demonstrate it can continue to operate as a financially viable standalone entity.
- **Future Organisational Function** - There is a risk that due to significant environment changes both nationally and within the local system that the Trust is not able to respond effectively to market forces and emerging opportunities and its ability to lead and influence is diminished.
- **Business As Usual –Demand and Capacity** – There is a risk that demand in the system outstrips our capacity that we are contracted /funded to provide.

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

Operational Risks

The most prevalent operational risks at the end of the financial year are identified below, however each are being managed by the services with oversight by the Executive Lead to reduce the risk to an acceptable level:

- **Information Technology** – risks associated with IT infrastructure and reports of issues associated with accessing our core systems and WiFi connectivity
- **Demand and Capacity** – risks associated with increasing demand for our services which is impacting on timely access to treatment and waiting times
- **Vacancies and recruitment** – risks associated with the high levels of vacancies which are difficult to fill due to wider system and national staff shortages

We will continue to monitor and mitigate all significant risks associated with efficiency saving plans identified via the Quality Impact Assessment process.

Information Governance and Data Security

Data Security is a significant part of the national Data Security and Protection Toolkit requirements as well as ensuring that at least 95% of staff have completed IG training annually, which is nationally recognised as an extremely challenging standard. Solent NHS Trust Data Security and Protection Toolkit for 2018/19 submission was identified as

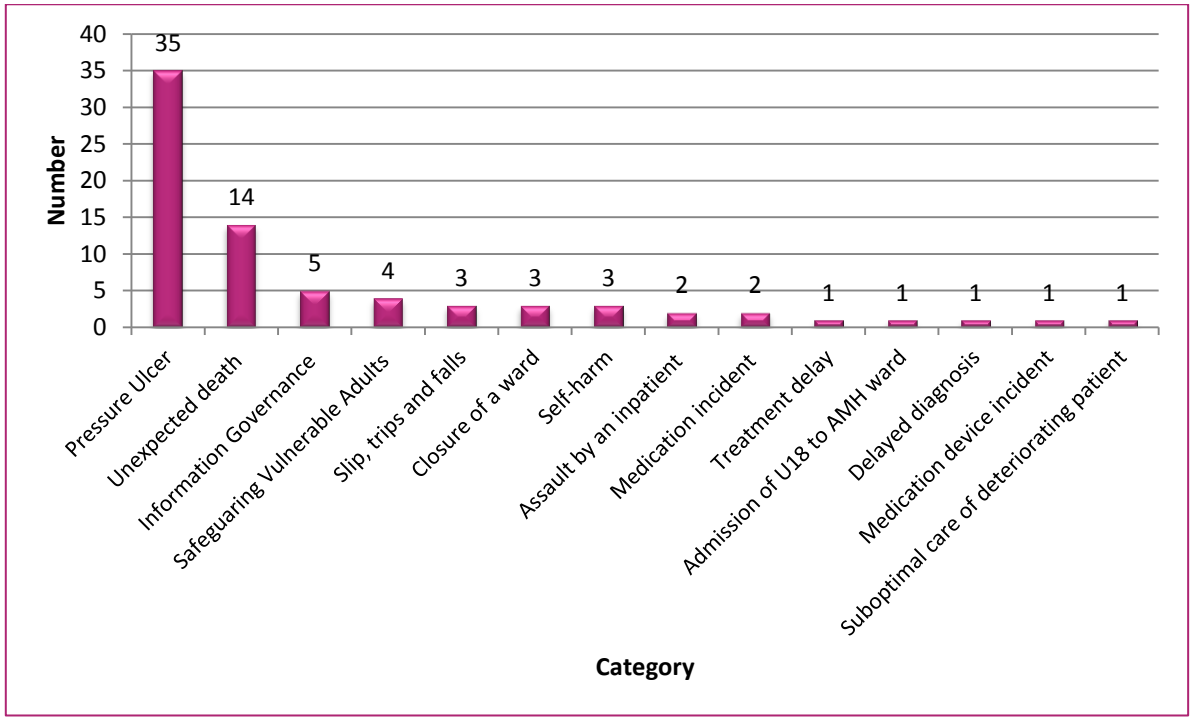
97%

We achieved 97% Information Governance Training Compliance

"Standards Met"; meaning all mandatory requirements have been achieved.
IG serious incidents are reported and monitored via the Toolkit and to the Information Commissioner's Officer as described below. We continue to monitor all incidents and risks associated with IG matters and ensure we learn as a consequence.

Serious Incidents Requiring Investigation

A total of 76 Serious Incidents (SI) were raised during 2018/19 as categorised in the below graph:



As part of our SI process we actively identify opportunities for shared learning.

We investigated and responded to 5 Information Governance (IG) SIs, which are categorised as:

- Staff Breaches – no impact to data subjects
- Staff Breaches – minor impact to data subject (one case)
- Personally identifiable data sent to the wrong person

None of the above SIs resulted in data loss, but did constitute a confidentiality breach, although in three cases the data subject confirmed no adverse effects had taken place and they were satisfied with the action taken.

Our Caldicott Guardian and Senior Information Risk Officer are consulted with whenever there is an IG Serious Incident and our commissioners provide scrutiny to our SI process and confirm closure on investigations once appropriate assurance has been sought.
The Information Commissioner's Officer are also advised of every incident and have confirmed that they are satisfied with the immediate actions taken and have closed their investigations into all incidents.

Care Quality Commission (CQC) Compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission and routinely receives visits and inspections from the CQC. There are no outstanding issues recorded against the Trust. In year our Primary Care services were inspected and in October 2018 eight CQC core service inspections were undertaken.
These were:

- Community Adults
- Community Children & Young People
- Primary Care Services
- Mental Health - Psychiatric Intensive Care Unit (PICU)
- Mental Health - Crisis and Health Based Place of Safety (HBPoS)
- Mental Health - Older Persons Mental Health (OPMH) /Ward
- Mental Health - Older Persons Mental Health (OPMH)/Community
- Mental Health Rehabilitation /Adults/Ward.

Following this, the Trust underwent its first focussed "Well led" inspection. This involved a team of CQC inspection staff accompanied by two Board level Specialist Advisors being onsite at our Headquarters for 3 days, examining the functionality and leadership of the Board and senior management teams.
We were rated as 'Good' across all domains for our Primary Care Services and 'Good' across our core services with an 'outstanding' in the Caring domain.
Further information about our CQC inspection process and our results can be found in our Quality Account.

Workforce Strategies and staffing Systems

The Chief Nurse meets with all service lines on a monthly basis to review a range of data and information relating to safe staffing including current establishments, vacancies, recruitment and retention programmes, turnover, roster management, sickness/absence levels and compliance with mandatory and statutory training - all of these areas are identified as key within in the National Quality Board (NQB) guidance: '*Developing Workforce Safeguards'*. During December 2018 to February 2019, our clinical service lines reviewed the guidance and plans are developing to ensure that a set of leading indicators for each service are agreed which will inform further discussions and actions required. The staff who attend the safe staffing meetings are those with clinical leadership roles as well as the professional leads and all teams are reviewed at least once in the year. Areas where there are concerns or on-going difficulties are reviewed more frequently and the meetings are supported by colleagues from workforce/HR, Learning & Development and the Roster team.
As part of the business planning process service lines are required to consider their workforce needs and any changes to establishments, skill mix, or the introduction of new roles – these are required to have a full Equality and Quality Impact Assessment completed and presented to the Chief Nurse & Chief Medical Officer for sign off. A six monthly safe staffing report is provided to Board which reports on progress against NQB guidance and the priorities set out in the previous six month report.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality impact assessments are carried out to assess the impact of the Trust's decisions and design of services as part of the Trust's legal duty under the Equality Act 2010 – we also use assessments in the development of policies and in consideration of cost improvement plans.
Our commitment is to ensure that leaders keep listening, learning and improving. To help us do this, we have invested in new senior roles for Diversity & Inclusion, Independent Freedom to Speak Up Guardian and Community Engagement and Patient Experience.
You can read more about Equality, Diversity and Inclusion within the Staff Report section of the Annual Report.

Register of Interests

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance. The register is available on our public website.

Environmental responsibilities

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. You can read more about our environmental reporting within the Performance Report section of the Annual Report.

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

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

- Scheme of Delegation and Reservation of Powers, Standing Orders and Standing Financial Instructions approved by the Board. These key governance documents include explicit arrangements for:
    - Setting and monitoring financial budgets;
    - Delegation of authority;
    - Performance management; and
    - Achieving value for money in procurement
- A financial plan approved and monitored by the Board
- The Trust operates a hierarchy of control, commencing at the Board and cascading downwards to budget managers in relation to budgetary control, balance sheet reconciliations, and periodic review of service level income with commissioners. In addition, the Finance Committee provides scrutiny and oversight which has been supplemented this year by independent commissioned reviews
- Robust competitive processes used for procuring non-staff expenditure items. Above £5,000 procurement involves competitive tendering. The Trust has agreed procedures to override internal controls in relation to competitive tendering in exceptional circumstances and with prior approval obtained
- CIPs, which are assessed for their impact on quality with local clinical ownership and accountability
- Strict controls on vacancy management and recruitment
- Devolved financial management with the continuation of service line reporting and service line management
- The Trust participated in the National Benchmarking Network's Children's & Adolescent Mental Health Services (CAMHS) project, with separate submissions for our Southampton and Portsmouth services, Corporate Services (both the Benchmarking Network and NHS Improvement returns), Mental Health (both benchmarking and survey), Community Services and Pharmacy and Medicines Optimisation projects. As well as taking part in the annual Learning Disabilities services benchmarking project, we participated in a new Learning Disabilities Trust

return, in conjunction with NHS Improvement. In addition, we have also been part of the monthly community indicator workstream and are part of the Model Hospital application

- The Trust Board gains assurance from the Finance Committee in respect of ensuring appropriate financial frameworks are in place to drive the financial strategy and provide assurance to the Board on financial matters as directed, including to review the impact of CIPs on forward financial planning and
- 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.

As stated within the Annual Results Report for the year ended 31 March 2019, our external Auditors anticipate issuing an unqualified Value for Money opinion and an unqualified opinion concerning the Trust's financial statements. *[statement to be confirmed]*

Performance Reporting

During 2018/19 the performance governance structure has continued to optimise escalations of significant performance to the senior leadership team and Trust Board. The meeting structures are described as follows;

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

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

During 2018/19 we developed our internal data quality tools, giving services simple, near real-time access to their information, including waiting lists and appointment outcomes, in order to validate and correct any data entry issues. As a result, the number of reported 52 week breaches and the number of reported 18-51 week waiters has dramatically reduced giving a clearer and more accurate position for the Trusts.

The Data Quality Team has received additional investment during 2018/19 to expand the resource available to work collaboratively with our services to validate data including waiting time performance indicators, continue to systemically review all service users on waiting lists to ensure they are accurate and appropriately recorded, and to investigate and resolve data quality issues as they arise. Regular automated reporting will be extended and oversight shared with services and senior management to ensure validations and outcomes are being recorded correctly and the quality of our data continues to improve.

An internal audit report on Clinical Data Quality was published in May 2018, assessing both the governance and implementation of data quality processes in order to establish adherence to national and internal guidelines. The main issue identified within the audit report was that reporting on clinical data was hindered by inaccurate and often delayed data entry by clinical service staff. The developments within the data quality function over the past year have aimed to address these issues and the additional resource should further help to alleviate this into 2019/20.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to Trusts on the form and content of annual Quality Reports – we have produced our annual Quality Account in compliance with these requirements, and in doing so has consulted with key stakeholders.
The Account includes a summary of the arrangements in place to assure the Board that the reporting of quality presents a balanced view and that appropriate controls are in place to ensure the accuracy of data.

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

Quality indicators are based upon a range of sources, including regulatory, national, best practice and locally agreed improvement targets. Many indicators are established internally in collaboration with clinical services to help achieve the highest possible standards of quality and care.
All quality metrics have systems to appropriately capture the information, analyse and onward reporting to the applicable stakeholders, including internally (the Board, Care Group Performance Subcommittees) or externally (for example NHS Improvement and local commissioners). Our Quality Account is available in section 5 of the Annual Report.

We launched our new Quality Framework in September 2018; it supports our vision and focus on making a difference to patients and their families and brings together how the Trust delivers Great Care in a way that is clear to patients, staff and our stakeholders
At the centre of the Framework is a formula designed to be easy for patients and staff to remember and relate to: SEE (Safe, Effective, Experience). The Framework sets out:

- what quality means to Solent, its patients and staff in terms of Safe, Effective and Experience (SEE)
- the pivotal role our staff play and how we support them to deliver Great Care
- how we check the quality and standards of care in our services
- how we use innovation, research and organisational learning to continually improve
- governance, risk management and leadership arrangements for quality, and
- how we talk about quality at all levels of the Trust

Significant Issues during 2018/19

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

In year the following significant issues occurred:

- Like many NHS organisations, a number of our services experienced **staffing pressures** due to sickness, vacancies and difficulties recruiting due to national staff shortages – particularly within our Mental Health Services and Community Adults teams. This has resulted a reliance on agency staff, as a result we have breached the mandatory spending cap. Workforce controls continue to be implemented including ensuring the vast majority of temporary staff are sourced through our in house bank, and where necessary block booking agency which has provided additional assurance in terms of the quality of temporary staff supply.
  Where we know we will have continued staff shortages and recruitment challenges, we are considering alternative staffing models and development packages. Our recruitment and retention programme has included innovative recruitment approaches and development programmes which will to help us 'grow' from within and provide innovative career pathways – for example, via the implementation of our apprenticeship programmes including Nursing Associate and Registered Nurse Apprentice, Advanced Practice and Allied Health Professional programmes.

- We continued to operate in **challenging financial times** with a deficit stretch target of £0.4m. In year we encountered a number of financial related risks as summarised below:
  - in relation to assumptions made regarding our final figures from 2017/18 from **NHS Property Services,** as well as an assessment as to what the value should be for this financial year.
  - in relation to the Hampshire & IOW STP and **related system financial pressures** including expectations to work together to reduce costs which could significantly destabilise Solent services and impact on neighbouring system partners as well as adversely affecting the quality of our service offer
  - we know our **IT expenditure** has identified us as an outlier – consequently we are further exploring opportunities for cost, efficiency and service improvement whilst considering our future IT and digitalisation strategy in accordance with requirements and aspirations of the NHS Long Term plan. Wherever possible we will look to work with system partners to maximise efficiencies and accessibility.

- **Operational Performance** was also impacted in year as summarised as follows;
  - We operate a few **small scale services,** meaning that service delivery can be fragile and unstable if we experience periods of unscheduled sickness and absence, or when staff chose to leave the organisation. We continue to work with commissioners and partners to ensure we can proactively provide sustainable pathways and services to our service users. The Commercial Group have a risk based oversight of plans to sustain services and reports through to assurance committee on progress.
  - **Demand** on our services at times does create **longer than acceptable waiting lists** in areas such as within our Domiciliary Phlebotomy service, Podiatric Services and Pulmonary Rehabilitation in the east, our Child and Adolescent Mental Health Services (CAMHS), Paediatric Medical service and Musculoskeletal Service (MSK). We continue to redesign services and work with commissioners to reduce waits. We also have escalation policies when individuals waiting find their needs have become more urgent.
  - A shortage of available theatre space has also impacted our ability to undertake **General Anaesthetic procedures** within our Specialist Dental service, creating waiting lists. During Quarter 4 2018/19 we took the decision to reassess patients from the north of the County and to allocate space at our Poswillo site (co-located with Portsmouth Hospitals NHS Trust) for those suitable. In year, and after significant discussions and negotiations with commissioners, we gave notice on contracts where it was clear that we were unlikely to achieve performance levels required, but ensured we took steps to support staff members affected.
  - We continue to work with the local **wheelchair provider** and the commissioners to reduce the delays experienced by our patients, particularly our 0-19 service users, when waiting for the supply of

wheelchairs and other bespoke equipment. We are also in continued discussion with the wider HIOW system to assist in reaching resolution to this complex issue, as well as NHS England and NHS Improvement.

- In year, we were awarded the **Isle of Wight Special Care Dental Service Contract** by NHS England. This in itself brought many challenges to the Trust – not least due to the remote geography and the short mobilisation period, but also in ensuring a robust due diligence process was conducted to identify and appropriately mitigate clinical risks. Since the commencement of the contract on 1 October 2018 we successfully integrated the service into our wider county offer and look forward to welcoming CQC inspectors in the near future.

- In year we sadly experienced a number of **deaths involving children** that our services had contact with; some were expected deaths but a number were unexpected and required the Trust to consider any themes and learning that will improve the support we provide to children and families in the future. One theme identified related to co-sleeping and another related to the support available to families of children whose children have complex needs, particularly during the extended school holidays. As a result the Health Visiting teams have reviewed both the literature they provide to families as well as the information given verbally at each visit. The safer sleep message has been shared across all the professional groups in children's services so that parents are receiving consistent messages. In relation to the children with complex needs, work is underway to ensure that contact is maintained during school holidays and that a clear plan is in place for families so that they know who to contact if they are worried.

- Following our CQC inspection we received one **Requirement Notice** for a breach of Regulation 12(2)(g): the proper and safe management of medicines, in one small discrete location. We have implemented a robust action plan to address this finding together with other 'should do' findings. Further information about our inspection and key findings can be found within the Quality Account.

Review of Effectiveness

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

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their Annual Audit 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 and Risk Committee, Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- a review of committee governance by the Governance and Nominations Committee. The Board consider recommendations made by the committee and is ultimately responsible for approving and monitoring systems to ensure proper governance and the management of risk
- reviews of key governance documentation such as Standing Orders, SFIs, Scheme of Delegation and the Board Assurance Framework
- the oversight by the Audit & Risk Committee of the effectiveness of the Trust's systems for internal control,

including the Board Assurance Framework (BAF). In discharging their duties the committee takes independent advice from the Trust's internal auditors (PwC) and external auditors (Ernst & Young). The BAF is also reviewed and challenged by the Board and updates are presented monthly via the Chief Executive's report to the Board
- the internal audit plan, which has been adapted in year to address areas of potential weakness in order that the Trust can benefit from insight and the implementation of best practice recommendations and the findings of relevant internal audits
- the scrutiny given to the Clinical Audit Programme by the Audit and Risk Committee
- the Trusts self-assessment against NHSI's and CQC Well Led Framework and associated action plan
- the scrutiny given by the Mental Health Act Scrutiny Committee in relation to the implementation of the Mental Health Act, and
- the review of serious untoward incidents and learning by SI and, Learning from Death Panels and Service Line Clinical Governance Groups.

The Head of Internal Audit Opinion (HOIA) concluded an opinion of 'Generally satisfactory with some improvements required'. It was noted however, that there are some areas of weakness and as such the Trust is actively addressing these. Of particular note are the findings and recommendations raised within the recent Demand and Capacity Audit which was rated as 'High Risk' – consideration will be taken by the executive team to analyse the risks associated and ensure appropriate mitigation. The HOIA also highlights areas of good practice identified as a consequence of our auditors reviews.

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

Conclusion

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

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

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

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

These include ensuring that:

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

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

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

Statement of directors' responsibilities in respect of the accounts

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

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

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

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 they have complied with the above requirements in preparing the accounts.

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. A statement regarding the going concern position in relation to the accounts can be found within Section 4.

Disclosure of information to auditors

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

By order of the Board

Insert signature

Sue Harriman
Chief Executive Officer

Date: 24th May 2019

Insert signature

Andrew Strevens
Director of Finance, Performance and Estates and Deputy CEO
Date: 24th May 2019

Remuneration and Staff Report

Remuneration report

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

The Remuneration Committee met once as a Committee during 2018/19 and twice in year on a virtual basis to deal with specific matters (once in Q2 and once during Q4).

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. The Chief Executive, Chief People Officer, and Director of Finance, Performance and Estates may attend the meetings by invitation, but are not members of the Committee.

The attendance by members is detailed below:

Member	Date of Meeting 24th May 2018
Mike Watts (Chair)	✓
Alistair Stokes	✓
Jonathan Pittam	✓
Mick Tutt	✓
Francis Davis	✓
Stephanie Elsy	✓

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

In year the Committee:

- were briefed on the NHS Pay Deal and Gender Pay Gap reporting
- discussed and agreed remuneration matters concerning executive pay and in light of executive appraisals
- were consulted on and discussed a number of senior appointments

- were consulted on the draft policy for Medical and Dental Employer Based Awards and subsequently ratified the recommendations made by the Clinical Excellence Awards Panel

Senior Managers Remuneration Policy

Our policy on the remuneration of senior managers for the current and future financial year is based on principles agreed nationally by the Department of Health taking into account market forces and benchmarking. During 2018/19 NHS Improvement undertook a benchmarking exercise on Executive Director and Non-executive Director pay, which has been used to review remuneration of the Chief Executive and Executive Directors.

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

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

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

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

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

The salary, emoluments, allowances, exit packages, and pension entitlements of the Trust's Senior Managers are detailed in the following sections. There were no senior managers seconded into the organisation during the year 2018/19.

Service Contract Obligations

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

Loss of office payment for Senior Managers are determined in accordance with Sections 14-16 and 20 of the NHS Terms and Conditions of Employment. In accordance with the following sections concerning duration of contracts and awards made, there have been no loss of office payments made during 2018/19.

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 2018-19 financial year there has been no early terminations of Executive Director's and no non contractual payments have been made.

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

Awards made to previous Senior Managers

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

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

Fair pay multiples (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/Member in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director/member in Solent NHS Trust in the financial year (£000), 2018-19 was £155-£160 (2017-18, £155-160). This was 5 times on 2018/19 (2017/18, 5 times), the median remuneration of the workforce which was £29,286 (2017–18, £28,746).

In the 2018-19 one (2017 - 18, one) employee received remuneration in excess of the highest paid director/ member. Remuneration ranged from £15k to £185k (2017–18, £14k to £185k).

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind, but does not include severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. When calculating the median figure, individuals employed via a bank contract who did not work on the 31st March 2019 have been excluded; together with employees who left prior to the April 2019, honorary appointments, Non-executive directors who receive allowances only, individuals who are undertaking training in receipt of a training allowance only and individuals who were not directly employed by the Trust.

The pay of Very Senior Managers is being impacted by the restrictions placed on pay rises for this group of staff. Several of the Very Senior Managers have not received a pay increase for several year, whilst other staff groups are receiving annual cost of living pay rises. As a result more staff are closing the gap between their pay and that of the highest paid Director

Exit packages (audited)

Changes have continued to take place within the organisation in the 2018-19 financial year and whilst we endeavour to do all we can to ensure the continued employment of our staff there has been 1 severance payment totalling £10k made in the year. This payment relates to compulsory redundancy. The payment does not relate to senior managers as detailed in the accounts. In addition 8 payments in lieu of notice have been paid. 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 2018-19

Exit Package cost band (including and special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	8*	13,000	0	0	0	0
£10,000 - £25,000	1	10,350	0	0	0	10,350	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	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	1	10,350	8	13,000	1	10,350	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 the full costs of departures agreed within the year. Other departures have been paid in accordance with the Mutually Agreed Resignation Scheme (MARS). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

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

Note: The expense associated with these departures may have been recognised in part or in full in a previous period. The following table reports the number and value of exit packages agreed in the year.

*Other departures detailed above relate to payment in lieu of notice for staff paid redundancies in 2017/18.

Analysis of Other Departures 2018/19

	Number of exit package agreements Number	Total Value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice *	8	13
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval **	0	0
Total	**8**	**13**

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

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

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

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

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 senior off-payroll engagements

In accordance with the DHSC Group Accounting Manual 2018-19, all public bodies are required to publish the following information within their 2018/19 Annual Report.

Off payroll engagements in place as at 31/03/19, for more than £245 per day that last longer than six months	
Total number of off pay scale engagements in place as at 31st March 2019	1
Of which, the number that have existed for:	
less than one year at the time of reporting	1
between one and two years at the time of reporting	0
between two and three years at the time of reporting	0
between three and four years at the time of reporting	0
four or more years at the time of reporting	0

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

All new off-payroll engagements or those that reached six months in duration between 01/04/18 31/03/19, at a rate of £245 or more per day and that last longer than six months	
Number new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
Of which number assessed as:	
caught of IR35	1
not caught by IR35	0
Number engaged directly (via PCS contracted to trust) and on the trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	5
Number of engagements that saw a change to IR35 status following the consistency review	0

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

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

Off payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 01/04/18 and 31/03/19	
Number of off-payroll engagements of board members, and or senior officers with significant financial responsibility, during the year	0
Number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility during the financial year. This figure includes both payroll and off-payroll engagements	7

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

Expenditure on consultancy

During the 2018/19 financial year £319k was spent on consultancy.

Salaries and allowances (subject to audit)

Name and Title	2018-19 (a) Salary and fees including R&R (bands of £5,000) £000	(b) Expense Payments (taxable) (total to nearest £100)* £00	(c) Performance Pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) Other payments (bands of £5,000) £000	(f) All pension-related benefits (bands of £2,500) £000	Total (a to f) (bands of £5000 £000
S Harriman – Chief Executive	155-160	3-4	0	0	0	25 – 27.5	180 - 185
A Strevens – Director of Finance, Performance and Estates	120-125	1-2	0	0	0	27.5 – 30	145 - 150
H Ives – Chief People Officer	110-115	1-2	0	0	0	22.5 -25	130 - 135
D Meron – Chief Medical Officer*	135-140	1-2	0	0	0	0	135 - 140
S Austin – Chief Operating Officer Portsmouth	115-120	0	0	0	0	82.5 – 85	200 - 205
D Noyes – Chief Operating Officer	110-115	2-3	0	0	0	30 – 32.5	140 - 145
J Ardley – Chief Nurse	110-115	3-4	0	0	0	0	110-115
A Stokes – Chairman, retired 31/03/2019	30-35	0	0	0	0	0	30-35
M Tutt – Non Executive Director	5-10	4-5	0	0	0	0	5-10
F Davis – Non Executive Director	5-10	0	0	0	0	0	5-10
J Pittam – Non Executive Director	5-10	1-2	0	0	0	0	5-10
M Watts – Non Executive Director	5-10	1-2	0	0	0	0	5-10
S Elsy – Non Executive Director.	5-10	0-1	0	0	0	0	5-10

*Note: taxable expenses and benefits in kind are expressed to the nearest £100. Pension benefits are calculated using the method set out in section 299 of the Finance Act 2004 as amended by the Large and Medium-sized Companies and Groups (Accounts and Reports) Amendment Regulations 2013.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase/decrease due to a transfer of pension rights.

The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual. For individuals who joined or left the Trust part way through the year, the full time equivalent salary plus any additional remuneration, excluding severance payments have been used to calculate the rate of payment.

* The Chief Medical officer role is combined with clinical duties. These figures include £40-£45k (expressed in bands of £5,000) relating to clinical duties.

Previous year Salaries and allowances - 2017/18

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

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

Pension benefits 2018-19 (subject to audit)

Name and Title	**Real increase in pension at pension age (bands of £2,500)** £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash equivalent Transfer Value at 31 March 2019 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employers Contribution to Stakeholder Pension £000
S Harriman – Chief Executive	2.5 -5.0	(2.5) – 0.0	35 – 40	70 - 75	540	109	649	0
A Strevens – Director of Finance, Performance and Estates	0.0 – 2.5	0	20 – 25	0	203	67	271	0
H Ives – Chief People Officer	0.0 – 2.5	0	0 – 5		14	24	38	0
D Meron – Chief Medical Officer	0.0 – 2.5	0.0	0 – 2.5	100 - 105	688	92	780	0
S Austin – Chief Operating Officer Portsmouth	2.5 – 5.0	5.0 – 7.5	55 – 60	105 – 110	852	196	1,047	0
D Noyes – Chief Operating Officer	0.0 – 2.5	0	0 – 5		14	24	38	0
J Ardley – Chief Nurse *	0	0	0	0	0	0	0	0

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

*The Chief Nurse is not in the NHS Pension scheme or alternative pension scheme so no values are appropriate

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 does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff Report

Our Staff

Last year, we employed 4,932 clinical and non-clinical members of staff (including part time and bank staff) which equates to 2943 full-time equivalents (FTE), who contribute to providing high quality patient care across our local communities. Our team members bring innovations in care to people who use our services, deliver enhanced effeciency and continously improve to meet national and local quality targets. Most of our people are permanently employed in clinical roles and deliver patient care either directly or indirectly. We also employ a number of administrative and estates staff members who provide vital expertise and support. The following table provides a breakdown of our Solent NHS Trust team at the end of the year (March 2019).

Total staff numbers as at 31 March 2019

Staff Group	Female FTE	Female %	Male FTE	Male %	Total FTE
Admin & Estates	573.01	87.86%	79.14	12.14%	652.15
Director	4.00	57.14%	3.00	42.86%	7.00
Healthcare Assistants and Other Support Staff	574.75	81.67%	129.02	18.33%	703.77
Managers and Senior Managers	41.29	61.98%	25.33	38.02%	66.63
Medical & Dental	98.63	76.98%	29.50	23.02%	128.13
Nursing & Midwives	723.25	92.71%	56.88	7.29%	780.13
Scientific, Therapeutic & Technical	531.07	87.73%	74.30	12.27%	605.37
Total	**2546.00**	**86.51%**	**397.17**	**13.49%**	**2943.17**

Our workforce is largely female (86.5%) and this is the predominant gender in all of the staff groups. We publish our Gender Pay Gap report (available on our website). The average (mean) hourly rate for our female employees in this organisation is 15.3% lower than for our male employees (14.74% in 2017/18). However, the median calculation (the average hourly rate at the mid-point for each gender) is only 0.4% lower for females. In 2017/18 it was 0.7%, and so we have improved on this calculation. The average pay gap in surrounding local Trusts is between 21.2% and 32.1%. Whilst we compare favourably with the national average there is clearly further work to be done to close the gap and we are committed to do so. Our gender pay gap exists largely because we have a greater number of women in the workforce with a higher proportion in our lower level roles. We remain committed to the Equality and Diversity agenda and to strengthening inclusive people practices across the Trust.

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

Employee benefits

Employee Benefits – Gross Expenditure (audited)	Permanent £000s	Other Agency £000s	Total £000s
Salaries and wages	99,867	4,240	**104,107**
Social security costs	9,177		**9,177**
Apprenticeship Levy	489		**489**
Employer Contributions to NHS BSA Pensions division	12,842		**12,842**
Other pension costs	8		**8**
Termination benefits	544		**544**
Total employee benefits	**122,927**	**4240**	**127,167**
Employee cost capitalised	290		**290**
Gross Employee Benefits excluding capitalised costs	**122,637**	**4,240**	**126,877**

Average staff numbers during 2018/19 period

Average Staff Number	Permanent Number	Other Agency Number (inc. Bank Staff)	Total Numbers
Medical & Dental	133	4	137
Directors	7	0	7
Admin & Estates	716	6	722
Healthcare Assistants and Other Support Staff	695	85	780
Nursing, midwifery and Health Visiting Staff	769	56	825
Nursing, midwifery and Health Visiting Learners	12	0	12
Scientific, Therapeutic & Technical	600	9	609
Other	0	0	0
Total	**2932**	**160**	**3092**

Despite on-going challenges with regards to recruitment in certain professional disciplines and particular areas, the overall level of vacancies is 4.3% of the total workforce (March 19). The demand for bank and agency staff remains high and the amount of spend on bank and agency is 7.6% of the total pay bill. This is reflective of patient demand for health and social care services, coupled with national staffing shortages across a range of professional groups, particularly mental health.

The Trust agency ceiling is set at £3.3 million for the year and our spend is above the ceiling at £4.2 million. There is an improvement plan in place to continually drive down the use of agency and this has delivered a year over year improvement.

Our Solent Trust in house bank service has filled 68.5% of requested shifts with internal bank staff and ensures that agency usage is reduced to the lowest level possible.

Staff retention programme

In 2018/19 we have continued to make good progress with this programme. We were pleased that our annual nursing turnover has reduced from 18% in April 2018 to 14.4% in March 2019, which is a reduction of 3.6%.

We have been working with service lines and engaging with groups of staff across the organisation to understand the root causes of staff turnover. We have progressed our priorities as follows:

- Recruitment – improved our employee value proposition & established a distinctive brand. We implemented our first digital recruitment campaigns and we were recognised nationally, with the receipt of an award, for online recruitment innovation in the public sector by the Online Recruitment Industry (OnRec annual awards)
- Flexible working arrangements – we continue to accommodate flexible working across the organisation which is supported via our Flexible Working Standard Operating Procedures
- Training for our managers in people and leadership development – We trained 793 managers and leaders across the 5 core essentials suite of training courses as well as 32 of our managers and leaders attending releasing potential training within the year 2018/19
- Reward and recognition – we launched our “Solent Awards” initiative recognising the individuals and teams that are making a difference. Additionally we held our 2nd annual Apprenticeship Awards event to recognise the contribution they make
- Career progression: defined progression routes – we have increased the number of our Apprenticeship programmes. This year we launched the Registered Nursing Degree Apprenticeship and Nurse Associate Apprenticeship programmes to grow our own nursing workforce and structure the career pathways for our health care assistants; and
- Induction – we continue to receive excellent feedback from new starters on our Induction process. We have implemented pre-employment meetings and allocate all necessary equipment, including laptops, on the first day of employment to ensure all new employees have a positive experience and can be effective as quickly as possible.

We will continue to focus on staff recruitment and retention into 2019/20.

Equality, Diversity and Inclusion

Equality, Diversity and Inclusion (EDI) are at the heart of the Trust's values. The Trust's Equality Standard Roadmap has been designed to ensure that all service lines and corporate services are able to demonstrate advancement in equality of opportunity and meeting the Trust's obligations and duties under the Equality Act 2010, Public Sector Equality Duty, Workforce Race Equality Standard (WRES) and the Equality Delivery System 2 (EDS2). The Roadmap had three overarching objectives:

- Enabling our staff to connect with our vision, values and behaviours
- Responding to our quality, safety, operational and financial obligations, and
- Attracting, developing and retaining skilled and committed people

All of the Trust's services have been working through the Equality Standards Toolkit as part of the Equality, Diversity and Inclusion Strategy (2015 – 2018), which includes undertaking an assessment for three levels of achievement and progress: Bronze, Silver and Gold. The Toolkit was designed to support services to identify a range of evidence for the EDI work and progress, which is used as part of the annual EDS2 report.

All services have completed the bronze baseline assessment and all but two have completed the silver standard. Some of the outcomes achieved in 18/19 are summarised below:

- Sexual Health Service targeted approaches for high risk groups & extensive outreach with Lesbian, Gay, Bisexual and Transgender (LGBT) clients
- Homeless Healthcare peer mentoring scheme
- Vocational Rehabilitation Service co-designed outcome measures for those with brain injury
- Care Home Research Partnership increasing access for seldom heard (including work with National Ethics Service to adapt consent process)
- Specialist Dental increased follow up of patients who were not brought to appointments and 75% of patients are now seen within 9 weeks of a missed appointment. Also all materials in accessible versions
- The 0 – 19yrs team has delivered a highly successful 'Healthy High 5' programme in Southampton, including the Good Grub Club project, which aims to combat hunger for children during the school holidays. The project, delivered in partnership with Radian Housing Association, was the proud 2019 Winner of the National Tpas Award for Community Focused Service
- OWLES health and wellbeing group, which is about optimising lived experience for staff with mental health issues

This year, we have made an appointment to a Strategic Lead for Diversity & Inclusion who will guide us in developing a new strategy for the next three to five years. We have also established three new staff networks for LGBT, Black, Asian and Minority Ethnic (BAME) and Carers and will continue to grow our networks to underpin our strategy. We are currently in the process of establishing a network for people with disabilities to build further on progress to date. Regarding disabled employees or those who become disabled whilst working for us, we already provide support, training and make reasonable adjustments as necessary to ensure our staff can enjoy a fulfilling career with us. We continue to encourage and support applications for employment from all individuals. For applicants who

disclose a disability, reasonable adjustments are put in place upon request and all appointments are based on merit. However, the establishment of this employee network will allow us to increase the focus on the needs of people with a disability within our Trust.

New Equality, Diversity & Inclusion objectives will be developed in consultation with our communities and progress will be reported to Trust Board annually. We will also be strengthening our Equality Impact Assessment process.

The Trust's Community Engagement Strategy was also launched in 18/19. The aim of the strategy is to make community engagement a core part of how the Trust operates so that it becomes embedded in the culture and practice of the organisation at all levels alongside the EDI Strategy.

By community engagement the Trust means the variety of ways in which it involves and works collaboratively with the full diversity of communities it serves, in order to improve the health and wellbeing of individuals from those communities. Working with and involving different communities in the work of the Trust is a means to address these barriers and ensure that everyone who uses and needs the Trust's services, can fully access them and gain the benefits and health outcomes that they need.

In 2019/20 the Community Engagement Delivery Plan will focus on priorities which will be monitored by the Community Engagement Committee:

- Intelligent use of data and information to determine needs, identify gaps and inform the evidence base for work with different community groups
- Workforce and leadership development including knowledge, skills and competencies and representation of different community groups
- Fostering good relations with different community groups
- Involvement of community groups in service delivery, evaluation and development to improve health outcomes, and
- Governance and leadership.

You can read more about our Community Engagement Strategy and priorities within our Quality Account.

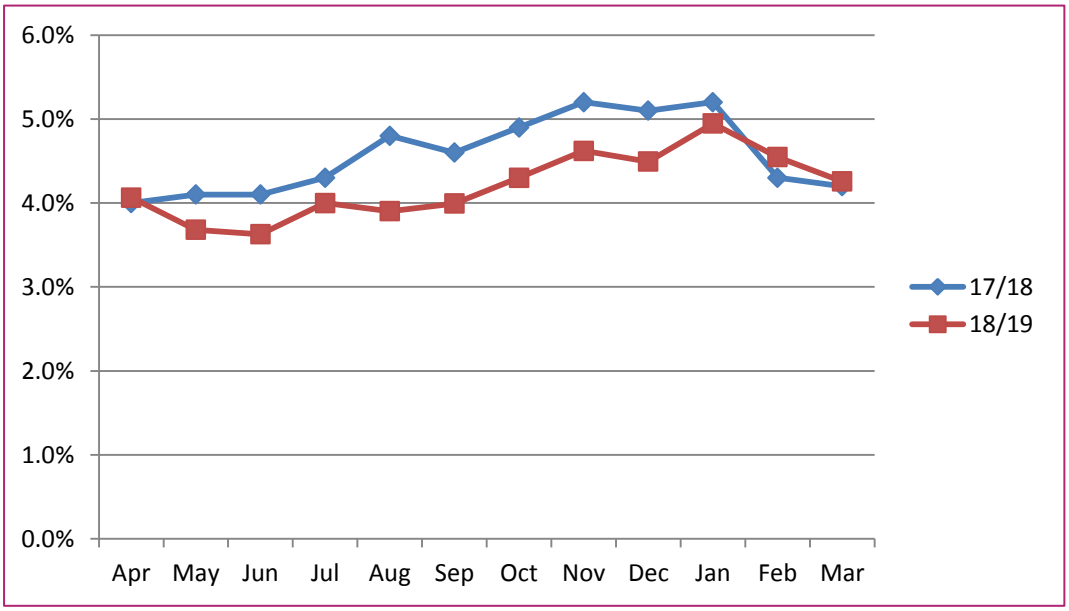
Partnership Working

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

Sickness Absence

Sickness rates have fluctated during the 12 month period between 3.6% and 4.9%, against our aspirational and challenging target of 4%. Mental health-related conditions are the main reported causes of sickness at 27.6%; this is down 0.8% on the previous 12 month period. The following graph shows sickness absence rates for April 2017 to March 2018 and April 2018 to March 2019. Sickness rates have fluctuated throughout the 12 month period, with a peak of 4.9% in Jan 2019.

The graph below represents sickenss data from April 2017 to March 2018 and April 2018 to March 2019:



In response to sickness absence data, various initiatives have been implemented and evaluated to improve staff health and wellbeing.

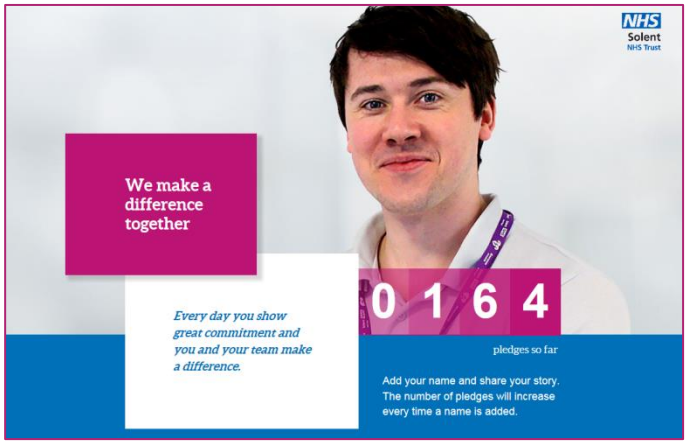
Employee Engagement

There is a clear relationship between employee satisfaction and patient satisfaction and we recognise that the highest quality of care for patients is delivered through a high quality and engaged workforce where people feel empowered to really make a difference.

Connecting people to the Solent Vision and the difference they make

A common theme in organisations with high levels of employee engagement and performance is a strategic narrative about an organisation that is compelling, authentic and which people can relate to.

This year we put additional emphasis on using storytelling to help people to connect to the Solent strategy and our strategic narrative, 'The Solent Story'. The story helps us to create a sense of trust, belonging and team. Our aim continues to be to create a connection with people that is relevant and repeatable.



Our communication and engagement programme, The Solent Difference, continued during the year with many people taking the opportunity to share their story directly with colleagues through The Difference website.

We also created additional opportunities and tools to help people develop their story and to find their connection to our Strategy. We developed a film of Sue Harriman, Chief Executive, sharing 'The Solent Story' in her own words, and some of our staff sharing their own personal stories. This was shared through communications channels and team meetings and was used to guide a conversation.

CuriosiTea events

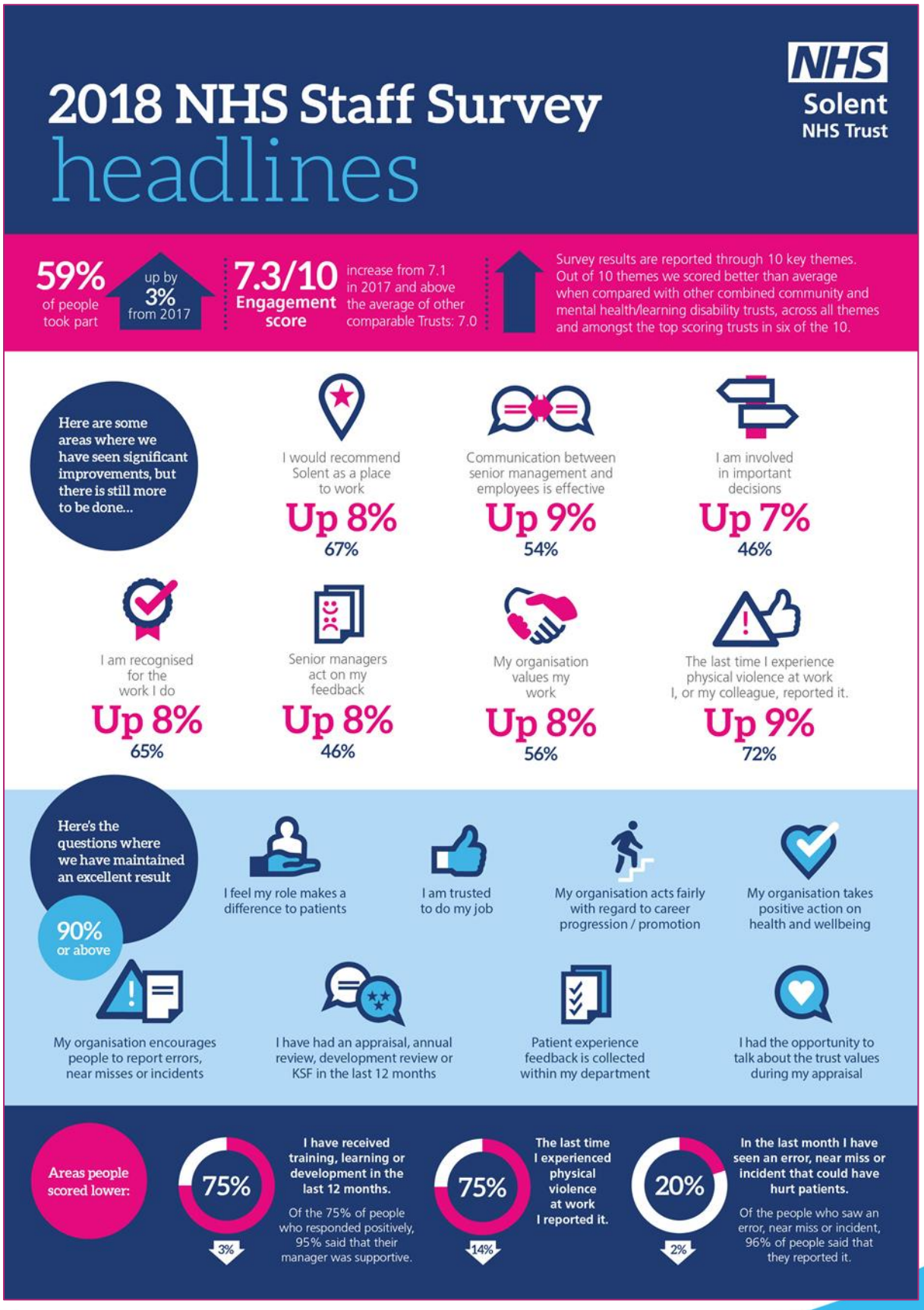
These 90 minute sessions, hosted by Sue Harriman, Chief Executive, are designed to provide people with the time and space to reflect, get professionally curious and to celebrate. At each event people spend time sharing their stories about how they have made a difference within their role, as well as meet other colleagues from across the Trust. These events are held at a variety of unusual community venues, such as the Bursledon Brickworks in Southampton and the Royal Marine Club in Portsmouth and are open to all Solent employees. To date, over 100 people have attended one of the five events, and the feedback has been overwhelmingly positive. Further events are planned for 2019/20.

NHS70 Tea Party

Around 300 people, including volunteers, from across Hampshire came together in July for a tea party at a local hotel, to celebrate and share their memories of working for the NHS. As well the chance to meet new colleagues and renew old acquaintances, these events were an opportunity to recognise and celebrate the commitment to care excellence demonstrated by all of our people.

Our 2018 NHS Staff Survey

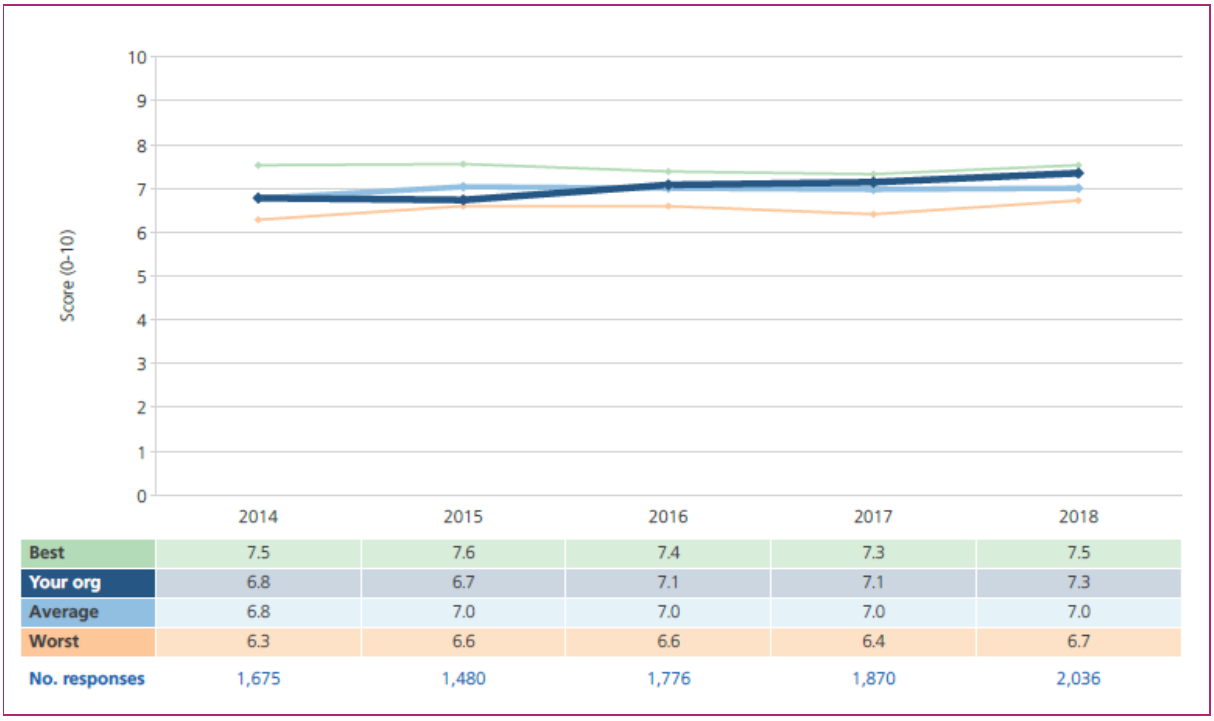
The 2018 Annual Staff Survey was carried out by Quality Health and we were pleased with a response rate of 59% which is above average for combined mental health/ learning disability and community trusts in England. A summary of our 2018 results are as follows:



In the recent Listening into Action results published in the HSJ, Solent was best in class for combined Community, Mental Health and Learning Disability Trusts.

Our engagement score has shown a steady increase over the past 4 years, and we are now above the average result for all combined Mental Health/Learning Disability Community Trusts as shown below:

Overall Staff Engagement



	2014	2015	2016	2017	2018
Best	7.5	7.6	7.4	7.3	7.5
Your org	6.8	6.7	7.1	7.1	7.3
Average	6.8	7.0	7.0	7.0	7.0
Worst	6.3	6.6	6.6	6.4	6.7
No. responses	1,675	1,480	1,776	1,870	2,036

In addition to these results, Solent are amongst the highest scoring Trusts for five of the ten Key Themes, and above average for all ten.

Top 3 ranking scores compared with combined Mental Health, Learning Disabilities and Community Trusts in England:

Key Theme	Solent 2017	Solent 2018	Average M/H/Comm Trusts
Equality, diversity and inclusion	9.4	9.4	9.2
Safe working environment - violence	9.7	9.7	8.2
Safe working environment - bullying and harassment	8.5	8.6	8.2

There is still more work to do to support our strategic priority of being a great place to work and each service line has a clear plan, which will be monitored through our governance process. We will continue the work we have been doing to actively engage all our people, develop our leaders and strengthen our culture through the HEART values.

Exit Packages

Details of exit packages can be found on page 80.

Off payroll engagements

Details of off payroll engagement can be found on page 82.

External consultancy

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

Occupational Health and Wellbeing Service

The Occupational Health & Wellbeing Team supports the Trust in meeting its responsibilities to support staff and managers to create a safe and healthy work environment.

We offer a comprehensive occupational health and wellbeing service that was SEQOHS accredited (Safe, Effective, and Quality Occupational Health Service) back in 2014 and we successfully maintained our accreditation as part of the annual review process in 2018.

Our Occupational Health Team continues to have an active presence in services, working alongside staff and managers to create a safe and healthy work environment where the health and wellbeing of employees is highly valued, encouraging and supporting staff to maintain and adopt healthy lifestyles.

Health and Wellbeing Improvement Plan

To demonstrate our on-going commitment to employee health and wellbeing our Health & Wellbeing Steering Group continues to work proactively to deliver our improvement plan. Key deliverables in the 2018 plan included a focus on mental wellbeing and prevention of workplace stress, musculoskeletal disorders and promoting healthy lifestyle choices. In year we offered an online programme called 'Shift Your Stress' and also implemented the Kaido Wellbeing Programme – offering staff a fun and focused programme of activities, challenges and resources to promote healthy lifestyles choices.

We participated in three 60 day Kaido Wellbeing Challenges during 2018/19; 'Walk the Great Wall of China' , the 'Artic Expedition' and 'Around the World in 60 Days' – all achieving positive outcomes and improvement scores for those who participated.

An extract of the results achieved for the Artic Expedition are below:

Alongside the Kaido and Shift your Stress programmes regular health and wellbeing articles were featured in our Staff Newsletters and a range of self-help resources made available and training sessions delivered. Our Occupational Health Physiotherapy services continue to lead on a targeted awareness campaign aimed at promoting musculoskeletal health and prevention strategies. In 2018 the programme focused particularly on risks relating to challenging work environments for our staff and early intervention.

We continue to work actively with our Employee Assistance Programme (EAP) provider who offers a range of staff support services including online and face to face counselling, webinars on topical issues and other work-life matters.

Flu vaccination rates

This year 73.5% of our frontline staff working with vulnerable patients took action to protect themselves and patients against the harmful effects of the influenza virus. Each year we strive to increase the uptake of the vaccine through implementation of an active campaign run throughout the autumn and winter period.

NHS Constitution

The NHS Constitution was established in 2009 and revised in summer 2015. The constitution sets out the principles and values of the NHS. It also sets out the rights to which patients, service users, the public and staff are entitled, a range of pledges to

THE NHS CONSTITUTION
the NHS belongs to us all

achieve and the responsibilities which patients, service users, the public and staff owe to one another to ensure that the NHS operates fairly and effectively. We operate in accordance with the principles and pledges as set out in the NHS Constitution and undertake an annual review of our compliance, which is reported to our In-public Board meeting.

Health and Safety

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

Trade Union (Facility Time Publication Requirements) Regulations 2017

Information on the amount and cost of facility time given to Trade Union representatives as specified within the Trade Union (Facility Time Publication Requirements) Regulations 2017 is shown below:

Table 1: Relevant Union Officials

Number of employees who were relevant union officials during the 2018-19 year	Full time equivalent employee number
27	18.63

Table 2: Percentage of time spent on facility time

The number of employees who were relevant union officials employed during the 2018-19 year spent a) 0%, b) 1% - 50%, c) 51%-99%, or d) 100% of their working hours on facility time

Percentage of time during the 2018-19 year	Number of employees
0%	26
1-50%	0
51 – 99%	0
100%	1

Table 3: Percentage of pay bill spent on facility time

First Column	Figures
The total cost of facility time	£29,934
Total Pay bill	£126,333,000
The percentage of the total pay bill spent on facility time *	0.23%

*(total cost of facility time divided by the total pay bill times 100)

Table 4: Paid trade union activities

First Column	Figures
Time spent on trade union activities as percentage of total paid facility time hours*	0%

*(total hours spent on paid trade union activities by relevant union officials during 2018-19 divided by the total paid facility time hours times 100)

For the purposes of this section paid facility time includes duties as a union learning representative, union representative, health and safety representative, for the purposes of training, consultation, or representation which arises under section 168, section 168A of the 1992 (Trade Union and Labour Relations (Consolidation) Act 1992), section 10 (6) of the Employment Relations Act 1999 and Regulations made under section 2(4) of the Health and Safety at Work Act 1974.

Trade Union Activities as specified in section 170 (1) (b) of the Trade Union and Labour Relations (Consolidation) Act 1992. This can include attending Regional or National policy making meetings, voting in Union elections, attending other Branch meetings, executive committee meetings, regional union meetings, and annual conferences, etc.

The Accountability and Corporate Governance Report is signed by;

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

Section three:
The Auditors Report

Independent auditors report to the Accountable Officer of Solent NHS Trust

(To be inserted from EY)

Section four:
Our Summary Accounts

Our summary accounts (unaudited)

Foreword and Statement on Financial Performance

We have ended 2018-19 by achieving three of our four financial statutory duties:

- External Financing Limit (EFL) which is an overall cash management control. The Trust was set an EFL of £11.1m cash outflow for 2018/19, actual EFL was £0.7m cash inflow and therefore the Trust achieved the EFL target with a positive variance of £11.8m.

- Capital Cost absorption rate is based on actual (rather than forecast) average net relevant assets and therefore the actual capital cost absorption rate is automatically 3.5%.

- Capital Resource Limit (CRL) which represents investments in fixed assets throughout the year. The Trusts fixed asset investment for 2018/19 was £8.5m, a £1.5m underspend against the target of £10.0m.

Whilst the Trust achieved an in year adjusted surplus of £1.4m, the Trust did not achieve its cumulative breakeven duty, a measure of financial stability, with a cumulative adjusted retained deficit of £6.8m reported in 2018/19.

The 2018-19 financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS. Where the Group Accounting Manual permits choice of accounting policy, the accounting policy which is judged to be the most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

Insert signature

Sue Harriman
Chief Executive Officer
Date: 24th May 2019

Finance Review & Statutory Duties in relation to the Accounts

The statement of directors responsibilities in respect of the accounts can be found on page 75.

Break-even position (a measure of financial stability)

The Trust has a statutory duty to achieve break-even in the year. The Trust has achieved the breakeven duty in year, reporting a £1.4m adjusted surplus in 2018/19. As the Trust has previously reported deficit results, the cumulative breakeven position has not been achieved, with a cumulative adjusted deficit of £6.8m. 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 £11.1m cash outflow for 2018/19 which it is permitted to undershoot. Actual external financing requirements for 2018/19 were £0.7m cash inflow and therefore the Trust achieved the target with a positive variance of £11.8m.

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 £10.0m for 2018/19. Its actual fixed asset investment was £8.5m, an £1.5m underspend against target.

Want to find out more?

Included on the following pages are the 'summary financial statements' 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 2019

	2018-19 £000	2017-18 £000
Employee benefits	(127,167)	(121,385)
Other costs	(62,782)	(58,341)
Revenue from patient care activities	171,897	167,059
Other Operating revenue	21,222	20,160
Operating surplus/(deficit)	3,170	7,493
Investment revenue	94	24
Other gains and (losses)	(1)	(4)
Finance costs	(152)	(151)
Surplus/(deficit) for the financial year	3,111	7,362
Public dividend capital dividends payable	(2,240)	(2,305)
Retained surplus/(deficit) for the year	871	5,057
Impairments and reversals taken to the revaluation reserve	(191)	(630)
Revaluations	419	351
Total comprehensive income for the year	1,099	4,778
Financial performance for the year		
Retained surplus/(deficit) for the year	871	5,057
Impairments (excluding IFRIC 12 impairments)	753	(4,310)
Adjustments in respect of donated asset respect elimination	(254)	(10)
Adjusted retained surplus/(deficit)	1,370	737

Statement of Financial Position as at 31 March 2019

	31 March 2019 £000	31 March 2018 £000
Non-current assets	90,808	86,351
Current assets	31,681	24,628
Current liabilities	(34,673)	(26,450)
NET CURRENT ASSETS / (LIABILITIES)	(2,992)	(1,822)
TOTAL ASSETS LESS CURRENT LIABILITIES	87,816	84,529
Non-current liabilities	(1,514)	(5,223)
TOTAL ASSETS EMPLOYED	86,302	79,306
FINANCED BY TAXPAYERS' EQUITY	86,302	79,306

Statement of Changes in Taxpayers' Equity for year ended 31 March 2019

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2018	**6,435**	**7,625**	**65,246**	**79,306**
Changes in taxpayers' equity for 2018-19				
Impact of implementing IFRS 9 on 1 April 2018		(5)		**(5)**
Retained surplus/(deficit) for the year		871		**871**
Net gain / (loss) on revaluation of property, plant, equipment			0	**0**
Public dividend capital received	5,902			**5,902**
Impairments and reversals			228	**228**
Transfers between reserves		231	(231)	**0**
Net recognised revenue/(expense) for the year	**5,902**	**1,097**	**(3)**	**6,996**
Balance at 31 March 2019	**12,337**	**8,722**	**65,243**	**86,302**
Balance at 1 April 2017	**6,435**	**8,163**	**59,930**	**74,528**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year		5,057		**5,057**
Net gain / (loss) on revaluation of property, plant, equipment				**0**
Impairments and reversals			(279)	**(279)**
Transfers between reserves		259	(259)	**0**
Net recognised revenue/(expense) for the year	**0**	**5,316**	**(538)**	**4,778**
Balance at 31 March 2018	**6,435**	**13,479**	**59,392**	**79,306**

Statement of cash flows for the year ended 31 March 2019

	2018-19 £000	2017-18 £000
Net cash inflow/(outflow) from operating activities	9,941	7,623
Net cash inflow/(outflow) from investing activities	(6,620)	(3,523)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**3,321**	**4,100**
Net cash inflow/(outflow) from financing activities	2,743	(790)
INCREASE / (DECREASE) IN CASH	**6,064**	**3,310**
Cash at the beginning of the period	9,601	6,291
Cash at year end	**15,665**	**9,601**

Better Payment Practice Code: Measure of Compliance 31 March 2019

	2018-19		2017-18	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	27,822	54,799	24,989	50,562
Total non-NHS trade invoices paid within target	25,115	45,438	23,479	47,509
% non-NHS trade invoices paid within target	90%	83%	94%	94%
Total NHS trade invoices paid in the year	1,381	14,880	1,230	17,446
Total NHS trade invoices paid within target	1,139	13,971	1,067	16,514
Percentage of NHS trade invoices paid within target	82%	94%	87%	95%

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

In an environment of rising service demand ensuring we deliver safe and effective services whilst balancing financial efficiencies is becoming increasingly difficult. Whilst we ended 2018/19 achieving a £1.4m surplus, the Board acknowledge that there are more challenging years ahead.

Our efficiency target for 2018/19 (Cost Improvement plan) was £7.7m and we delivered cost savings of £6.1m (the balance was achieved by other measures) but we recognise that there is more to do – both internally within the organisation and with partners to radically transform health and care pathways in accordance with the ambition and plans of the Hampshire and Isle of Wight STP.

Working differently and with our partners as part of a 'system' may, at times, mean we need to make difficult decisions for the greater good of our service users and the wider NHS – we will always endeavour to put our citizens and communities before services, and services before organisations, in accordance with our guiding principles.

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

The key challenges we face in 2019/20 are as follows:

- Delivery of our breakeven Control Total, particularly in the current absence of funding for pay uplifts for our Public Health contracts
- Delivery of the efficiency savings programme (£8.1m) – including continuing to reduce our agency spend in order to be compliant with the regulatory agency ceiling cap. However, the quality and safety of our services must always remain our highest priority
- Delivery of key programmes including estates rationalisation – including the redevelopment of the St Mary's campus and consolidation onto the Western Community Hospital campus and Bitterne Health Centre, and
- Continued working within the Sustainability and Transformation Programme, developing Integrated Care Partnerships and Systems.

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

Going Concern

The Trust's Finance Committee and Audit and Risk Committee have been reviewing evidence around the Going Concern statement, in light of our deficits in 2014/15, 2015/16 and 2016/17.

Our 2018/19 surplus supports our financial statements being prepared on a going concern basis, and management have no significant reasons to believe this to be inappropriate, or otherwise. This is further supported by the recent contract negations with NHS and Local Authority organisations to provide continuing services throughout 2019/20 within an agreed breakeven Control Total.

In conclusion, having considered the challenges we face, particularly with reference to our operating plan for the next twelve months, and having reviewed with our external auditors, the Board has a reasonable expectation that the Trust has access to adequate resources to continue in operational existence in the foreseeable future. For this reason the Trust continues to adopt the going concern basis in preparing the annual accounts.

The statement of financial position is signed by:

Insert signature
Sue Harriman
Chief Executive Officer
Date: 24th May 2019

Section five:

Quality report incorporating the Quality Account 2018/19

Presented separately to the Board for approval

(to be inserted post approval)

Appendix 1:
Full Accounts

Presented separately to the Board for approval

(to be inserted post approval)

NHS
Solent
NHS Trust

Solent NHS Trust

Quality Account 2018/19

Contents

Part One: Statement on quality from the Chief Executive

Introduction

Each year all providers of NHS healthcare services are required to produce an annual Quality Account for publication. The Quality Account sets out our commitment to continuous quality improvement and shows what we have achieved in the past year. It reflects and demonstrates the importance our board and our staff place on quality.

This is our eighth Quality Account since the Trust was established in 2011 and it is divided into three sections:

- Part One contains introductory statements from myself the Chief Executive, the Chief Nurse and Chief Medical Officer
- Part Two contains a review of our progress in delivery of our quality priorities for 2018/19, we also set out our priorities for improvement for 2019/20, and mandated quality statements and indicators as detailed in the *'Detailed Requirements for Quality Reports 2018/19'* published by NHS Improvement in December 2018
- Part Three contains details of other quality initiatives not covered elsewhere in the report and includes examples of quality improvement projects and patient stories from across our clinical servies which show how we have made a difference to patients

I hope this report provides a useful insight into our approach to quality, our performance and achievements, and our plans and priorities for the year ahead.

The Solent Story

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

People, values and culture drive us. The best people, doing their best work, in pursuit of our vision. People dedicated to giving Great Care to our service users, and great value to our partners.
We aspire to be the partner of choice for other service providers. With them we will reach even more people, and care for them through even more stages of their lives. Ultimately it is the people we care for who will tell us if we are successful and who will help shape our future care.

We know our vision is ambitious, but we have excellent foundations. Our priorities are what we do all of the time, they are how we:

Deliver Great Care

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

Make Solent a great place to work

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

Deliver the best value for money

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

Quality Framework

We launched our new Quality Framework in September 2018; it supports our vision and focus on making a difference to patients and their families and brings together how the Trust delivers Great Care in a way that is clear to patients, staff and our stakeholders

At the centre of the Framework is a formula designed to be easy for patients and staff to remember and relate to: **SEE** (Safe, Effective, Experience).

The Framework sets out:

- what quality means to Solent, its patients and staff in terms of Safe, Effective and Experience (SEE)
- the pivotal role our staff play and how we support them to deliver Great Care
- how we check the quality and standards of care in our services
- how we use innovation, research and organisational learning to continually improve
- governance, risk management and leadership arrangements for quality
- how we talk about quality at all levels of the Trust

The Framework will help us ensure that providing Great Care is at the heart of everything we do and we will be doing more work to embed it in the coming year.

Care Quality Commission

We were pleased to welcome the Care Quality Commission (CQC) to the Trust this year. I am delighted and extremely proud that following their inspections the CQC have rated Solent as "Good" overall and providing "Outstanding" care. Our Primary Care Services were inspected separately and were also rated as "Good" overall.

Within their reports, CQC identified several areas of "Outstanding" practice including:

- Our vision and purpose was found to be clearly stated and understood by our staff
- We have a holistic approach to ensuring mental health is part of overall health and not separate
- We have a positive culture developing across the Trust in respect of Allied Health Professionals (AHPs)
- Our strong medical leadership for supervision and training, alongside a quality improvement culture
- Our rates of Information Governance compliance and awareness resulting in our ranking as second out of 55 Mental Health Trusts on the Information Governance Toolkit
- The way we learn and improve when things don't go as planned and when there are positive outcomes for patients
- Our success in research and our top position in the National Institute for Health Research's annual league tables
- Our approach to actively engaging in collaborative work with external partners, such as involvement with sustainability and transformation plans, and our proactive approach to system changes and integration being essential for the future and to manage resources
- Outstanding practice in the Children's and Young People core service including:

- The take up for the National Child Monitoring Programme (97.1%. compared to the national average of 90%).
- The way in which the services used methods, such as Solent Young Shapers and the 15 Steps Challenge process, to seek the views of children and young people who used the services to support development and improvements to the services

We are especially proud that CQC found that our managers across the Trust promoted a positive and patient centred culture that supported and valued staff, creating a sense of common purpose based on our shared values and vision to make a difference to patients.

These results are a tribute to our everyone who works in Solent; those who work directly with patients and in back office teams, to give consistently give Great Care, create a great place to work and to keep people safe and well at, or close to, home. I'm especially proud that the CQC found we are "Outstanding" at providing caring services; this reinforces what I see and hear every day about our innovative and inspirational patient care.

We pride ourselves on being an organisation with improvement and learning at its heart, and the CQC's report is a testament to that. There will always be areas where we can do better and there are some areas where more work is required. We are committed to making these improvements and continuing to improve the quality of care for our patients.

Quality Improvement Priorities

We are extremely pleased with the progress we've made in delivering the priorities we set for last year. These were framed around our corporate strategic goals and were designed to provide a foundation for future quality improvements. Many projects will continue in the coming year.

Our trust-wide priorities for 2019/20 take into account the findings from CQC inspections and Staff Opinion Survey and this year each of our clinical services have identified their own priorities; all our priorities reflect staff and patient feedback and as well as national and local drivers. The service-led priorities resonate strongly with our frontline staff and will make a real difference to patients and their families.

We're Listening

Listening to our patients, their families and carers, our staff, people who live in the communities we serve, and our partners and stakeholders, helps us make sure we are doing the right thing.

Our overall Trust Friends and Family Test (FFT) results have been very positive this year with above 95% of respondents saying they would recommend Solent and below 5% saying they would not recommend us; this means we are consistently achieving the targets we have set ourselves and we score more highly than the national averages. We review every source of feedack we receive, even if it is positive, and our services provide feedback on changes and improvements they've made as a result using "You Said, We Did" posters and bulletins and there are examples in this report.

We are also especially proud of our Staff Opinion Survey results for 2018. Results show we are among the best when compared with other combined mental health and community trusts, we are one of the top performing Trusts in the country for six key themes, and above average across all ten. We maintained excellent results in some important areas, and I am thrilled our engagement score, which tells us how staff feel about their work, has increased for the third year in a row. There are some other significant improvements such as staff feeling more valued and recognised for the work they do, and a significant increase in the number of people who would recommend Solent as a place to work.

The survey continues to highlight some challenges for example, staff can find it hard to take care of their own wellbeing, so I want to make sure Solent becomes an organisation where we achieve a balance between looking after ourselves and our patients. We also need to make sure we provide an environment where staff are able to speak up when they see and/or experience something that isn't right. To reflect their importance these are two of our Trust-wide quality improvement priorities for this year.

The 2018 results tell me staff feedback is making a difference, and we really are creating a great place to work. My commitment is to ensure that leaders and managers keep listening and making changes to improve the Trust for everybody.

Working Together

This year we developed our *Community Engagement Strategy* which will help us to address health inequalities, ensure we have meaningful involvement with our local communities and involve them in planning and decision-making. We held a very successful community engagement event before our Annual General Meeting in September which involved round-table discussions and a Q&A session between members of the Trust Board and a wide range of stakeholders. We plan to hold more events like this in future.

We have provided more opportunities for staff to talk directly to our leadership team such as CuriosiTEA events and Schwartz Rounds and have continued the *Solent Difference*, with many more staff taking the opportunity to share their story directly with colleagues through *The Difference* intranet page. These powerful stories shine a light on examples of great service and care that many people aren't aware of; it also encourages people to reflect on their own role and the many ways they make a difference to their colleagues or service users.

New for 2018/19

We are pleased to report on new aspects of our quality performance this year in relation to Speaking Up (whistleblowing), Doctors and Dentists in Training and Learning Disabilities Improvement Standards and in Part 3 of this report we provide insight into the various other ways we have improved quality over the past year.

I confirm that to the best of my knowledge the information in the Quality Account is accurate.

(signature)

Sue Harriman
Chief Executive

Statement from Chief Nurse and Chief Medical Officer

Thank you for taking the time to read our Quality Account for 2018/19. It has been an incredibly busy and successful year when our focus has been to embed a culture of safety, continous improvement and learning, while we develop how we manage quality across the Trust. Below are some of the ways we have improved how we support our staff to deliver Great Care, made changes to our approach and the way we work, and how we plan to contine to improve in the year ahead.

Our new **Quality Framework** was developed and provides a clear blueprint to putting patient safety, clinical effectiveness and patient experience at the heart of everything we do. We plan to further embed the Framework in 2019/20 by:

- reviewing our governance and assurance reporting arrangements to make sure the Quality Framework domains of Safety, Effective and Experience are reflected
- developing a communication plan to make the Framework more accessible to all of our staff
- evaluating the level of awareness and impact of the Framework at the end of next year

We are delighted our Primary Care services were rated "Good" following **CQC inspections** last year, and following inspection of other core services the Trust was rated "Good" overall and "Outstanding" in the caring domain. Achieving "Outstanding" in the caring domain reflects how well Solent NHS Trust involves and treats people with compassion, kindness, dignity and respect. The CQC repeatedly praised our staff for the commitment they show to patients, commenting that: "staff were kind, caring and treated patients with dignity and respect, and patients spoke of the positive care they received from staff". They said people "involved patients, and those close to them, in decisions about their care and treatment".

We have worked hard to ensure we have a strong quality improvement culture in the trust. The CQC were very complimentary of this culture, and said that people were proud to work for the Trust; "There was a positive organisational culture, which supported openness and transparency" and staff"spoke highly of their leaders".

The CQC's report identifies some areas where we need to make improvements and we will be adressing these in the coming year; some have been identified as **quality improvement priorities** alongside those developed by our clinical services. At a corporate level we have identified what we will do to support staff to deliver these priorities including:

- Developing the Ulysses system to improve the effectiveness of risk management and organisational learning from complaints, patient feedback and incident trends
- Implementing a consistent approach to developing new clinical roles across the Trust
- Developing and implementing an Organisational Safety Programme across our core clinical services
- Increasing access to research and improving the experience of being involved
- Continuing to foster a climate for learning, improvement and innovation across our organisation and community
- Strengthening patient and community involvement and engagement in improvement activity across the organisation

Our ambitous **Community Engagement Strategy** developed in 2018/19 sets out how we will build on the best engagement activities we undertake in Solent and ensure these are adoped widely across the organisation. The Framework identifies how we will work more closely with our stakeholders including patients, families and carers, people who live in our communities, the voluntary sector and other public bodies. We are commited to improving the health and wellbeing of individuals by reducing health inequalities and seeking wider community involvement when setting our goals and vision, designing and delivering our clinical services, and evaluating services and making

improvements. We hope the shared culture and values, and ethos of collaboration and partnership with all of our stakeholders will become more embedded as we begin delivery of the strategy this year.

The **Solent Quality Improvement (QI) Programme** continues to grow in strength and impact, aiming to equip those that work with us (employees, patients and colleagues) with both the skills and confidence to identify, deliver and sustain improvements across our services. It has been extended this year to include 'Foundation Level' one day training to provide an introduction to QI methodology, as well as bespoke QI sessions within Trust leadership and development programmes. We have also delivered two cohorts (of 8 multidisciplinary teams) of our core programme which incorporates a facilitated QI project. A key part of the Foundation and Core programmes is the involvement of patients, service users and families in both identifying what could be improved and delivery and testing changes.

We have implemented our **Learning from Deaths** programme in line with the National Quality Board Guidance, with an emphasis on what we can learn to improve the care we provide to patients. The learning from deaths is shared at the monthly Learning from Deaths panel. If a mortality review indicates the need for a more thorough review or investigation then a strategy meeting is held and a decision taken as to the level of investigation required. All deaths which are investigated as a Serious Incident (SI) are presented to the same panel and the learning is recorded on the Verto learning log with review dates to ensure the change made has had a positive impact on the experience of patients, families and staff. In their recent inspection CQC commented that we have a very positive organisational learning culture, which supports openness and transparency and we are particularly proud of this achievement.

In response to the **Gosport War Memorial Independent Panel Report** we reviewed the findings and the Board received assurance that having completed an initial review, there were no risks identified which required immediate actions. However, we have put in place a plan to make improvements based on the findings in the report. In January 2019 the Trust Board received an update on progress against the improvement actions and a formal report was presented to Board in February 2019.

We developed our new **Learning Disabilities Strategy** this year which is an enabler to help us meet the Learning Disability Improvement Standards published in June 2018. In meeting these standards we will demonstrate we are delivering high quality services for people with learning disabilities, autism or both. We have already made good progress and a summary of our current performance against each standard and improvement measures is in Section 3. Following approval by our Board we plan to launch the strategy at our nursing conference in May 2019.

We have now embedded **Accessible information** (AI) screening into all electronic patient record systems across the Trust. The screens have been designed to meet the requirements of the NHS England Accessible Information Standard (DCB1605 Accessible Information).

Looking ahead, providing Great Care remains remains our highest priority. Through this Quality Account we pledge our commitment to continue to support our staff to deliver the highest standards of quality across all the clinical services we provide, and in those clinical services where we work in partnership with others.

(signature)

Jackie Ardley
Chief Nurse

(signature)

Dan Meron
Chief Medical Officer

Part Two: Priorities for improvement and statements of assurance from the Board

2.1.1 Progress against Priorities for Improvement 2018-19

Our quality improvement priorities for 2018/19 were based on themes linked to our strategic corporate goals. The overarching aim of this approach was to create a sustainable dynamic framework of co-operative working which would deliver a shared vision and provide foundations for future improvement.

We are pleased to be able to report that significant progress has been made in the delivery of each priority and for the majority of these initiatives work will continue in 2019/20:

Priorities	Action/s to be taken	Progress
Theme 1: Involving People		
1.1 Embed a sustainable Community Engagement Strategy which is inclusive of patients, people who live in our communities, local partner organisations and external stakeholders.	• Development and delivery of a comprehensive action plan (Greater Together – Delivery Plan) to deliver the Community Engagement Strategy. • Development of Equality, Diversion and Inclusion (EDI) Strategy	• Delivery Plan complete and implementation led and monitored by new Community Engagement Committee which reports directly to Board. • Community Engagement data review is underway and due to report to Community Engagement Committeee in May 2019. The review is identifying gaps in the evidence base and providing an anlsysis that can be used to determine priorities to inform the Delivery Plan actions, so these are evidenced based. • External mapping of community and voluntary sector has been completed. This will be used to map engagement with the sector against relevent population group priorities (as evidenced in data review) against service line leads. • Engagement Communications Strategy in development to underpin the Delivery Plan and create a coherent narrative across business planning activities. • Business case developed for skills and competency work under the QI programme for community and service user enagement. • EDI Annual Report completed and discussed at Board. The new EDI Strategy is subject to further data analysis, which is being undertaken, in order to determine the Trust's equality objectives.
1.2 This will incorporate the use of assistive technology to successfully access "hard to reach" groups such as the frail, elderly and housebound in improving services.	• Use of AI to deliver the Community Engagement Strategy. • Research & Improvement (R&I) Team to use technology to support and learn how to engage	• Successful delivery of Community Engagement Event and Accessible Annual General Meeting (AGM) in September 2018 in line with Communication Access Standards. • Number of R&I projects that involve technology to increase access to

Priorities	Action/s to be taken	Progress
	with frail and elderly people receiving care in their home (housebound).	services and supported self-management. For example, Virtual Reality for mental health therapies, pedometers to improve physical health in mental health, and COPD; web-chat; and 'AI' for sexual health triage/ advice, particularly for high risk populations.
1.3 We will seek out and work with mental health patients and their families, and use them as subject-experts to ensure we meet their highly specific needs to make our environments as safe as possible for them. We will also be able to demonstrate learning from their experiences, and from the very precise knowledge patients can be enabled to share with us.	• We will develop a link role with Solent MIND; the post holder will work with patients and carers to ensure their views are sought and considered when we are developing our services. Members of our Patient Forum are invited to attend our Clinical Governance meeting and Solent MIND represent patients and their families at Solent other user groups and forums. • We will actively engage patients and their families in our forthcoming Quality Improvement Projects such as Older Peoples Care Planning, developing joint pathways with Southern Health, reducing violence and aggression on in-patient units and consulting with patients during ward remodelling about their preferences regarding furniture and art work • During the vanguard remodelling in our Substance Misuse service we plan to consult extensively with service users about their environmental preferences.	• Link role with Solent Mind has now been developed and recruited to. This post holder will bring patient and carers views to appropriate meetings and discussions. • Patients and carers have formed part of QI projects in varying degrees. Patients have also chosen art work and furniture in our inpatient wards. • Patients and carers have been consultated throughout as we have remodelled our Substance Misuse Service and we have taken their feedback into account when designing the new environment
1.4 We will increase our engagement with local Healthwatch groups, to ensure they are aware of our most up to date quality work. A measurable outcome will be held within records of these meetings and their opportunity to feedback real-time quality comments to further improve our relationship and functional work dynamic with our partners.	• Healthwatch to be invited to specific forums and events e.g. the Complaints Scrutiny Panel; the Annual General Meeting • Healthwatch to be involved in projects e.g. the complaints quality improvement project	• Healthwatch are active participants in the quarterly Complaints Scrutinty Panel. They were also active participants in the Annual General Meeting • A member of Healthwatch Portsmouth was a member of the QI project which worked on the local resolution process
Theme 2: Ensuring Safe Care		
2.1 Launch the Research and Improvement Academy. Using different learning	• Research Academy to be formally launched in July 2018.	• Academy of Research & Improvement launched in July 2018, including a new website.

Priorities	Action/s to be taken	Progress
approaches which our staff will be able to access at home or at work. The quality of care will improve as a direct result of staff working within an active learning culture, where the everyday norm is looking for improvement.	• Structured programme of learning opportunties to be introduced, including face to face, and through facilitated projects, workshops and masterclasses. Also to be made available as online materials	• Prospectus outlining support, opportunities and training events published, both in hard copy and online • Annual programme of learning events, and facilitated projects in place including extended scope for QI programme
2.2 Roll out the QI Leaders programme. This is aimed at all staff, both clinical and non clinical.	• Funding obtained from HEE Wessex to trial QI Leaders programme – cohort of 10 'leaders' recruited, to start their training in December 2018	• 8 QI leaders mid-way through a leadership programme. • This will form the first cohort of QI coaches that can support teams within services across the organisation. Second cohort to be advertised in Autumn 2019
2.3 Ensure patient safety is integrated and evidenced through documented one to one supervision conversations and pre-set personal outcomes for learning.	• Supervision policy to be reviewed and updated • Safety to be a focus of discussions with Professional leads and Matrons during Q3/2018 • Addendum to Clinical Supervision Policy to strengthen approach to 'eyes on practice' will be made emphasising link to safety and learning • Safety will be integrated into the Appraisal process and linked to personal development	• The Clinical Supervision and Safeguarding Supervision policies have been reveiwed and updated • Safe Staffing meetings have been introduced at which patient safety is considerd and discussed. Actions are taken when indicated. • Services across the Trust have introduced 'eyes on practice' through shadowing and some areas have introduced quality peer reviews
Theme 3: Learning and Improving		
3.1 Utilise the Learning from Deaths and Serious Incident Panels to learn, implement and disseminate positive change	• Learning when a change is identified that can be monitored, is tracked through "VERTO" and reviewed at future panels • Professional Leads to disseminate learning thorugh their service line governance structures • Different methods of dissmeninating learning to be piloted piloted e.g. Biteable videos • A shared learning page on the Quality and Professional Standards page to be developed • Establish good working relationships and links with the Research Academy teams-including clinical effectivemess and audit	• VERTO continues to be a successful process to monitor and track changes. The updates and progress, change outcomes continue to be monitored at panels • The Service Line Professional Leads use a variety of methods to disseminate learning, including local meetings and newsletters. • Other methods for dissemination continue to be piloted. A learning zone is under construction on the intranet to enable staff to access learning outcomes form a variety of sources • The Quality and Safety team held a joint meeting with the Research and Audit Team and continue to consider ways to collaborate and work together. The learning framework development work continues in collaboration
3.2 Launch a change and improvement database	• Establish the database/learning collection tool • Gather learning at SI and LfD panels • Allocate leads for each action and establish process for evidencing the improvements have been embedded in practice and shared across	• VERTO is now live, the action spreadsheet was transferered onto the live system in late December 2018 • Learning is noted for VERTO tracking at SI and LfD Panels. • Work continues to develop the learning zone. Once this is constructed extracts from VERTO can be added for all staff to access

Priorities	Action/s to be taken	Progress
	the organisation • Make database accessible via SolNet	
3.3 Develop a toolkit for learning from excellence	• Reverse SI's carried out and learning shared • Favourable event reporting piloted and being implemented into trust wide reporting system. • Trust wide launch to happen early in 2019 • Materials on SolNet	• Appreciative enquiry carried out with 'reverse SIs' and shared via SI panel and Learning & Improvement Group • Learning Strategy & Framework developed with Delivery Plan in place for 2019 • Favourable Event reporting built into Ulysses system, with new branding, and paper copy to be made available • Materials available on SolNet with videos to share learning • Research & Improvement Conference 2019 themed around learning from excellence
3.4 Evidence the improvements as a result of learning and change	• Clinical Audit and Evaluation report templates to identify improvements rather than just completed actions to be put in place • QI projects to focus on outcomes and change (including skills development for teams)	• Improvements and learning captured in reporting templates, and reports to service line and Board committees – this applies to all Clinical Effectiveness and QI activity • Case studies now written for each project for easy to access summaries, to include outcomes and learning
	• Establish the use of "VERTO" to monitor and evidence change impact • Evidence of the learning to be reviewed at panels and the evidence of the product embedded and the value/change it has resulted in reviewed and discussed	See section 3.2 above
Theme 4: Sharing excellence		
4.1 Continue to present at local or national conferences on subjects of interest and expertise	• We will Increase the number of local and national conferences we present at. For instance, plans for 10 posters at the HEW Patient Safety and QI conference, including a prize winner; presentations at Health Services Research UK, R&D Forum – present jointly with patients; International Sexual Health Conference; International Quality Conference; National Falls and National Geriatric Society Conference; International SLT Conference	• Strong conference attendance, including presentations. Number of keynote talks given from Solent at national events, including NHSI patient experience conference
4.2 Work with system partners to ensure they are fully briefed on our most up to date improvement work	• QI programme to be open to external partners. • Training to be delivered to CCG in Hants, and joint teams in Soton and Portsmouth (eg Care Homes, PRRT, Autism Pathways)	• External partners, colleagues and patients are on the majority of QI teams. • Training completed

Priorities	Action/s to be taken	Progress
4.3 Work towards identifying all people with a learning disability and/or communication disability accessing any of our services and provide appropriate adjustments to support person centred planning	• Communication and information needs will continue to be collected via Accessible Information Screening available on all electronic patient records • Schedule analysis of contacts to investigate how services are meeting the specific communication and information needs of patients • Share best practice examples of Easy Read care plans and develop new templates to be made available on SolNet • Develop Easy Read / Accessible versions of Education Health & Care Plans	• Accessible Information screening embedded into all electronic patient records • Analysis of contacts as of February 2019, 11,646 discussions about communication and/or information needs have been recorded • Of these, 5,020 people went on to have a full accessible information screen completed. Through screening, 1,941 people with communication and/or information needs were identified, which equates to 39%. • There is a high proportion of people requesting information in a verbal format; provision of audiovisual information remains low
4.4 Replicate outstanding success factors from the learning disability service across other service lines	• Evaluate the impact of the Portsmouth CAMHS-LD accessible sleep help resources in relation to self-management and the teams productivity. • The Trust will develop a trust wide Learning Disability Strategy to be launched in Spring 2019. The Strategy will ensure the Trust meet its responsibilities within the Learning Disability Improvement Standards as set out by NHS Improvement in June 2018	• The 'Sleep Help' resources were launched in February 2019 and can be access via the Solent Healthier Together website: https://www.what0-18.nhs.uk/solent/camhs/sleep-help • Our new Learning Disabilities Strategy has been developed and approved by the Trust Board; the Strategy will be launched across the Trust in May 2019 • Section 3 of this Quality Account provides details of our progress in implementing the new national Learning Disabilities Improvement Standards
Theme 5: Supporting vulnerable people		
5.1 Further embed Mental Capacity Act (MCA) and Safeguarding training across our services	• Strengthen links with MCA lead for the Trust • Review MCA training offer and ensure people can access case based learning • Review Safeguarding trainng to maximise attendance	• The Trust has agreed to implement the national comeptency framework and the 4LSAB toolkit both of which will be rolled out across the Trust in 2019/20 • The Trust has invested in a MCA training role which will support implementation fo the comeptencies and toolkit as well as delivering scenario based training to all clincal staff. In 2018/19 we have seen significant improvements in compliance with MCA and safeguarding training
5.2 Develop our capabilities in the application of the MCA and safeguarding principles	• Consider adopting the National Competency Framework for staff across the Trust • Develop a scenario based trainng to support frontline practice • Work with colleagues across the 4LSAB's to learn from SAR's and embed learning in practice	• As above • Learning and actions as a result of SARs have been discussed at Safeguarding Steering Group

Priorities	Action/s to be taken	Progress
5.3 Ensure senior managers and the Executive Team attend MHA-specific training to use as a senior information resource for staff	• Work with MH Lead to develop trainng for senior managers and executives • Deliver training to senior managers and executives • Develop resource pack for senior managers to support decsion making and to enable high quality advice to staff	• The resource pack for senior managers will be delevoped when the newly appointed MHA lead is in post early in 2019/20
Theme 6: Looking after each other		
6.1 By promoting equality and diversity initiatives	• Establish forums to engage with diverse staff groups across the organisation such as LGBTQ and BAME • Launch of Commuity Engagement Strategy and EDI Strategy (see 1.1 above) • Creation of Carer's Staff Network	• LGBT+ Staff Network: survey monkey questionnaire completed by 29 respondents. Focus group held on 5th December and attended by 5 people. Terms of refrerence agreed. Date of next meeting to be confirmed in April. Launch of network planned for NHS National Equality, Diversity & Human Rights week commencing 13th May. • BAME Staff network: survey monkey questionnaire completed by 11 respondents. Focus group to plan next steps taking place on 24th April. • Staff Who are Carers network: survey monkey questionnaire completed by 28 respondents. Focus group took place on 12th February and attended by 6 people. Terms of Reference to be developed by small group and plan of meetings to be announced. • Launch of EDI strategy has fed into the launch of the Community Engagement Strategy
6.2 Supporting openness about mental health challenges	• Increasing participation and awareness of the work undertaken by the Health & Wellbeing Group incorporating OWLES agenda (Optimising, Wellbeing & Lived experience of staff)	• Health & Wellbeing Trust wide group meets bi-monthly and has delivered the 2018/19 associated H&WB Plan linked to H&WB CQUIN • Our OWLES membership (Optimising wellbeing and lived experience of staff with MH problems) continues to grow and supports staff with MH problems and encourages open conversations and support network
6.3 Developing our apprentices and reviewing their planned progression	• Career conversations with services and individuals regarding staff development and progression. Identification of staff that wish to progress thorough an apprenticeship and ensure they gain the correct entry requirements • Quarterly reviews with apprentices and their managers • Careers events promoting apprenticeships	• Career conversations with adult mental health bands 2 and 3 completed • Career conversations offered to all services and individuals • 80 apprenticeships started since 1/4/2018 • Increased uptake of functional skills in Maths and English for preparation of apprenticeship • Quarterly reviews on target for all apprenticeships • Attendance at career events at local schools for year 11 and at sixth form colleges
6.4 Increase health, well-being and resilience learning and development opportunities	• Shift Your Stress Online Programme focused on boosting resilience and managing workplace	• On-going development of self-help resources and support mechanism. • Solnet pages refreshed with a dedicated Mental Health page with

Priorities	Action/s to be taken	Progress
	stress • Mindful and Stress Buster workshops • Exploring Wellbeing in Practice workshops	resources and how to access help when needed • Proactive communications platforms have been available to include; regular staff briefings for employees and managers, social media , SolNet health & wellbeing pagers, newsletters, focused awareness campaigns, stress buster workshops, mindfulness workshops and online initiatives e.g. Shift your Stress, Kaido Wellbeing and Mindfulness online sessions
6.5 Creating internal and external opportunities for professional and personal development as part of on-going strengths based performance appraisal and talent management	• Following feedback from Exit Inteviews , review annual appraisal to develop more conversational approach which is focussed on career development • Development and delivery of new L&D Stragegy which includes expanision of Apprenticeship programme, launch of development tool to enable staff to map their career journey, creation of more CPD opportunities and leadership training delivery	• Annual appraisal has been refreshed and presentations have been provided to team meetings on how to get the most out of the appraisal. Career conversations have been provided to groups as requested by the Learning & Development Department • Draft Learning & Development Strategy has been endorsed by the People and Oganisational Development Committee and will be finalised by the end of March 2019 for launch in May 2019. • Interactive career tool continues to develop
6.6 Rewarding excellence in our people, by the use of nominations for national award schemes, internal awards and celebration events.	• Solent Conference including Research & Improvement Awards • 2 Celebration events a year for Research & Improvement projects	• Solent Awards event confirmed for 6th June 2019; will include Research and Improvement Awards. • Additional celebration events for Research and Improvement are planned

2.1.2 Priorities for Improvement 2019-20

This year in addition to identifying Trust-wide priorities, each of our clinical services have developed their own quality improvement priorities. These are framed around our Quality Framework domains of Safe, Effective and Experience and take into account local and national priorities, our business plan objectives and recent CQC inspections. Progress will be monitored through governance meetings in clinical services and the Trust's Quality Improvement & Risk Group and reported to our Assurance Committee and the Trust Board.

Trust-wide

<table>
<tr><th colspan="4">SAFE, EFFECTIVE, EXPERIENCE</th></tr>
<tr><td colspan="4">Priority 1: Deliver the Learning Disability Strategy across all Trust services</td></tr>
<tr><td>Why we chose this as a priority and what it means for patients:</td><td colspan="3">Patients with a learning disability are more likely to have poorer health and die at a younger age than the general population. This is mainly due to unmet health needs due to difficulties identifying and addressing health concerns. We have developed our 3-year Learning Disability Strategy to enable us to build on existing good practice of providing support to this vulnerable group and to improve engagement and co-production. The Strategy is also an enabler to support delivery of the new national Learning Disability Improvement Standards and performance indicators introduced in June 2018.</td></tr>
<tr><td>What we are planning to do:</td><td colspan="3">In year 1 (2019/20) of the Strategy we will:
Run staff awareness sessions and Expert by Experience training
Update resources for all staff around "reasonable adjustments" with clearer access within SolNet and the introduction of "grab guides" for common issues
Review how clinical services are making their information accessible and explore the benefits of existing resources (e.g. Books beyond Words)
Explore how our electronic patient records can improve the "flagging" of patients with a learning disability that results in consideration of vulnerabilities and the need for reasonable adjustments
Make links to local external learning disability support networks with the support of Healthwatch
Develop, and trial, a system of "quality checking" that includes patients with a learning disability
Liaise with local external specialist services to explore voluntary work, paid work, or, apprentices for people with a learning disability in Solent
Recognise that many Solent staff will have family members and friends who have a learning disability and include "signposting" information within SolNet</td></tr>
<tr><td>Performance measures:</td><td>Proposed Measure:
Strategy Delivery Plan for Year 1</td><td>Target:
Finalise Year 1 Delivery Plan by 30th May 2019
Deliver all Year 1 actions in 2019/20</td><td>Reporting Cycle:
Report progress on Delivery Plan to Steering Group and QIR three times a year in July, November & March.</td></tr>
</table>

EXPERIENCE

Priority 1: Ensure all staff understand their responsibilities for Duty of Candour

Why we chose this as a priority and what it means for patients:	Duty of Candour is a legal responsibility for Trusts and healthcare professionals to be open and honest with patients when something that goes wrong with their treatment or care (moderate harm or above). From our own Serious Incident Panels we were aware that our staff had variable understanding of their responsibilities under the duty of candour requirements and this was highlighted in our CQC inspection report published in February 2019.		
What we are planning to do:	• Revised *Being Open and Duty of Candour Policy* developed and to be approved in 2019. • The policy has been completely re-written to make clear Duty of Candour thresholds and requirements and distinguishes between these legal requirements and staff doing the right thing by saying sorry when things go wrong. • Develop and deliver general Duty of Candour training across the Trust to launch the policy • Update mandatory Duty of Candour training		
Performance measures:	**Proposed Measure:** • Survey Monkey to assess staff level of understanding to be conducted before and after launch of new policy and training delivery • Monitor through Serious Incident Panels	**Target:** • Survey Monkey to be repeated with target to show an improved understanding following policy launch and training roll-out • SI Panels to show increasing numbers of appropriate investigations have Duty of Candour requirements met	**Reporting Cycle:** • Policy launch by June • Mid-year survey/ reporting in October 2019 • End of year survey/reporting in March 2020
Engagement and consultation:	Revised policy circulated to clinical services for comments		

Priority 2: Ensure all staff are aware of and know how to access our Freedom to Speak Up Guardians

Why we chose this as a priority and what it means for patients:	*Freedom to Speak Up* is a national initiative to enable a more open and supportive culture that encourages staff to speak up about issues of patient care, quality or safety. Our CQC inspection report published in February 2019 stated that staff in some teams had limited understanding about the Freedom to Speak up Guardian role		
What we are planning to do:	• Review the Freedom to Speak Up Communication Strategy to re-establish and refresh the identity of the Guardian role • Develop and implement a plan to deliver the FTSU Comms Strategy • Increase the FTSU Guardians visibility and accessibility by visiting services, attending Team Meetings, running workshops and drop-in sessions, etc.		
Performance measures:	**Proposed Measure:** • Strategy completion • Strategy Delivery Plan established • No of contacts and referrals • Locations of cases	**Target:** • Strategy to be refreshed by April 2020 • Strategy Delivery Plan to be in place by April 2020 • Sustained increase in referrals and contacts	**Reporting Cycle:** Quarterly

Priority 3: Support our staff to maintain their on-going health and well-being			
Why we chose this as a priority and what it means for patients:	Staff health and well-being is important to patients because staff that are healthy and happy at work are better equipped to deliver the best care. There are national and local drivers for improving the health and well-being of staff including *Thriving At Work* which focuses on mental well-being, and contractual CQUIN targets and contractual service improvement requirements. Our 2018 Staff Survey results published in February 2019 have improved 3 years in a row; however results highlighted challenges some staff face finding the time to take care of their own health and well-being. Although this is an area which has shown improvement year-on-year we want to continue to ensure our staff are equipped to take care of themselves and have access to support when they need it.		
What we are planning to do:	• Develop service improvement plan to deliver *Thriving At Work* (mental well-being) • Deliver all elements of *National Health & Well-being Framework* including development of stress trigger tools, self-awareness guides and self-help tools as well as where to find help from the Trust and other sources • Explore use of national ("Britain's Healthiest Workplace") monitoring tool for use at organisational level		
Performance measures:	**Proposed Measure:** • Staff Survey • Staff Absence Rates • Staff Turnover • Employee Assistance Programme (EAP) Utilisation Reports – analysis of usage/ topics accessed • Britain's Healthiest Workplace (BHW) monitoring tool (if adopted)	**Target:** • Overall Health & Well-being score in Staff Survey is 6.5 in 2018 – continual improvement against this score • Absence and staff turnover rates to be maintained or reduced • EAP – decreasing access to work-related stress/ well-being topics • Britain's Healthiest Workplace monitoring tool (if adopted) - continual improvements against benchmark	**Reporting Cycle:** Staff Survey – annual Absence & Turnover – monthly EAP – quarterly BHW tool - TBC

Adults Services Portsmouth

SAFE			
Priority 1: To improve the dressings process in Portsmouth			
Why we chose this as a priority and what it means for patients:	We want to improve patient's access to the most economical effective dressing and reduce delays in ordering processes. It is not unusual for there to be delays of up to 6 weeks in dressing's processes and historically we have had a high number of incidents due to dressing's delays and prescribing processes were lengthy. In order to raise standards we have implemented sign-in and sign-out processes for dressings. We have sought pharmacy advice to work with community nurses to ensure the stock list is as economical as possible and effective. We have worked with services and GPs to pilot electronic processes to speed up prescription request. We now have the capability to order using System1 tasks and the S1 function links directly with pharmacy. A pilot with two GP practices and one pharmacy has been successful.		
What we are planning to do:	We plan to roll out the new systems and processes developed in the pilot across the city in April 2019.		
Performance measures:	**Proposed Measures:** • Reduction in delays in dressings • Reduction in complaints about dressings.	**Target:** Dressings to be available within 2 days of prescription.	**Reporting Cycle:** It will be audited October 2019 & March 2020.
Engagement and consultation:	We have listened to feedback from our patients from PALS and complaints.		
Priority 2: To improve the NEWS2 process in Portsmouth			
Why we chose this as a priority and what it means for patients:	NEWS2 is a standardised approach to recognise and care for any patients who may deteriorate in our care. On 3rd September 2018 NEWS2 was launched across the Trust. Prior to launch community nurses and support staff were trained via the National NEWS2 E-Learning module and face to face training sessions, supported by podcasts and other eLearning resources including access to an accredited App that informed and supported learning. Training included what's changed from the original NEWS assessment tool, situational and scenario based training and practical sessions on completing a NEWS2 assessment. Escalation guidance was also provided. Since the launch date NEWS2 has been used in community nursing when assessing patients who are suspected to have or be at of risk of deteriorating.		
What we are planning to do:	• Continue to update and support learning regarding NEWS2 to all staff - new and existing • All clinical staff are required to revisit and refresh competencies yearly, on return from long term leave or if practice issues occur		
Performance measures:	**Proposed Measures:** • Daily review of incidents	**Target:** • NEWS2 to remain embedded in clinical practice • Daily review of all incidents and the use of the NEWS2 assessment and any actions taken: Escalation if any and appropriateness of escalation responses • Incident management will measure all actions and the	**Reporting Cycle:** It will be audited October 2019 & March 2020.

		benefit to patients is timely assessment, appropriate response and care	
Engagement and consultation:	We have listened to feedback from our patients from PALS and complaints.		
EFFECTIVE			
Priority 1: To set up a pilot long-term conditions hub in Portsmouth			
Why we chose this as a priority and what it means for patients:	We will pilot a central hub in Portsmouth between Primary Care and Solent NHS Trust where patients with respiratory conditions and diabetes will be seen. The hub will have improved access to psychological therapies offering holistic streamlined care to patients and improved clinical outcomes which will be measured. We chose this priority as a business objective in Portsmouth as part of a system wide delivery governed by the Multispecialty Community Provider (MCP).		
What we are planning to do:	The LTC hub will address issues of duplication and variation in care, as activities traditionally conducted in general practice would transfer to the remit of the LTC Hub under the leadership of a Multi-Disciplinary Team (MDT) following a standardised, evidence-based approach to care management. In order to harbour an environment for improved multi-disciplinary working, staff from primary, secondary, and community care will pool together in the LTC Hub, enabling opportunities for individuals to bring learning and best practice back to their host organisations. In order to address the issues outlined above regarding patients' involvement in their care, the model includes patients being assessed for both their clinical and wellbeing needs and a holistic care plan being developed, with easy referral to a range of support organisations, statutory and non- statutory. This is in line with national and local strategies, *Portsmouth Blueprint for Heath and Care,* which include a focus on improving the management of LTCs. The service objectives for the Hub are outlined as delivery of: • Reduced variation in care, through standardised pathways (which enables personalised care) • Enhanced MDT support and more comprehensive care planning, improving outcomes • Increased levels of self-management and patients engaged in education • Reduced chance of patients reaching crisis • Improved diagnostic accuracy • Increased appointment availability and choice, with the aim of reducing DNA rates, at early stages of the disease. In addition, there are a series of other non –patient benefits, including: • Reduced training burden on individual GP practices • Up-skilling of primary care workforce through rotational input into the Hub • Reduced isolation of community staff through MDT support • Reduced clinical risk through all staff accessing full medical records • Real time updates of the clinical record		
Performance measures:	**Proposed Outcome Measures:** KPIS to be agreed by	**Targets:** To achieve key project milestones in year 1: pilot start date: April 2019, for an 18 month period with a 9 monthly review and a	**Reporting Cycle:** Quarterly

	28/02/19 and include: • Quality measures • Outcome activity • Patient activation measures • Data collection will be built into IT system • Patient questionnaires	further 6 months to finalise recommendations and/or plan for exit or extension.	
Engagement and consultation:	The Communications and Engagement Strategy due in March 2019 will include patient leaflets and engagement with Health Watch.		
Priority 2: To pilot a leg ulcer hub in Portsmouth			
Why we chose this as a priority and what it means for patients:	Chosen as a system piece of work in order to rationalise and provide cost effective care in one place for patients with leg ulcers. The hub will also enable skills transference between practice nurses and community nurses. It will make it easier for staff to sign off their competencies and will enable practice nurses and community nurses to see more patients as they will be brought to the hub.		
What we are planning to do:	We will pilot the hub in May 2019. The hub will be evaluated and rolled out at scale following the evaluation.		
Performance measures:	**Proposed Measure:** • Reduction dressing costs • Improve learning/ training and competency and mentorship • Reduce recurrence rates • Reduce need for secondary care • Reduce appointment times	**Target:** • Reductions against all proposed measures • Adherence to Solent Leg Ulcer SOP 2017	**Reporting Cycle:** Via MCP evaluation. Will be audited September 2019
Engagement and consultation:	The pilot will include a full evaluation of service user experience and stakeholder feedback.		
EXPERIENCE			
Priority 1: To pilot an intermediate care practitioner role and crisis GP within PRRT (Portsmouth Rehabilitation and Re-ablement team)			
Why we chose this as a priority and what it means for patients:	We chose to do this pilot in response to system pressures within the Portsmouth system.		
What we are planning to do:	We are going to pilot the implementation of an intermediate care practitioner and crisis GP role within PRRT. This will enable the team to deal with patients with higher acuity which will relieve system pressures and enable patients to receive timely care.		

Performance measures:	**Proposed Outcome Measures:** • Prevention of unnecessary hospital admissions • Enable more frail elderly patients to be nursed in the community	**Pilot Targets:** To be determined once data baseline established in July 2019	**Reporting Cycle:** Via MCP evaluation starting in September 2019
Engagement and consultation:	MCP project as a pilot. Once pilot has completed there will be a comms plan from the MCP. The evaluation will include service user and stakeholder feedback.		

Priority 2: To reduce discharge delays in Jubilee House			
Why we chose this as a priority and what it means for patients:	We have a number of discharge delays in our inpatient units and we wish to reduce these in order to achieve timely discharges for all our patients irrespective of final destination. This will ensure the patient, carer and staff experience is enhanced and the discharge is safe for the patient.		
What we are planning to do:	1. Establish data regarding the length of stay broken down into patient groups in Jubilee House • End of life • Continuing Health Care Assessment • Bridging patients (admitted from PHT and community) 2. Confirm project lead 3. Review all internal processes from admission to discharge including; • Admission criteria and local policy • Information provided to patients and relatives • Managing expectations of all concerned • Referral & triage process 4. Review external processes and national standards within which we are required to work including ; • Continuing Health Care process • Fast track and end of life contracted resource • Social service support for those patients who do not meet the above • Greater understanding of support services such as PRRT, community nursing and community nursing support service (CNSS) previously known as 'Blue team'		
Performance measures:	**Proposed Measures:** • Length of stay • FFT • Complaints • 28 day CHC tracker	**Target:** To be determined once data baseline established.	**Reporting Cycle:** Monthly internal
Engagement and consultation:	Contact will be made with all appropriate external partners as required.		

Adults Services Southampton

SAFE			
Priority 1: Red and Green Days at Royal South Hants Hospital			
Why we chose this as a priority and what it means for patients:	Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a Patient's journey. This approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. At the centre of the system is the person receiving acute care whose experience should be one of involvement and personal control, with an expectation of what will be happening. It links flow, safety and reliability and has a pro-active escalation process.		
What we are planning to do:	To reduce the length of stay to 20 days or under in our Royal South Hants Hospital wards, Fanshawe and Lower Brambles, by implementing a community bed adapted safer patient bundle and red and green days. This is supported by Discharge to Assess care packages to prevent delayed transfers of care. This will then support flow through the wider healthcare system.		
Performance measures:	**Proposed Measure:** Daily electronic reporting tool completed 5 days a week (Mon-Fri) with identified associated escalation processes in place.	**Target:** • To collect data to set baseline of red days April 2019 to support identifying agreed % target • The target will be a 10% reduction in red days over the year • In reducing reasons for internal red days, aim to pre-empt external red days to support patient flow.	**Reporting Cycle:** Quarterly reporting
Engagement and consultation:	Multi professional engagement required including social services. Launch meeting held in September 2018. Requirement of success to have data retrieval - to enable set support setting % targets - with transformation.		
Priority 2: Chronic Obstructive Pulmonary Disease (COPD) , Pulmonary Rehabilitation (PR) Audit			
Why we chose this as a priority and what it means for patients:	We know patients who complete PR have less exacerbation, improved Health Related Quality of Life (HRQOL), reduction in risk of admission and the associated complications of this. If patient are referred for assessment for PR they are assessed by a specialist service and optimised, further improving their care. One area that has been reported by us to be below the national average is primary care referrals. The national average is 51 % and the referrals to the team were 38 %. We will engage in the COPD national Pulmonary Rehabilitation (PR) audit which commences in March 2019. We had previously participated in sporadic tri-yearly audits; this is now continuous data collection which should deliver QI initiatives and practical implementation outcomes to improve patient care and safety. This will help to give an overview of many aspects of our interventions and collate key performance indicators (KPIs). This will help with service evaluation in-line with clinical guidelines and best practice to optimise patient safety.		
What we are planning to do:	Complete the COPD national Pulmonary Rehabilitation (PR) continuous audit which commences March 2019		
Performance measures:	**Proposed Measure:** Look at % of patient referred to PR from GP practices (GP or Practice Nurse)	**Target:** Increase this by 15%	**Reporting Cycle:** Every other month

EFFECTIVE			
Priority 1: Project to assess and manage pain on Snowdon Ward			
Why we chose this as a priority and what it means for patients:	We chose this priority as it has been highlighted from a documentation review and structured interviews with staff and patients that there is a requirement for a more robust conversations/ assessment around identification, recording and managing of patient's pain. This can be especially challenging when patients have communication and cognitive impairments. We chose this so we can up skill all staff to feel confident to discuss and assess pain with patients, which will lead to more effective pain management for patients.		
What we are planning to do:	Under take a QI project to clearly define the current position and address issues identified through use of QI tools and staff training.		
Performance measures:	**Proposed Measure:** Documentation audit to check patients have an appropriate pain assessment and management plan.	**Target:** 85% of patients reporting pain will have a full assessment and plan of care to support pain management.	**Reporting Cycle:** Documentation audit at start and finish of project – months 1 and 6 to 9
Engagement and consultation:	Engagement with patients and staff at all levels, senior managers, matrons, Clinical Director and Professional Lead.		
Priority 2: The Women's Health Project			
Why we chose this as a priority and what it means for patients:	1 in 3 women experience stress urinary incontinence and 1 in 10 will experience overactive bladder symptoms. 1 in 2 postmenopausal women will experience prolapse symptoms. Conservative management is the first line treatment prior to secondary care and can help in up to 70% of cases avoiding surgery and consultant management. It allows women in Southampton to self-refer/GP refer and receive first line treatment to help improve their quality of life and reduce symptoms.		
What we are planning to do:	• A physiotherapist will be in post to assist with managing and treating women experiencing Bladder and Bowel symptoms. • Deliver in-service training and arrange regular company representative updates to ensure service provision remains up to date with new treatments. • Reporting outcomes to interventions to measure effectiveness with baseline and post treatment ICIQ (International Consultation on Incontinence Questionnaire) scores.		
Performance measures:	**Proposed Measure:** Measure the effect of the women's health service for bladder and bowel conditions through utilisation of a Quality of Life measure.	**Target:** 50% improvement in quality of life measures over a one year period starting Nov 18-19	**Reporting Cycle:** Jan 2019 April 2019 July 2019 October 2019 Jan 2020
Engagement and consultation:	We have engaged frontline staff to ensure they are aware of the outcome measures we need recorded. We have spoken to operational staff as we have to supply quarterly reports with performance outcomes on. Consultation with Southampton CCG occurred to get gain funding the new physiotherapy service.		

EXPERIENCE			
Priority 1: Implementation of My Medical Record (MMR)			
Why we chose this as a priority and what it means for patients:	Supporting self-management of long term neurological conditions is a key national and local priority. Solent is working in partnership with University Hospitals Southampton to deliver a digital platform called "My Medical Record". The platform has been developed in partnership with staff and patients and My Medical Record sites are live for multiple sclerosis, motor neurone disease, Parkinson's Disease, epilepsy and Huntington's Disease. Patients are be able to: • see their clinical documents • see their upcoming appointments • see their test results • send secure messages to their clinical teams • read condition specific information • see information on clinical trials and find out how to take part • complete health outcomes questionnaires • complete online health diaries to share with their clinical teams • co produce online care plans to document patient centred goals and outcomes		
What we are planning to do:	Roll out the platform to a wider number of patients. Increase the interaction between patients and staff on MMR		
Performance measures:	**Proposed Measure:** Increased number of patients accessing MMR (current uptake 70)	**Target:** In partnership with UHS, 250 patients will be registered on MMR to support their ability to self-management by end March 2020.	**Reporting Cycle:** Quarterly reports from UHS.
Engagement and consultation:	Solent staff, UHS staff, Patients across SNRS and UHS services.		
Priority 2: Improved Pathway for City patients into CR2/CR3			
Why we chose this as a priority and what it means for patients:	Percutaneous Cardiac Intervention patients should be seen within 2 weeks of a referral being received. This wasn't happening as the CR2 clinics which were often booked up in advance so patients were waiting longer to be seen and start cardiac rehabilitation. Seeing patients within the correct time frame enables us to pick up any problems earlier, answer any questions they may have about their cardiac event, help them maintain their overall health and wellbeing, start returning to life prior to their event and may reduce hospital admissions		
What we are planning to do:	Move the assessment to a community cardiac rehabilitation venue where a class is taking place as we have more staff available due to patient numbers to undertake the assessment.		
Performance measures:	**Proposed Measure:** Number of patients seen within 14 days of referral measured on City KPI. 100% for months 9 & 10 2018/19.	**Target:** Increase in the KPI for this measure	**Reporting Cycle:** Monthly
Engagement and consultation:	Staff within service and patient feedback through current patient experience format.		

Child & Family Services

SAFE			
Priority 1: To ensure assurance tools and governance processes are in place to ensure those at risk of Childhood Sexual Exploitation (CSE) are identified and appropriate interventions put in place			
Why we chose this as a priority and what it means for patients:	Young people under the age of 18 can be at risk of childhood sexual exploitation and therefore it is important that a risk assessment is completed at each visit as this can highlight concerns.		
What we are planning to do:	We would want to ensure all children seen by our services over the age of 13 are screened using the CSE tool and appropriate referrals are completed if risks are identified.		
Performance measures:	**Proposed Measure:** Overall number of completed CSE assessments in 18/19 as a baseline and then quarterly in 19/20	**Target:** Sustained improvement in documentation and completion of assessment tools	**Reporting Cycle:** Quarterly to performance meetings
Engagement and consultation:	This has been identified through recent Serious Incidents requiring investigation		
Priority 2: To improve young people's access to and understanding of their health care plan (Looked After Children) and Care plans within the CCN team including special schools			
Why we chose this as a priority and what it means for patients:	It is imperative that children and Young People (YP) are engaged in the care planning process to ensure that health needs are assessed and children and YP are engaged in how to improve their health. This also includes working with partner organisations to ensure that care plans are used within health and education settings. This was identified as an area of improvement within our CQC report of 2019.		
What we are planning to do:	Improve the engagement of young people in writing care plans to ensure they are meaningful and useful to them. This would be through a user engagement forum.		
Performance measures:	**Proposed Measure:** • Audit how many care plans are undertaken jointly with young people and/or education. • Deep Dive Q2 and Q4 for care plans (10 CCN and 10 LAC east and west each quarter)	**Target:** Sustained improvement	**Reporting Cycle:** Twice yearly through the audit group
Engagement and consultation:	YP engagement forum.		

EFFECTIVE			
Priority 1: To develop a career pathway in the child and family service line for Advanced Clinical Practice (ACP)			
Why we chose this as a priority and what it means for patients:	At present there is no career pathway for ACP; as we transform our services over the next four years we need to ensure that changes to service delivery are made safely and staff receive adequate training and supervision. This will ensure safe and effective service delivery. This relates to our business plan in terms transforming services to ensure we have the right staff in the right roles to deliver the right care.		
What we are planning to do:	This will be managed as a formal Project for 4 years; the milestones will include a clear plan of what the workforce will look like in 4 years including a forecast of how many ACP positions will need to be in post and the training that will be required to meet the competencies.		
Performance measures:	**Proposed Measure:** Effective delivery of key project milestones for year 1	**Target:** Delivery of Year 1 key milestones	**Reporting Cycle:** Quarterly to Service Line Governance
Priority 2: To improve the pathway for children and young people with depression.			
Why we chose this as a priority and what it means for patients:	As a service we need to ensure we are following the national guidance for safe and effective care for children and young people with depression. There is draft national NICE guidance in place at present due to be ratified in Spring 2019 which we must implement. The improvement will make a difference through a clear pathway for children and young people that is shared with partner organisations in the local authorities, acute sector and voluntary agencies. This links to the CAMHS business plan regarding transforming services to better enable access and outcomes for children		
What we are planning to do:	Assess our service delivery against the NICE guidance and remodel service delivery as appropriate.		
Performance measures:	**Proposed Measure:** Benchmarking practice -audit care plans to check that the depression pathway is followed	**Target:** 90% of care plans audited included consideration of depression triggers	**Reporting Cycle:** Quarterly to Service Line governance
Engagement and consultation:	Through sharing pathways with the young people's engagement groups in East and West		
EXPERIENCE			
Priority 1: To develop the offer for children and families service delivery to include Remote Consultation (Skype), telephone and texts and use of translation services as required.			
Why we chose this as a priority and what it means for patients:	Young people and families report through engagement meetings that they would like our services to be more user friendly and accessible. This links into our business plan around transforming the role of business support and particularly making best use of digital and business platforms to improve services. This was also identified as an area of improvement within our 2019 CQC report for CYP.		
What we are planning to do:	Deliver some consultations through other means other than face to face. This will need to be completed as part of a risk assessed service		

Performance measures:	**Proposed Measure:** • Effective delivery of key project milestones for year 1 which will include the sign off of the process and risk assessment.	**Target** • Delivery of all Year 1 Project Milestones • Feedback from patients and families indicates higher levels of satisfaction with accessibility and user-friendliness of services	**Reporting Cycle:** Quarterly to Service Line governance
Engagement and consultation:	Through Young Shapers forums		
Priority 2: To develop client involvement in their treatment plan, developing choice within the pathway of care delivery.			
Why we chose this as a priority and what it means for patients:	Engagement with parent forums has highlighted that parents would like to be involved in the best way to meet their child's needs be that through seeing a consultant or having a course of 6 therapy sessions. This will increase patient engagement and is hoped will reduce complaints and non-attendance (was not brought) to appointments. This quality priority will improve the overall quality of the clinical model/care being offered and therefore will help address this poorly scoring area of the quality of care within our staff survey		
What we are planning to do:	Using evidence based practice have clear pathways in place with identified outcomes including choice of service delivery		
Performance measures:	**Proposed Measure:** • Effective delivery of key project milestones for Yr. 1 • Patient feedback on new approach.	**Target:** • Delivery of Project Plan key milestones for Year 1 • Higher levels of patient/parent satisfaction	**Reporting Cycle:** Quarterly to Service Line Governance meeting
Engagement and consultation:	Parent Forums, Young Shapers Meetings.		

Specialist Dental Services

SAFE			
Priority 1: Aligning General Anaesthetic (GA) pathway on the Isle of Wight (IOW) and Hampshire			
Why we chose this as a priority and what it means for patients:	The Dental Service has recently commenced delivery of Special Care Dentistry on the Isle of Wight. It has been noted that there is an absence of clear protocols for provision of dental care under General Anaesthesia. There is inconsistent availability of patient records (electronic/paper) in theatre. This has the potential to adversely affect Patient Safety and Quality of Care.		
What we are planning to do:	1.To incorporate the GA list on the St Mary's site into the Solent Specialist Dental Service GA Procedures Document 2.Produce updated care pathway for patients requiring Dental Care under General Anaesthesia 3.Introduce checklists to ensure that patient information is appropriately recorded and transferred to the GA session 4.Improve numbers of clinicians trained to operate at St Mary's by provision of honorary contracts and providing training via a shadowing programme 5. Ensure availability of a Second operating Dentist where a patient having treatment under General Anaesthesia lacks capacity to consent.		
Performance measures:	**Proposed Measure:** Audit the use of the GA procedures document by measuring completion of the GA checklists	**Target:** To align Procedures with those on the mainland (using existing GA pathway as a standard).	**Reporting Cycle:** July 2019 – **50% complete** December 2019 – **70% complete** March 2020 – **100%**
Engagement and consultation:	The clinician providing GA services on the IOW has been consulted and contributed to the GA procedures document review in Dec 2018. Members of staff on the Isle of Wight to be trained in the GA procedures document and the use of checklists. GA training Day to be organised on the Isle of Wight involving members of staff from Hampshire and the IOW GA teams to improve awareness and improve treatment planning for GA patients and to allow staff to ask questions about the procedures and pathway.		
Priority 2: Introduction of Intraoral Radiography into Dental General Anaesthetic (GA) Sessions			
Why we chose this as a priority and what it means for patients:	Radiographs are a valuable diagnostic tool to diagnose dental pathology. The facility to take intraoral radiographs in theatre is not currently available at all GA sites. The exception is Poswillo where radiographs can be taken. Some patients with special needs are unable to tolerate intraoral radiographs routinely. Where dental care for this group of patients is provided under general anaesthesia, the availability of radiographs would enhance treatment planning and improve the quality of patient care. In addition to caries diagnosis, information from diagnostic radiographs would provide important detail about root morphology and adjacent structures which inform decisions based on need for treatment balanced against the risks of complications. Radiographs also form an important part of the clinical records and provide important evidence for medico-legal reasons. This has been on the service risk register for a period of time.		
What we are planning to do:	To introduce digital radiography into each of our general anaesthetic sites. Currently this is only available at our own site (Poswillo) and not at sites where we are hosted by other hospital providers.		

	This will require 1. Achieving funding for equipment 2. Securing IT access in theatre at each site 3. Purchasing equipment 4. Liaising with hospital sites to carry out works required 5. Preparing Local rules and procedure documents 6. Training staff		
Performance measures:	**Proposed Measure:** **Audit:** To record availability/unavailability of intraoral radiography at Dental GA sites	**Target:** To implement intraoral radiography in theatre at all external GA sites (North Hampshire Hospital, Royal Hampshire County Hospital, SGH, St Mary's)	**Reporting Cycle:** September **2019 – 50%** December **2019 – 70%** March 2020 – **100% of sites**
Engagement and consultation:	Consultation with hospital teams will be key to ensure that equipment can be appropriately stored. Support from IT services in Solent and within other provider organisations will be essential to secure the required access to systems.		
EFFECTIVE			
Priority 1: Introduction of Inhalation Sedation (IS) Service for Patients on the Isle of Wight (IOW) to facilitate dental treatment under conscious sedation as opposed to a general anaesthetic (GA)			
Why we chose this as a priority and what it means for patients:	**Inhalation Sedation:** The General Dental Council states that "patients' dental pain and anxiety should be managed appropriately". As a dental service providing specialised dental care to patients, such as those with physical, intellectual and/or medical impairments or disabilities, these needs should be met. Thus, forms of conscious sedation should be available to allow the delivery of a high standard of patient care. The provision of this service on the Isle of Wight would also act to reduce the General Anaesthetic waiting list and hence waiting time for patients – as well as offering an alternative approach with fewer risks than a general anaesthetic. Finally by offering the service of conscious sedation it will ensure an equality of access for patients on the IOW, as well as the mainland.		
What we are planning to do:	• Arrange accredited in-house training for dental team to include supervised cases • Ensure suitability of environment and correct equipment available for IS e.g. scavenging • Arrange for staff members on IOW to shadow sedation clinic on the mainland • To implement the same protocol and procedures used on the mainland to the IOW • Show all staff relevant sedation SOPs and guidance on R drive • Ensure checklist being used on IOW is consistent with mainland • Create sedation folder for IOW to replicate mainland copy • Commence sedation for patients under guidance of sedation leads • Provide training updates as required • Ensure opportunity for case reflection and appraisal		

Performance measures:	**Proposed Measure:** 1. Audit clinical notes for IS – to ensure compliance with sedation policy 2. Ensure IS pre- and post- op machine checks being completed for 100% of cases 3. Audit use of IS checklist and clinical note keeping for 100% of cases 4. Review any sedation related incidents and share learning at Sedation Network 5. Case reflection and discussion with sedation leads 6. Record patient feedback around sedation for 100% of cases	**Target:** • Monitor introduction of sedation service against agreed timeline • Compliance on IOW with mainland sedation policy and procedures	**Reporting Cycle:** June 2019 **-30%** September 2019 **– 50%** December 2019 **– 70%** March 2020 **– 100% completed**
Engagement and consultation:	Encourage networking between members of staff on the IOW and those providing sedation on the mainland Invite IOW staff to Sedation Network meetings. Arranged clinical supervision visits to IOW and for staff on IOW to visit sedation clinics on mainland. Review of audit – repeat to ensure correct standards being maintained – with any recommendations to improve standards from IOW or mainland staff members. Discussion of sedation cases, incidents and patient feedback with sedation leads and at Sedation Network		
Priority 2: Introduction of an Intravenous Sedation (IS) Service for patients on the Isle of Wight (IOW) as an alternative option for some patients who would otherwise only be able to access dental treatment under general anaesthesia			
Why we chose this as a priority and what it means for patients:	**Intravenous Sedation:** The General Dental Council states that "patients' dental pain and anxiety should be managed appropriately". As a dental service providing specialised dental care to patients, such as those with physical, intellectual and/or medical impairments or disabilities, these needs should be met. Thus, forms of conscious sedation should be available to allow the delivery of a high standard of patient care. The provision of this service on the Isle of Wight would also act to reduce the General Anaesthetic waiting list and hence waiting time for patients – as well as offering an alternative approach with fewer risks than a general anaesthetic. Finally by offering the service of conscious sedation it will ensure an equality of access for patients on the IOW, as well as the mainland.		
What we are planning to do:	• Arrange accredited training for dental team to include supervised cases • Assess sedation related training and CPD for new member of staff • Ensure suitability of environment and correct equipment available for IVS • Arrange for staff members on IOW to shadow sedation clinic on the mainland • To implement the same protocol and procedures used on the mainland to the IOW – Show all staff relevant sedation SOPs and guidance on R drive • Ensure checklist being used on IOW is consistent with mainland • Create sedation folder for IOW to replicate mainland copy • Arrange shadowing/mentorship program until confident to provide sedation independently • Commence sedation for patients under guidance of sedation leads		

	• Invite clinicians to Sedation Network meeting • Provide training updates as required • Ensure opportunity for case reflection and appraisal		
Performance measures:	**Proposed Measure:** 1. Audit clinical notes for IV sedation – to ensure compliance with sedation policy. 1. Audit use of IV checklist and clinical note keeping for 100% of cases. 2. Review controlled drugs record book for 100% of cases 3. Review any sedation related incidents and share learning at Sedation Network 4. Case reflection and discussion with sedation leads **5.** Record patient feedback around sedation for 100% of cases	**Target:** Monitor introduction of sedation service against agreed timeline Compliance on IOW with mainland sedation policy and procedures	**Reporting Cycle:** June 2019 **-30%** Sept 2019 **– 50%** December 2019 **– 70%** March 2020 **– 100% completed**
Engagement and consultation:	Encourage networking between members of staff on the IOW and those providing sedation on the mainland. Invite IOW staff to Sedation Network meetings. Arranged clinical supervision visits to IOW and for staff on IOW to visit sedation clinics on mainland. Review of audit – repeat to ensure correct standards being maintained – with any recommendations to improve standards from IOW or mainland staff members .Discussion of sedation cases, incidents and patient feedback with sedation leads and at Sedation Network		
EXPERIENCE			
Priority 1: Introduction of a training package for oral health care and carer training for use in nursing and residential care homes			
Why we chose this as a priority and what it means for patients:	Following NICE guidelines, the NHS 10 year plan and feedback from special care dental staff who deliver regular domiciliary dental care in nursing and care homes, there is an obvious need to deliver Oral Health carer training and provide a training package, including a workbook and face to face training sessions. Oral health is as important for vulnerable adults in the latter stages of life, as it is for children in the early years of life. Poor oral health has found to be linked with heart disease, diabetes, sepsis, etc. and can be extremely debilitating, especially when unable to communicate feelings of pain, diet, oral function and self-esteem.		
What we are planning to do:	Pilot carer training in designated carer/ nursing homes with the aim to implement the use of oral health assessment forms and daily mouth care plans for each resident.		

Performance measures:	**Proposed Measure:** **Audit:** Number of practitioners working with vulnerable adults and old people in care homes who have received OHP training.	**Target:** 100% of patients in one care home have an oral care plan.	**Reporting Cycle:** August 2019 – **40%** January 2020 – **60%** March 2020 – **100%**
Engagement and consultation:	Care home staff, residents, family members of residents, commissioners as required and Solent staff.		
Priority 2: Development of Accessible Information (AI) Champions at each Service Locality			
Why we chose this as a priority and what it means for patients:	Research found that 12-30% of the population have a communication need. The Accessible information Standard was set in 2016. This legislation means that NHS organisations and public services must: Ask, document, share and support service users/carers/parents with communication needs. Attending health care appointments can be overwhelming. The health sector often use medical terms 'jargon'. At the end of the appointment some patients may have left feeling confused and agreed to something they don't really understand so imagine how difficult it is for someone with learning difficulties, learning disability, and visual or hearing impairment. The new legislation will mean that these service users will now have support by highlighting their needs.		
What we are planning to do:	• To have in place AI Champions at each Service locality: North, West, East and Isle of Wight. • To support new and existing members of staff to comply with the AI Standard – Assess/Record/Support needs of our Service Users. • Identify the communication needs of all our Service users – Using the Toolkit Guide • Record needs in their dental records, AI recording format and highlighting using the AI. An AI icon will be on their records. It highlights and identifies that the patient have a communication need and may require additional support.		
Performance measures:	**Proposed Measure:** 1. AI Champions will be identified, trained and can train and support members of staff 2. Communication needs are recorded and highlighted on R4 dental system and monitored for completion 3. Dental records will be monitored every 3 months	**Target:** 1. On going 2. End of year 40-50% of patient records will have documented AI needs and increase by 20% over the following years 3. To start monitoring records quarterly (Audit). 10 patient records per clinician assessed over a set week for completion.	**Reporting Cycle:** April 2019 – **30%** July 2019 – **50%** October 2019 – **70%** January 2020 – **90%** March 2020 – **100%**
Engagement and consultation:	Staff will be informed at locality meetings and supported by AI champions to complete records for all patients.		

Mental Health Services

SAFE			
Priority 1: Physical Health Monitoring in Substance Misuses Services (SMS)			
Why we chose this as a priority and what it means for patients:	Within our Substance Misuse Services we do not at this time routinely undertake physical health care monitoring. This client group is vulnerable to ill health and may not be accessing their GP due to complications such as homelessness, lack of funds to get to the surgery, or lack of relationship with these services.		
What we are planning to do:	• We will train Solent staff within the service to undertake physical health care monitoring and use NEWS2 • We will offer this to service users who will be attending for a pre alcohol detox with one of the registered nurses within the service		
Performance measures:	**Proposed Measure:** Offering of physical health monitoring within the substance misuse assessment.	**Target:** 90% of patients offered	**Reporting Cycle:** Quarterly
Engagement and consultation:	Discussed with relevant staff within the service and with SSJ as an integrated partner.		
Priority 2: High Dose Antipsychotic Treatment (HDAT) monitoring			
Why we chose this as a priority and what it means for patients:	Some patients in mental health services require high dose antipsychotic treatment (HDAT). For some patients this is short term at the point of a crisis, but for others this is a longer term treatment. There are risks for HDAT which need to be considered and monitored to ensure patient safety. The CQC stated in their visit in 2018 *the trust must ensure Medication Management is safe for all patients (Regulation 12). Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.*		
What we are planning to do:	We have developed a HDAT monitoring form which will be part of Systm1. We plan for all Patients who are prescribed HDAT to have a HDAT form in place.		
Performance measures:	**Proposed Measure:** Eligible patients have a HDAT form in place on system 1.	**Target: 90%**	**Reporting Cycle:** Q2 and Q4
Engagement and consultation:	Discussed with the medical staff, nursing and system 1 colleagues.		

EFFECTIVE			
Priority 1: Patients within our rehabilitation service achieving their recovery goals			
Why we chose this as a priority and what it means for patients:	We are in the process of reviewing our rehabilitation offer, moving this from an inpatient service to a community service. Monitoring of the Patient Recovery Outcome Measure (PROM), of which Dialog is used within the service, will enable us to ensure we are continuing to be an effective service, and meeting the patient's goals and priorities.		
What we are planning to do:	At the start of the patients engagement with the rehabilitation team a Dialog questionnaire will be used to agree the patient's recovery goal. At the point of discharge the questionnaire will be undertaken again to determine whether the patient feels an improvement has been made.		
Performance measures:	**Proposed Measure:** There is an improvement for patients self-rating following engagement with the rehabilitation services.	**Target:** 90%	**Reporting Cycle:** Quarterly audit

Priority 2: Did Not Attend (DNA) rates in A2i			
Why we chose this as a priority and what it means for patients:	Currently the A2i service has a DNA rate on average of 20%. This is a service in high demand with an average of 155 referrals each month and this DNA rate is equivalent to 31 patients a month. Each new patient assessment will take 2 hours (including write up) meaning on average 62 hours of lost activity each month. This 20% DNA rate is therefore wasted time that would be better used in a patient facing activity.		
What we are planning to do:	The service will seek to understand why the DNA rate is high and look to reduce this. In order to do so the service will establish a task and finish group to obtain feedback from service users who DNA to ascertain the reason for their non-attendance, we will analyse these results and put measure in place to improve attendance.		
Performance measures:	**Proposed Measure:** **Q1-** task and finish group is established and service user feedback tool agreed. **Q2-** Feedback obtained from patients who DNA on reasons for this DNA. Feedback analysed and actions agreed. **Q3**- Actions/ changes embedded in practice. **Q4**- reduction in DNA rates.	**Target:** Minimum of 5% reduction in DNA rates within the service.	**Reporting Cycle:** Quarterly
Priority 3: Psychology input into OPMH inpatients			
Why we chose this as a priority and what it means for patients:	The CQC stated in their visit in 2018 *the trust should ensure they continue to develop psychological treatments to meet patients' needs.*		
What we are planning to do:	Develop a pathway for psychological therapies access for older persons which include psychological therapies access within the ward setting.		
Performance measures:	**Proposed Measure:** Q1- • Baseline figures obtained for older adults access to psychological therapies within the ward setting • Pathway developed for both primary (IAPT) and secondary care access for older persons Q2- Pathway agreed through appropriate governance routes and put into place Q3- reporting on the whole of Q3 to be submitted in Q4	**Target:** An increase in baseline figures for ward psychological therapies.	**Reporting Cycle:** Report for Q3 to be submitted in Q4.
Engagement and consultation:	Patients and staff will be consulted as part of the pathway development work.		

EXPERIENCE			
Priority 1: Care planning in community services.			
Why we chose this as a priority and what it means for patients:	The mental health in-patient services went through a programme of improvement in care planning last year to ensure that care plans were meaningful for our patients. The outcome of this is that the care planning process is simpler for both the patient and the service, and is led by the needs of the individual. We now wish to extend this improvement to our mental health community services.		
What we are planning to do:	A task and finish group will be set up to review the current care planning processes in the community services. This group will determine whether the changes made to care planning in the in-patient setting are appropriate for the community services or whether further changes are required. This will then be built on Systm1 and all staff appropriately trained to complete this. Practice will be embedded with the service with all patients having a new community care plan by Q4.		
Performance measures:	**Proposed Measure:** Q4 would see all patients for whom we are providing care in community services having a "new" community care plan.	**Target:** 90% of patients with a new community care plan in Q4.	**Reporting Cycle:** Q4
Engagement and consultation:	Community services staff and managers.		
Priority 2: Carer's engagement with OPMH inpatient service (Brooker)			
Why we chose this as a priority and what it means for patients:	Carers are able to provide invaluable information and support to both the services and the service users. This is particularly important within our older person's wards when we are caring for persons with dementia or memory problems. Whilst the service has taken steps to improve this through the introduction of "this is me", there have been some complaints in the past 12 months whereby carers have not felt appropriately engaged in their loved ones care.		
What we are planning to do:	The service will undertake a Quality Improvement (QI) project starting in May (Q1) to look at how engagement with carers can be improved within Brooker. Within Q2 the service will be engaging with carers and staff to understand the needs of both and any barriers to this currently. Q3 will focus on making changes to improve engagement with carers, reviewing these changes and amending as required. Q4 should see the changes embedded and improvements measurable.		
Performance measures:	**Proposed Measure:** To be established through the quality improvement project.	**Target:** QI project undertaken by the service which is able to demonstrate and improvement in the services engagement of carers.	**Reporting Cycle:** Q4
Engagement and consultation:	QI team has been established and has begun to engage with the Solent QI team. Further engagement will take place as part of the QI project.		

Primary Care Services

SAFE			
Priority 1: Developing "multi chair" Podiatry Clinics			
Why we chose this as a priority and what it means for patients:	We believe that developing "multi chair" clinics within our podiatry service will promote a positive and safe environment for both staff and patients. This development will aim to reduce lone worker/isolated clinics therefore improving support for staff with a complex and challenging cohort of patients. We believe this approach will support retention of junior podiatrists by creating a positive learning environment, providing opportunities to observe, escalate and provide/receive mentorship. The benefit for patients is that staff will be able to escalate, receive advice and guidance promptly with the potential to reduce appointments.		
What we are planning to do:	Develop hubs with "multi chair" clinics at strategic sites across the geographical area and reduce lone working. This will enable junior and senior staff to work alongside each other and provide the ability to give clinical support, education, training and escalation promptly to enhance the patient and staff experience.		
Performance measures:	**Proposed Measure:** Improved percentage of B5/B6 and B6/B7 multi chair clinics	**Target:** Increase multi chair clinics by 75%	**Reporting Cycle:** Via Podiatry operational meetings and Governance meetings to monitor impact on staff and patients experience
Engagement and consultation:	This will be an informal consultation with staff and due to the reduction of sites will require consultation with our commissioners and patients. It is anticipated that this will evolve over a two year period. Year 1 will involve the review and consultation period with the development of the clinics with latter quarter year 1 / year 2.		
Priority 2: Rationalisation of podiatry clinic locations			
Why we chose this as a priority and what it means for patients:	We have chosen this priority as it has multi-facetted benefits. The rationalisation of sites supports our vision to develop multi chair clinics (above) and enables the service to consolidate the estate provision across the geographical area reducing expenditure and providing value for money. It is recognised that reducing sites has the potential to impact on patient experience (due to preferred location) however the benefits of delivering specialist quality care do provide the opportunity to improve outcomes for patients.		
What we are planning to do:	We aim to reduce our podiatry estate to key "hub" locations. This will be dependent on Estates and Facilities Team support regarding the development of St Marys (Block B) and Adelaide Health Centre.		
Performance measures:	**Proposed Measure:** The number of current sites	**Target:** To reduce the number of Podiatry sites by 50%.	**Reporting Cycle:** Via Podiatry operational meetings and Governance meetings to monitor impact on staff and patients experience
Engagement and consultation:	The project will evolve over 2 years and will require consultation with Estates and Facilities Team, commissioners, staff and patients. Year 1 will see the redevelopment of key sites to support the project, year 2 will seek to complete and embed transition		

EFFECTIVE			
Priority 1: Increase patient and public engagement to support improved patient outcomes			
Why we chose this as a priority and what it means for patients:	We recognise that we have vulnerable patient groups within our service line; in particular pain management and homeless health. Often the patients are challenged to attend consultations and at times do not consider the supportive programme/ onward referrals to be of benefit. The project aims to improve engagement of patients through patient advocacy.		
What we are planning to do:	1) Within pain management team the aim is to initiate Follow on Groups (FOG). Often patients participate in a programme of support and upon conclusion of the programme feel that they need continued support (which cannot be offered within the service). It is proposed that patients are invited to participate in an on-going programme that is facilitated by the service but lead by the patients themselves. 2) Within Homeless Health patients often require secondary care for the management of acute and chronic conditions however often will disengage due predominately to a chaotic lifestyle. The aim is to utilise participates in a supportive role to encourage patients to attend secondary care appointments, help with issues with transport, accommodation etc.		
Performance measures:	**Proposed Measure:** 1) To monitor the impact of FOGs upon the re-referral to pain management services. 2) To monitor the conversion of patients who attend secondary care appointments (for specific condition)	**Target:** 1) To reduce re-referral to pain management service by 25% 2) To improve attendance at secondary care appointment by 20%	**Reporting Cycle:** 6 monthly report to governance
Engagement and consultation:	This will be a two year programme for both projects. Year 1 to establish cost benefit analysis of schemes and if applicable identify funding support. Year 2 to facilitate and embed in practice.		
Priority 2: To review the workflow management across the service line			
Why we chose this as a priority and what it means for patients:	Within the service line we receive and send data in multiple formats. It is imperative we deal with this in a safe and effective way ensuring we maintain information governance standards and are as “stream lined” as possible. We aim to utilise technology to support the management of this to improve the experience for staff (both clinical and administration) and improve effective communication to patients and healthcare professionals.		
What we are planning to do:	To undertake a full review of our current processes both person and technology focused with regards to the management of information “in and out” of the service to reduce the administrative burden		
Performance measures:	**Proposed Measure:** Audit	**Target:** • To reduce the workflow burden and improve the efficiency of workflow management. • To reduce information governance errors by 50 %	**Reporting Cycle:** Audit – frequency to be confirmed
Engagement and consultation:	Two year project in liaison with IT and our administration leads.		

EXPERIENCE			
Priority 1: Solent GP Surgery Transformation			
Why we chose this as a priority and what it means for patients:	In 2016 our three independent GP Surgeries merged to form Solent GP Surgery. Since its formation we have been challenged to standardise our processes and work cohesively as one surgery and realise the benefits this provides from a workflow and professional perspective. The aim is the transformation project will benefit the surgery from a patient and staff perspective but also will provide financial efficiencies and enable us to consider our estate requirements, alternative workforce provision (taking into account reduced numbers of GP availability), staff retention, and development of clinical and administration staff.		
What we are planning to do:	Undertake a transformation project over a two year period of our GP Surgery		
Performance measures:	**Proposed Measure:** Delivery of identified project mile stones	**Target:** To potentially reduce number of premises and improve efficiencies within workforce and workflow	**Reporting Cycle:** Monthly via Project initiation document within operational and governance forums
Engagement and consultation:	This will require engagement with staff, patients, Trust (Estates & Facilities, Finance and Contracts) and SC CCG.		
Priority 2: Development of web site & digital platforms within MPP			
Why we chose this as a priority and what it means for patients:	We aim to optimise the Solent MSK Website and other digital platforms to provide effective MSK guidance prior to accessing the MSK Service		
What we are planning to do:	Improve our patient's pathway ensuring patients are seen at the right time & right place by the right clinician. The aim is to ensure our website offers advice and guidance supporting patients to make decisions regarding self-referral and signposting.		
Performance measures:	**Proposed Measure:** The number of patients who appropriately self-refer following visit to web site.	**Target:** To have 50 % of appropriate referrals	**Reporting Cycle:** Quarterly audit of self-referrals
Engagement and consultation:	This will be a two-year project with year one reviewing the current website and digital platform and redesign with year two ensuring web site in place with processes in place to ensure the platforms remain current and relevant,		

Sexual Health

SAFE			
Priority 1: To implement a monthly patient safety quality assurance process			
Why we chose this as a priority and what it means for patients:	We chose this priority because we want to be able to provide assurances that all mandated checks are being completed within the service to ensure we are providing safe care.		
What we are planning to do:	We are going to develop a process to provide monthly assurance to the clinical governance service line meeting that the following tasks are being carried out: • Fridge and drug room temperature checks • Completion of cleaning schedules • Checking of resuscitation equipment • PAT testing • Changing of patient curtains • Correct signage of waste bins • Sharps bins are being closed appropriately		
Performance measures:	**Proposed Measure:** Completion of the above tasks	**Target:** Sustained improvement in completion of the above tasks	**Reporting Cycle:** Reported monthly to service line clinical governance meeting
Engagement/consultation:	This has been identified as an area for improvement during quality visits		
Priority 2: To ensure that 95% of patients under the age of 18 have a Risk Assessment Tool (RAT) completed			
Why we chose this as a priority and what it means for patients:	Young people under the age of 18 are at risk of criminal sexual exploitation and therefore it is important that a risk assessment is completed at each visit as this can highlight concerns. At the end of QRT 3 2018/19 the completion rate was 98.9% in Hampshire, 98.5% in Portsmouth and 100% in Southampton. The service wants to maintain this high completion rate to ensure that young people who are vulnerable and at risk are identified and referred to relevant agencies.		
What we are planning to do:	Every month the notes of patients under the age of 18 are reviewed to ensure that a RAT has been completed. If a RAT has not been completed it is discussed with the staff member concerned and any lessons learnt shared with the team. Throughout 2018 risk assessment training was provided to staff, as well reminders in the staff newsletter to improve the amount of risk assessments completed. This notes review will continue monthly to ensure that completion rates remain high; the results will be shared at the monthly service line clinical governance meetings.		
Performance measures:	**Proposed Measure:** Overall number of RAT completed in under 18 year olds	**Target:** Sustained improvement of completion of RAT	**Reporting Cycle:** Bi-monthly at the performance meeting
Engagement and consultation:	This has been identified by our commissioners as a key performance indictor. We have consulted with our staff about the importance of completing RAT and extra training has been provided		

EFFECTIVE			
Priority 1: To improvement the treatment pathway for non-complex Chlamydia treatments by introducing treatment by post			
Why we chose this as a priority and what it means for patients:	We chose this priority to reduce the time is takes for patient to receive their Chlamydia treatment by developing a treatment by post scheme. A patient survey showed this was the preferred method to receive treatment. It will also increase access into the service for other more complex patients.		
What we are planning to do:	To develop and implement a treatment by post pathway.		
Performance measures:	**Proposed Measure:** Implementation of treatment by post	**Target:** Delivery of plans to implement the treatment by post	**Reporting Cycle:** Stage 1 - Create patient health record due to go live 30/06/19 Stage 2 – Self-managed partner notification due to go live 30/09/19 Stage 3 – Treatment by post due to go live 01/11/19
Engagement and consultation:	A patient survey was completed in 2018 asking patients how acceptable it would be for them to receive their treatment by post, pharmacy or in clinic. The majority of patients wanted to receive their treatment by post.		
Priority 2: To develop an online platform for partner notification			
Why we chose this as a priority and what it means for patients:	We want to improve the uptake of treatment for partners, to reduce re-infection and complications related to untreated infection by introducing an online platform for patient notification.		
What we are planning to do:	We are working with our IT provider to develop an online system for partner notification so patients can enter their partner details anonymously.		
Performance measures:	**Proposed Measure:** Implementation of the online partner notification platform	**Target:** Delivery of plans to implement the online partner notification platform	**Reporting Cycle:** Stage 1 - Create patient health record due to go live 30/06/19 Stage 2 – Self-managed partner notification due to go live 30/09/19
Engagement and consultation:	IT provider and staff working on the project		
EXPERIENCE			
Priority 1: To develop a patient portal			
Why we chose this as a priority and what it means for patients:	We want to improve the way patients can access appointments, receive their results and request online testing. The current online booking service requires patients to enter their details each time they book an appointment and we have had feedback from patients that this is cumbersome.		
What we are planning to do:	We will work with our electronic patient record (EPR) provider INFORM, to develop a patient portal that allows patients to log in to their EPR to receive results, book appointments and request online tests.		

Performance measures:	**Proposed Measure:** Implementation of the patient portal	**Target:** Delivery of plans to implement the patient portal	**Reporting Cycle:** Stage 1 - Create patient health record due to go live 30/06/19
Engagement and consultation:	We have listened to feedback from our patients via FFT, service concerns and complaints		
Priority 2: To improve the referral pathway between Sexual Assault Referral Centre (SARC) and Sexual Health (SH)			
Why we chose this as a priority and what it means for patients:	Patients that are a victim of a sexual assault should be followed up in Sexual Health for screening, post exposure prophylaxis for sexual exposure to HIV follow-up and on-going contraception. The referral process has just been updated to improve the patient pathway and support vulnerable patient to attend Sexual Health services		
What we are planning to do:	We will be completing an audit to see how effective our referral pathway is by reviewing how many people that are referred from SARC attend Sexual Health services.		
Performance measures:	**Proposed Measure:** Number of patients that attend SH compared to the number that are referred by SARC baseline audit to be completed by the end of May.	**Target:** To see a sustained increase in the number of patient referred from SARC attending sexual health	**Reporting Cycle:** This is a service evaluation on the 19/20 audit plan. To be presented in December 2019 CG
Engagement and consultation:	This has been identified by staff in both SH and SARC as an area for improvement. We have consulted with our staff so they are aware of the new referral pathway.		

2.2 Statements relating to quality of NHS services provided

The statements and wording in this section are mandated by NHS regulations and enable patients, the public and stakeholders to compare performance and data across health care providers. We cannot change these statements but we have added further information to provide context where appropriate.

Review of services

During 2018/19 Solent NHS Trust provided and/or sub-contracted 153 relevant health services.

Solent NHS Trust has reviewed all the data available to them on the quality of care in 153 (100%) of these relevant health services. Data relating to the quality of care in our services is reviewed at Service Line governance and business meetings, Service Line and Care Group Performance Review Meetings, at Quality Improvement & Risk Group, Assurance Committee and the Trust Board.

The income generated by the relevant health services reviewed in 2018/19 represents 89% of the total income generated from the provision of relevant health services by Solent NHS Trust for 2018/19.

Participation in local and national clinical audits and national confidential enquiries

National Audits

During 2018/19, 14 national clinical audits and 2 national confidential enquiries covered relevant health services that Solent NHS Trust provides.

During that period, Solent NHS Trust participated in 93% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- the national clinical audits and national confidential enquiries that Solent NHS Trust was eligible to participate in during 2018/19
- those it did participate in
- 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

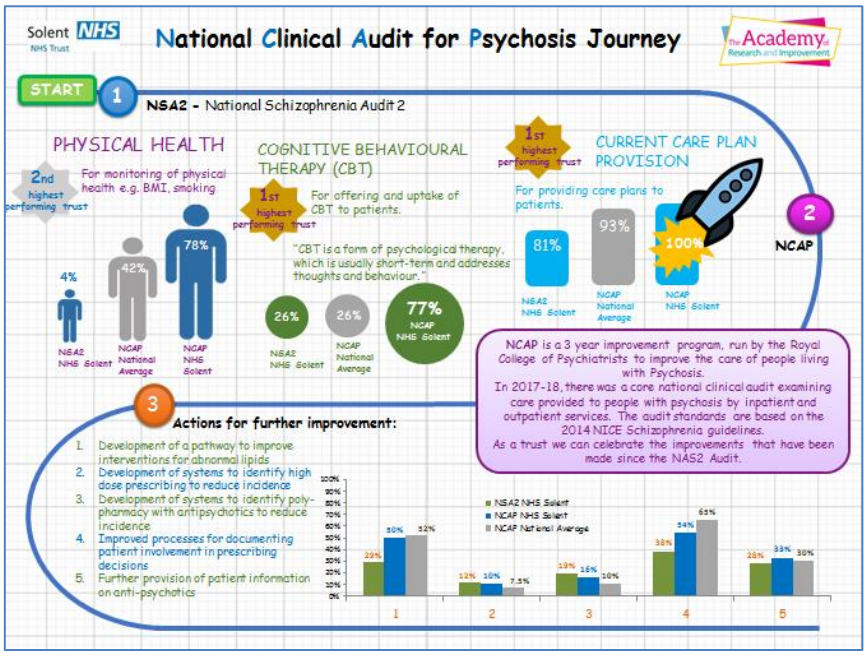
National Clinical Audits & Confidential Enquiries that Solent NHS Trust was eligible to participate in during 2018/19 are as follows:	**Did Solent participate?**	**Number of cases submitted to each audit or enquiry** (as a % of no required or * if not applicable)
National Clinical Audits		
Prescribing Observatory for Mental Health Quality Improvement Programme: 6d - Assessment of the side effects of depot antipsychotics	Yes	180 (100%)
Prescribing Observatory for Mental Health Quality Improvement Programme: 7f - Monitoring of patients prescribed lithium	Yes	90 (100%)
National Clinical Audit of Anxiety and Depression (NCAAD)	Yes	30 (100%)
National Clinical Audit of Anxiety and Depression (NCAAD):	Yes	30 (100%)

National Clinical Audits & Confidential Enquiries that Solent NHS Trust was eligible to participate in during 2018/19 are as follows:	Did Solent participate?	Number of cases submitted to each audit or enquiry (as a % of no required or * if not applicable)
Psychological Therapies spotlight audit		
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) spotlight audit	Yes	49
Falls and Fragility Fractures Audit Programme: National inpatient falls audit (NAIF) organisational audit	Yes	Submitted as required*
National Audit of Cardiac Rehabilitation	Yes	431 (100%)
National Audit of Care at the End of Life (NACEL)	Yes	24 (100%)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12):	Yes	Submitted as required*
National Diabetes Audit – Adults: National Core Diabetes Audit	Yes	845
National Diabetes Audit - Adults: National Foot Care Audit	Yes	79
Sentinel Stroke National Audit Programme (SSNAP)	Yes	328
Learning Disability Mortality Review Programme (LeDeR)	Yes	Submitted as required*
National Audit of Intermediate Care	No	
National Confidential Enquiries		
Mental Health: Suicide, Homicide & Sudden Unexplained Death	Yes	3/3 (100%)
Maternal (& New-born / Infant): Maternal morbidity and mortality confidential enquiry (including psychiatric morbidity)	Yes	No submissions required

The reports of 100% national clinical audits were reviewed by the provider in 2018/19 and examples of actions Solent NHS Trust intends to take to improve the quality of healthcare provided are below:

- National audit reports were distributed on publication to the relevant service line and local audit leads along with a summary of recommendations and an action tracker to measure compliance. National audit reports are also highlighted at the trust Learning and Improvement Group to promote cross service learning for improvement

- In one example of a repeated national audit, the National Clinical Audit of Psychosis, we submitted 88 cases and shared results across the trust in a range of formats including video and info-graphics. The info-graphic below shows key findings and actions for improvement



Local Audits and Service Evaluations

The reports of 124 local clinical audits were reviewed by the provider in 2018/19 and Solent NHS Trust intends to take the actions set out in the table below to improve the quality of healthcare provided.

These projects are determined by each service, based on their priorities, and are as a result of patient and staff feedback, business plans, complaints investigations, serious and high-risk incident investigations, as a means of measuring compliance with NICE guidance and as a baseline measure for Quality Improvement projects. At the start of each year, all service lines meet to develop and share ideas for projects in a trust wide improvement planning event.

Audit plans and actions are reviewed at service line audit groups with key learning and improvements shared at the trust learning and improvement group. Audit and evaluation action planning for improvement is increasingly integrated into the trust Quality Improvement programme. Specific training on audit and evaluation has had a high uptake.

Examples of some of the improvement outcomes achieved and actions planned as a result of local audits and service evaluations are detailed in the tables below:

Audit title	Improvement as a result of audit
(Adult services) Wound assessments	158 patients with wound care plans were audited of which 137 had a wound assessment (87%) which exceeded requirements and showed an improvement from 80% in the last audit, and 65% in the audit prior to that
(Adult Services) Nutritional screening	100% (37) of patients were screened for malnutrition status within 24 hours of admission - this was an 18% improvement from 2017-18; 92% overall had this repeated weekly
(Mental Health) Cardio metabolic monitoring	In this and the previous audit 100% of patients had their blood pressure screened. There were improvements in all other screening factors and both glucose and lipid were 100% compliant. The range of percentage improvement for the 5 areas that improved was between 7% and 25% (mean 13%)
(Mental Health) Completion of individualised care plans	Four audits were completed between January to June 2018. Between the first and last audit there was improvement in all areas measured: • Care Plan in place - 30% improvement • Care Plan current and in date - 60% improvement • Relevant to episode of care - 40% improvement • Documentation of capacity - 60% improvement • Documentation of consent - 40% improvement
(Podiatry) Post-op complications following nail surgery	The number of patients lost to follow up before wound healing improved by 3.7% to 13.3%. Post-operative infection rates improved by 19% to 13.3% whilst delayed wound healing improved by 6% to 33% patients
(Primary Care) Liver fibrosis markers in non-alcoholic fatty liver disease (NAFLD)	Coding of NAFLD has increased from 61 to 75 cases which may be due to increased awareness of this condition amongst clinicians since the initial audit. The percentage of patients with NAFLD who have been screened for liver fibrosis has increased from 20% to 43%
(Sexual Health) HIV History taking	Improvements on the previous audit were: from 50% to 75% in having a 6 monthly sexual history documented; from 85% to 94% for those appropriately offered any STI screening
(Sexual Health) Complication rates of vasectomies	Occurrence of complications has been overestimated - when coded complications were checked, only 12 out of 31 coded were appropriately coded according to definitions of complications (infection and haematoma). This gave an overall complication rate for Solent vasectomy department of 0.79% (12/1525 operations) which is within the limits quoted in the evidence and an improvement on the previous audit rate of 5.8%
(Sexual Health) Partner notification (PN)	Since implementation of an operating procedure, the Trust has improved on 2 of the 3 primary outcome measures. PN discussions are occurring in a timely manner

Audit title	Improvement as a result of audit
and testing of contacts of new HIV patients	with almost half done on the same day as diagnosis. The longest time to PN discussion was 11 days which is still within the 4-week target. The percentage of partners tested (86%) has increased since the procedure was introduced.
(Specialist Dentistry) Recording parental consent	The compliance reported in this audit (87%) shows continued improvement since the previous audit (83%). General anaesthetic sessions and assessment clinics had a compliance of 93%. This is an improvement since the last audit from 85%
(Specialist Dentistry) Recording of patient risk assessment	66 adult examinations were reviewed, compliance was Caries Risk - 47/66 (71%); Periodontal Risk 45/66 (68%); Oral Cancer Risk 33/66 (65%). These results indicate a significant improvement in recording of adults' risk (previously 31%, 26% and 16% respectively)
(Child and Family) Consent for comparative genomic hybridisation (CGH) blood test	Since the last audit, a consent form and CGH array pack has been introduced, leading to an improvement in the documentation of discussion around this investigation. In 2015, provision of an information leaflet had dropped to 31%. In this audit 46% were fully informed and consented, with a further 34% receiving information and/or being consented in a less clearly documented way
(Child and Family) Transition of young person to adult	There was an improvement from 42% in 2014 to 62% for plan of transition starting at appropriate age. Information in health care plan had also significantly improved with, for example, young person views increasing from 47% to 55% and list of professionals increasing from 33% to 100%

Audit/Evaluation title	Example actions planned as a result of audits and evaluations
(Adult services) Audit of patient wristbands	Implement an additional safety measure to support nurses: include a photo with prescription cards that have the patient's DOB & NHS number
(Mental Health) Audit of individualised care plans	Copies of care plans where appropriate will be sent to the patient with the patient's assessment letter. It will be documented in the electronic record whether a patient was offered a copy of their care plan, and whether it was accepted, given or declined
(MSK) Evaluation of Lower limb rehabilitation classes	Implement a patient resource pack; review and formalise class structure to complete a standard operating procedure; remind clinicians leading the class to discuss, agree and record SMART goals with patients; agree outcome measures and inclusion criteria for the programme; agree on class DNA / follow-up policy
(Primary Care) Re-audit of patients taking Spironolactone and Ace Inhibitor/Angiotensin receptor Antagonist – Risk of Hyperkalaemia	Initiate a monthly batch report to identify patients who are due a blood test & send the report to the medicines manager each month; put pop up prompts on electronic records when prescribing spironolactone; educate clinicians by emailing all clinicians via the coffee break MHRA update
(Sexual Health) Audit of complication rates following vasectomy	Remind staff to encourage men to contact the service if they experience complications and fill in & return the 4 month post op questionnaire along with their semen sample. Post-op, code complications according to agreed criteria. Remind lab that received questionnaires should be sent to service to be analysed
(Specialist Dental) Audit of recording of patient risk factors	Inform dentists of the re-audit results by a presentation and discuss area for improvement with them; provide links for clinicians to the documents Good Practice Guidelines (FGDP, NICE recall and SCDEP OHAR); encourage and monitor the use of templates on electronic records that include a risk factor assessment prompt
(Child and Family) Evaluation of GP and Health visiting liaison	Clarify with every GP practice how information is communicated and shared with the service/duty HV; introduce process to have a spread-sheet to record GP Liaison, provide an HV Service Update at GP training Day; meet with CCG Safeguarding Lead to discuss effective ways to promote GP/HV liaison and improved information sharing

Quality Improvement Programme

Solent's Quality Improvement (QI) Programme, launched in July 2016, is designed to support individuals and teams to develop the skills and capability to successfully identify and implement QI projects within their workplace. The growing success of the initial offer of a six monthly QI training programme for teams of staff has resulted in the successful launch this year of a stepped QI training programme comprising:

1. Introduction to QI: this short introductory session provides teams with a brief overview of QI.
2. Foundation day: this day long training provides an introduction to key QI methods. It is available to staff, patients and others using our services and includes support to carry out small scale QI projects within the workplace.
3. QI Practitioner: This is a team based training programme, bringing together staff and patients to build upon skills and knowledge in QI and use these to deliver improvement projects in their workplace.
4. QI Leaders: this year long programme is open to staff who have experience of successfully delivering QI projects and who want to develop their ability to lead QI activities across the Trust. The programme provides 4 externally facilitated training days, individual support with personal development and QI project delivery, and funding to support, for example, external site visits and project dissemination at conference.

This year approximately 350 staff and patients have participated in QI training.

Eleven Foundation Days have been delivered, 21 Foundation Day projects have successfully completed and 15 projects are underway. Examples of successful Foundation Day projects include:

- A team in our Special Care Dental Service has implemented a standardised process for follow up of patients who either did not attend or were not brought to their appointment. This resulted in a 50% increase in the number of patients seen after missing an appointment. Following implementation of the new process staff also reported increased confidence that patients who missed appointments were now being followed up appropriately

- A Specialist Community Nursing team increased the number of care plans completed by their staff from 28% to 100%. They also worked with their patients to co-design a Home Health Monitoring Care Plan

- A Community Therapy team identified that their current urgent waiting list was growing. The team identified that a new triaging system could help manage the urgent waiting list. This reduced the waiting time on the Urgent List from 13 weeks to 3 weeks and 3 days

Twelve teams also participated in two QI Practitioner programmes, 8 QI Practitioner projects have successfully completed and twelve projects are underway. Staff attending the training report better knowledge and increased confidence on how to make improvements; Charts 1 and 2 show outcomes for the most recent QI Practitioner cohort.

Chart 1: Results of Cohort 7 QI Practitioner participant evaluation of QI knowledge and skills

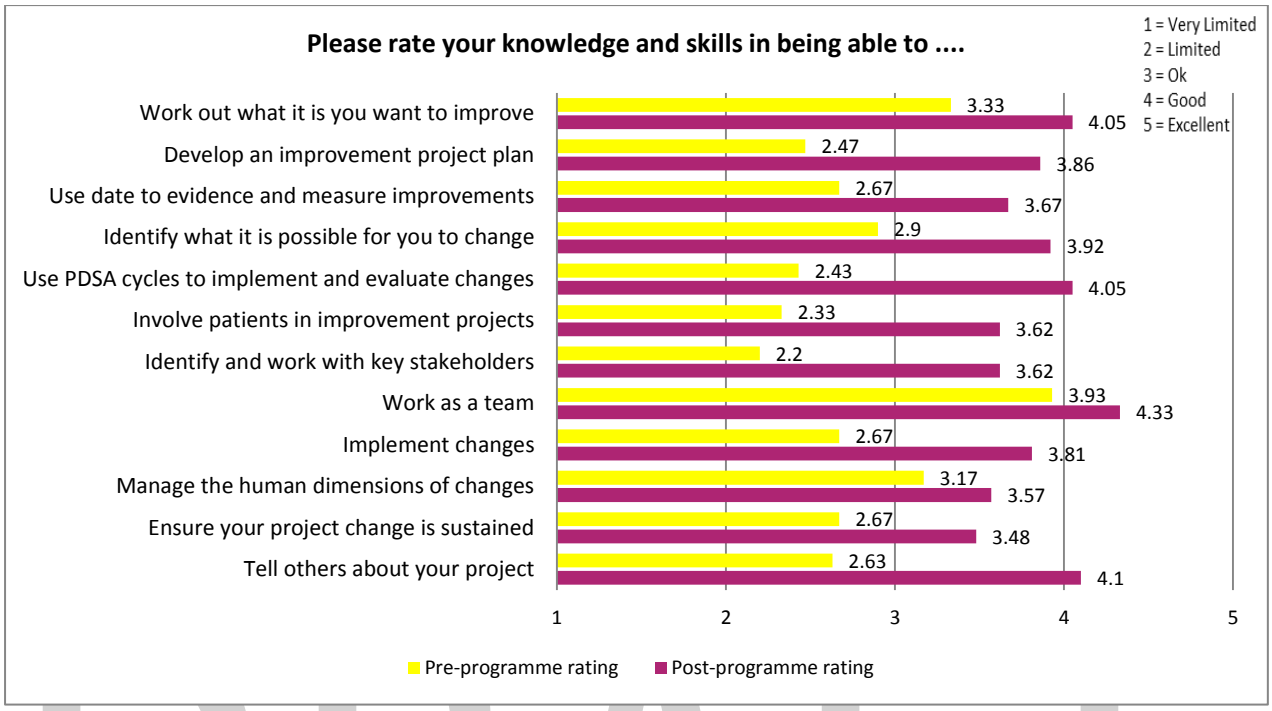
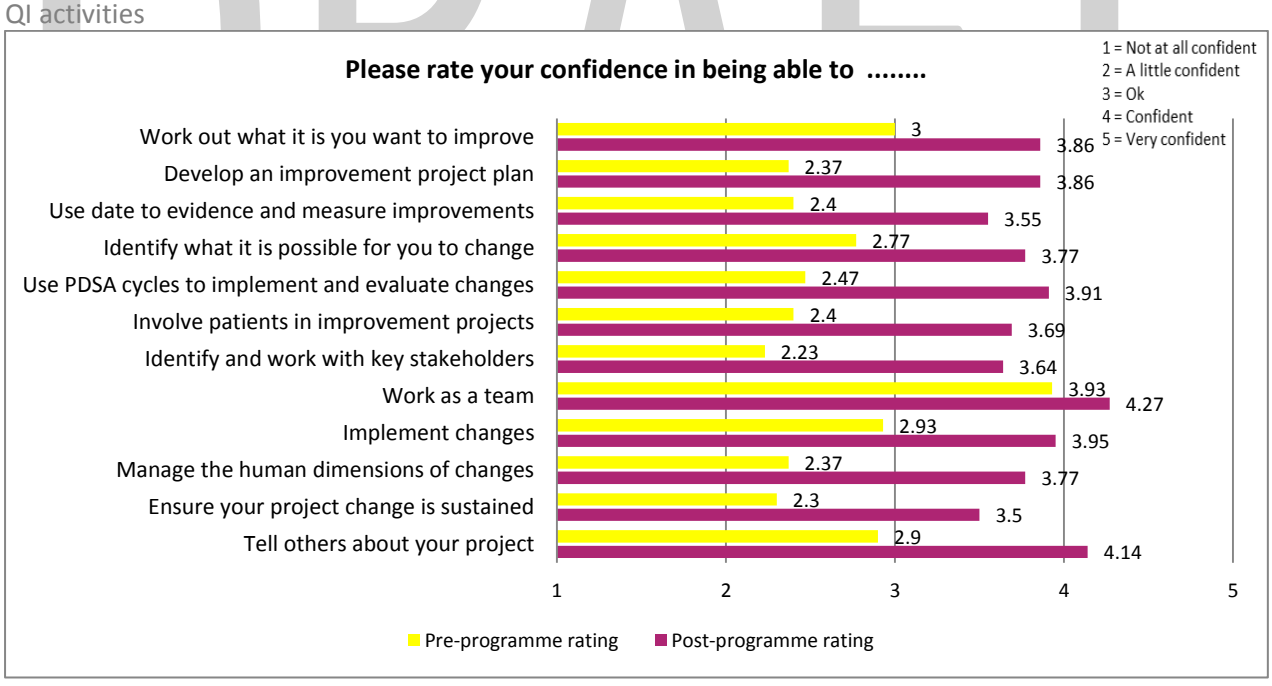


Chart 2: Results of Cohort 7 QI Practitioner participant evaluation of confidence in ability to deliver QI activities



Examples of successful QI Practitioner projects include:

- A podiatry service worked to ensure their emergency appointment slots were no longer being booked for planned appointments. Following extensive data analysis, routine and follow up waiting lists across clinics were pooled, the number of daily emergency slots was adjusted, the length of each slot was increased and telephone triage to confirm the need for an emergency slot was introduced

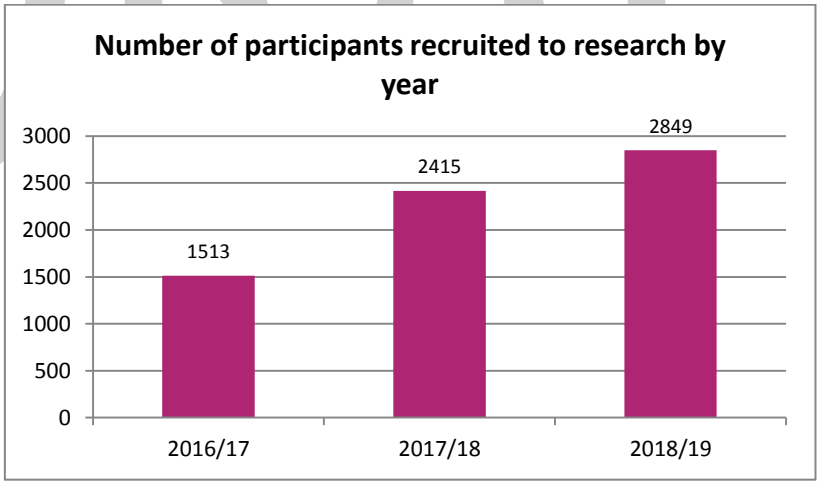
- The Portsmouth Children's Healthy Weight team worked with two schools to increase engagement between the school and school nurse team with parents/carers of children identified as obese at their year R National Child Measurement Programme screening. Changes implemented, following consultation with parents, included timely distribution of the pre-measurement letter, text messaging reminders to parents the day before the measurement, promoting the role of the school nurse and translation of information into other languages

- The Sexual Health Services project ensured specimen logging and labeling errors were reduced and that when errors were made they were identified and rectified prior to samples being sent for laboratory processing. Changes made included implementation of a new process and standard operating policy, introduction of new logging sheets, display of flow charts in specimen logging areas and a programme of staff training. These changes have been spread Trust wide

Research

The number of patients receiving relevant health services provided or subcontracted by Solent NHS Trust in 2018/19, that were recruited during that period to participate in research approved by a research ethics committee is 2,849.

Solent NHS Trust continues to grow its research activity, with nearly 3,000 participants being involved in 50 studies over the past year. Solent was named as the most research active Care Trust in the National Institute for Health's most recent national league tables.



Solent NHS Trust conducts community-based health and social care research across a range of specialty areas including infection, neurology and stroke, musculoskeletal, mental health and ageing. We host grants and lead trials as well as contributing to research studies being led by other NHS trusts and universities.

We are working with a team at the University of Southampton to support research into antibiotic resistance, and carriage rates for infection. We take samples from people of all ages from the community. This enables the research team to determine community carriage levels of common respiratory pathogens and the prevalence of antibiotic resistance. To date we have recruited over 2,000 participants, across the full spectrum of age groups.

The PrEP Impact study is funded by NHS England and is taking place across the UK. It is testing medication to reduce the risk of contracting HIV. Solent NHS Trust offers participation in this trial at our three Sexual Health Service hubs. Interest in the trial has been high and, to date, we have recruited 146 participants. Our role includes regular follow up visits and collection of samples to determine successful avoidance of infection.

The Vision in Parkinson's disease study (led by University College London) investigates how, when and where visual processing breaks down for patients. Solent recruited 16 participants to this study who will be followed up over a four year period. Long-term this study will increase understanding of visual breakdown and contribute to the development of effective treatment.

The Ankle Recovery Trial (ART) compares two methods of managing ankle fractures after surgery using either a plaster cast or removable boot. This study was conducted in conjunction with a local orthopedic surgery department at Portsmouth Hospital Trust. Solent NHS Trust's research team co-ordinated the study, recruited 19 participants and provided the physiotherapy intervention. Formal results are awaited and will be used to guide future management of this patient group.

The CAP-MEM study (led by Northumberland, Tyne & Wear NHS Trust) explores the cause and prevalence of memory problems in mental health. It assesses self-reported concentration and memory problems amongst people with a clinical diagnosis of a psychiatric disorder and a comparison group of healthy controls. To date, Solent NHS Trust has recruited 263 participants to the study. This initial study will be used to establish the feasibility of conducting similar research amongst larger numbers of individuals in the future. Ultimately, findings will enable researchers to better understand the relationships between psychiatric diagnoses and memory and concentration problems, taking into account factors such as medication type and dosage.

The SCIMITAR study (led by the University of York) involved a bespoke intervention to support individuals with serious mental illness to stop smoking. Smoking cessation is often particularly difficult for this population cohort, and comorbid physical health problems are widespread. Solent NHS Trust recruited participants and delivered the intervention. Results of this study have recently been published in The Lancet demonstrating high rates of quitting in the intervention group compared to the usual care control group.

Our full Academy of Research and Improvement Annual Report is included in Appendix C of this report.

Commissioning for Quality and Innovation (CQUIN)

** Q4 data not available until the end of May 2019 **

A proportion of Solent NHS Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Solent NHS Trust 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 payment framework.

This table shows the number of CQUINSs schemes in place for 2017-2019 and the number of schemes achieved:

Chart 1: Number of CQUIN schemes in place 2017-2019

			Q1		Q2		Q3		Q4	
Care Group / Service Line	**Scheme**	**Commissioner**	**Due**	**Achieved**	**Due**	**Achieved**	**Due**	**Achieved**	**Due**	**Achieved**
Portsmouth Care Group	#1 – Improving Staff Health and Wellbeing	Portsmouth							3	
Southampton Care Group	#1 – Improving Staff Health and Wellbeing	Southampton							3	
Adults Mental Health	#3 – Improving Physical Health for people with Severe Mental Illness	Portsmouth	4	4	1	1	1	1	6	
Adults Mental Health	#4 - Improving services for people with Mental Health needs who present to A&E	Portsmouth	1	1			1	1	5	
Childrens East	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	Portsmouth	1	1	4	4			4	
Childrens West	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	Southampton	1	1	4	4			4	
Adults Portsmouth	#8b – Supporting proactive and safe discharges - Community	Portsmouth							1	
Adults Southampton	#8b – Supporting proactive and safe discharges - Community	Southampton							1	
Portsmouth Care Group	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	Portsmouth	5	5	5	5	5	5	5	
Primary Care	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	Southampton	5	5	5	5	5	TBC	5	
Adults Portsmouth	#10 – Improving of Wounds Assessment	Portsmouth			1	1			1	
Adults Southampton	#10 – Improving of Wounds Assessment	Southampton			1	1			1	
Sexual Health Service	#1.1 – Activation System for Patients with Long Term Conditions (LTCs)	NHS England	1	1	1	1	1	1	1	
		Total	18	18	22	22	13	8	40	
			100%		100%		62%		TBC	

Care Quality Commission (CQC)

Solent NHS Trust is required to register with the Care Quality Commission and the Trust is registered with no conditions.

The Care Quality Commission has not taken enforcement action against Solent NHS Trust during 2018/19.

Solent NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Solent NHS Trust underwent a comprehensive core services inspection of all 15 core services in June 2016. The overall rating at that time was "Requires Improvement" with Mental Health and Learning Disabilities service given an "Outstanding" rating.

Our Primary Care services at Adelaide Health Centre (Solent GP Surgery) were inspected early in October 2018 and services were rated "Good" across all population groups with Primary Care rated "Good" overall.

Later in October 2018 we welcomed back the CQC to undertake a core services inspection of all services that previously had a 2016 "Requires Improvement" rating. The CQC inspected eight core services:

- Adults Community Services
- Children and Families
- Mental Health Psychiatric Intensive Care Units
- Older Peoples Mental Health Inpatient Ward
- Older Peoples Mental Health Community Services
- Mental Health Rehabilitation Integrated Practice Unit
- Mental Health Crisis 136 Suite

In November 2018, CQC returned to undertake a Well-Led inspection. This involved 31 interviews, mainly of the Board and senior leadership teams, plus two focus groups over a 2 ½ day period.

All inspections were announced, and no NHS Improvements "Use of Resources" inspection was deemed required at this time.

On February 27 2019, the final inspection report was published, and the Trust was given an overall rating of "Good". Our Older Peoples Mental Health (OPMH) in-patient unit was awarded a rating of "Outstanding" in the caring domain following the submission of additional information by the Trust. This had the benefit of raising the whole Trust rating to "Outstanding" in caring, which we believe is well-deserved recognition of our exceptional care. Every core service inspected in 2018 was rated "Good" or "Outstanding" overall.

Our CQC ratings are now as follows:

Figure 1: Overall Trust Ratings

Figure 2: Ratings for Primary Care services by population group

Older people	Good
People with long-term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Figure 3: Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Community health services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community health inpatient services	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community end of life care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019

Figure 4: Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Wards for older people with mental health problems	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community-based mental health services for adults of working age	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Mental health crisis services and health-based places of safety	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019
Specialist community mental health services for children and young people	Good Sept 2017	Good Sept 2017	Outstanding Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017
Community-based mental health services for older people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community mental health services for people with a learning disability or autism	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016
Substance misuse services	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
Overall	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

We were advised of 36 minor breaches of regulations; these areas for improvement are spread across the trust and clinical services. While action is not mandated, the findings will positively

influence us to deliver best practice and the time frame we have set to make improvements is 6-12 months.

We were issued with one Requirement Notice for a breach of *Regulation 12(2) (g): the proper and safe management of medicines* in our Adult Mental Health services. This breach was found in one location only, was not system-wide and we have submitted a comprehensive action plan to CQC which addresses the regulatory requirements. The actions are already well underway and will be tracked and maintenance monitored through service-level governance meetings, the Quality Improvement & Risk Group and monitored by the Assurance Committee and Trust Board.

Two other reviews of services have been undertaken by the Mental Health Act Review team, resulting in two positive reports.

Our Specialist Dental Services and Sexual Health were not inspected in 2018 and we look forward to welcoming CQC back to review these services.

Information Governance

The Solent NHS Trust *Data Security and Protection Toolkit for 2018/19* was submitted on 27 March 2019 as Standards Met; meaning all mandatory requirements have been achieved.

Payment by Results (PbR) Clinical Coding

Solent NHS Trust was not subject to the Payment by Results clinical coding audit by the Audit Commission during 2018/19.

Data Quality

During 2018/19 we developed our internal data quality tools, giving services simple, near real-time access to their information, including waiting lists and appointment outcomes, in order to validate and correct any data entry issues. As a result, the number of reported 52 week breaches and the number of reported 18-51 week waiters has dramatically reduced giving a clearer and more accurate position for the Trust.

The Data Quality Team has received additional investment during 2018/19 to expand the resource available to work collaboratively with our services to validate data including waiting time performance indicators, continue to systemically review all service users on waiting lists to ensure they are accurate and appropriately recorded, and to investigate and resolve data quality issues as they arise. Regular automated reporting will be extended and oversight shared with services and senior management to ensure validations and outcomes are being recorded correctly and the quality of our data continues to improve.

An internal audit report on Clinical Data Quality was published in May 2018, assessing both the governance and implementation of data quality processes in order to establish adherence to national and internal guidelines. The main issue identified in the audit report was that reporting on clinical data was hindered by inaccurate and often delayed data entry by clinical service staff. The developments within the data quality function over the past year have aimed to address these issues and the additional resource should further help to alleviate this into 2019/20.

Learning from Deaths

During 2018/19 1867 people who have been in receipt of services provided by Solent NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 383 in the first quarter;
- 458 in the second quarter;
- 505 in the third quarter;
- 521 in the fourth quarter.

By end of year, 751 case record reviews and 14 serious incident investigations have been carried out in relation to 1867 of the deaths included above

In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 223 in the first quarter;
- 204 in the second quarter;
- 190 in the third quarter;
- 168 in the fourth quarter.

Our current process does not identify how many patient deaths scrutinised by case record review during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. However, where concerns were noted an incident review meeting was held to determine whether a serious incident investigation was required. From April 2019, the Trust will record on the mortality dashboard how many deaths were identified with concerns relating to quality of care and or deaths that were noted as more likely than not to be attributed to the care provided by our organisation. This will be discussed at the monthly Learning from Deaths panel where all service lines are represented.

The Trust continues to develop its Learning from Deaths Framework and was one of the first community Trusts in the country to adopt the Structured Judgement Tool Reviews before the expectation that all Trusts would adopt this methodology (it was originally piloted for acute Trusts only).

The inclusion criteria in our current policy, results in a high number of reviews being undertaken when our organisation was not the main provider of care (for example, where we provided dental or podiatry services). We continue to review and update our criteria for review as we strive to ensure that reviews are meaningful and supportive of identifying lessons and improvements. This is reflected in the quarterly data which shows a decreasing number of cases reviewed over the year.

When learning is identified this is added to the Trust Learning Framework Database; changes and outcomes are monitored at the monthly Learning from Deaths panel.

To date, on review of our care provided we have not identified any deaths relating to our care provision which were thought to be avoidable. We have also not identified any deaths in which the quality of care was noted to have been a contributing factor in the patient's death. Had this been identified, a serious incident would have been declared.

In cases when we have attended the Coroners court we have not received any Prevention of Future Deaths Notifications or been notified that any other actions need to be undertaken. In cases where a serious incident has been completed, the Coroner has been satisfied with the recommendations and actions the Trust has already agreed or implemented. In all cases, it was confirmed that had

these actions been undertaken, it would not have resulted in a different outcome for the patient (i.e. prevented their death).

Below is a summary of the learning we have identified by undertaking reviews of deaths, and the subsequent actions taken. Delivery of actions has been monitored through the Trust Learning Database:

Service	Learning and Improvements
Children's and Families	The team has reviewed all safe sleeping information and introduced standardised paperwork including leaflets to ensure staff members always confirm where a baby is sleeping
Children's and Families	A training programme has been introduced for staff relating to the management of pre-term babies
Children's and Families	We are now working with acute providers to strengthen the pathway for managing babies with identified risk factors when discharging to the community nurses
Children's and Families	We can now link a child's records to the father/significant other on the electronic recording system. Previously it was only possible to link with the mother's records
Adults Portsmouth	Nurses are now able (after training) to verify deaths when a patient's death is expected in an end of life care setting to avoid distressing delays for families out of hours
Adults Portsmouth	Safeguarding guidance and the referral process has been updated on the Trust intranet to support staff in their decision making
Adult Mental Health	Guidance has been introduced to guide staff on the referral and management processes between the Hampshire Liaison and Diversion Service (HLDS) and the Police
Adult Mental Health	Guidance has been updated and implemented for staff to follow when agreeing informal leave for patients who are not detained under the Mental Health Capacity Act
Adult Mental Health	Training sessions and simulation exercises have been completed (and continue) across the service to improve staff competency and confidence in immediate life support and airway management in an emergency situation
Adult Southampton	A decision making tool has been rolled out to support pain assessments to improve end of life care in non-end of life care settings and is available on the electronic patient record system
Adult Mental Health, Adults Southampton and Adults Portsmouth	The service is developing collaborative guidance for preadmission assessments and referral processes to ensure that we transfer patients safely to the correct environment according to their needs
Adult Mental Health	We have written a clear process and guidance for staff advising when to repeat VTE assessment when a patient's condition
Adult Mental Health	We have developed a process to highlight a list of most "at risk of suicide" patients who are then discussed in depth at the multi-disciplinary team meetings by those present
Children's and Families	We have implemented an SOP to provide guidance to staff on how to complete an assessment and when and how to escalate concerns relating to child sexual exploitation
Children's and Families	We have implemented an SOP on the process and requirements needed when transferring a patients care to another provider to ensure that the safety of the patient is consistently maintained
Children's and Families	The process for the support of staff involved with a child who dies unexpectedly has been developed and improved upon. This is now provided in the form of debriefs and supervision and since the implementation of this there have not been any further reported issues regarding this
Children's and Families	Guidance has been introduced for staff on when and how to refer patients to the pharmacy technician for review of patient medications. This will include concerns regarding safeguarding and compliance
Adult Southampton	The Trust Mental Capacity Tool is now easily available on the clinical tree within the electronic patient record to enable staff to complete the assessment as required
Adult Southampton	An audit has been completed to demonstrate the impact of change relating to the

Service	Learning and Improvements
	development of a pain tool on the electronic record system –this related to the management of end of life care for patients on wards that rarely provide this form of care. Staff had varied knowledge and experience of the tool and the service has committed to continue to promote the knowledge and use of this tool and will now monitor at service level

There were 16 case record reviews and 0 investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period 2018/19.

None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

None of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

As stated above, during this period the Trust did not have a process in place identify how many patient deaths scrutinised by case record review during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. A process has been introduced from April 2019.

Speaking Up (New for 2018/19)

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle blowers).

Since the introduction of Freedom to Speak Up in 2015 and as a consequence of recommendations made by Sir Robert Francis, we have implemented processes within the Trust to ensure our staff are able to easily raise concerns and seek confidential advice and support.

We have an Independent Freedom to Speak up (FTSU) Lead Guardian who is supported by 5 Guardians working across our services. Staff can speak up on any issue using a variety of communication mechanisms; Freedom To Speak Up Guardian (FTSUG) inbox, email FTSUG individually, face to face meetings, telephone call, video call. Feedback is requested verbally and recorded quarterly using our data return log to the National Guardian Office.

Our Quarterly Freedom to Speak Up (FTSU) Steering Group is chaired by a Non-Executive Director (Chair of the Audit & Risk Committee) and is attended by the Chief Executive, Chief People Officer, Chief Nurse and our Independent Lead FTSU Guardian. At the meeting, the Independent FTSU Lead Guardian and Executives provide assurance to the Lead Non-Executive Director for FTSU on behalf of the Board that issues raised are dealt with promptly and appropriately by the Trust. The FTSU Independent Lead Guardian briefs colleagues on:

- current cases and actions taken taking into account confidentiality and anonymity
- regulatory/national requirements from the National Guardian Office

The Chief Nurse and Chief People Officer brief members and provide assurance that appropriate actions are being taken where any matters concern patient and staff safety and /or wellbeing.

The Group also oversees work programmes associated with FTSU including the development of the strategy and associated implementation plan, the completion of the National Board Self- Assessment and ensuring appropriate promotion and engagement to support an open culture of raising concerns, continuous learning and organisational development.

As of 14th Feb 2019 the Trust has had 35 logged of Freedom to Speak Up cases. Three themes have been identified in 2018/19:

- Bullying & Harassment
- Systems and processes
- Behaviours & relationships

As a result of these cases the Trust has reviewed and assessed its Freedom to Speak Up processes by:

- Carrying out deep dives into specific service areas which have involved analysis of local data, listening exercises with staff groups and onsite assessments
- Engaged in consultative & collaborative working with senior managers to improve service areas and working culture relationships
- The Trust Board also led on the appointment of an independent, impartial Lead Freedom to Speak Up Guardian in December 2018

Doctors and Dentists in Training (New for 2018/19)

The Trust produces quarterly and annual Guardian of Safe Working Reports and these indicate we are doing well in ensuring all the provisions and Terms & Conditions from the 2016 Juniors' Contract are being followed.

Gaps are mainly evident in two rotas, both of which are held jointly with other Trusts and the longer term management of the rotas will involve wider systems including other Trusts, CCGs, especially for the Child & Adolescent Mental Health Services (CAMHS) rota as well as Sustainability & Transformation Partnerships (STP) systems.

Actions being taken to address gaps in the two rotas include:

- Child and Adolescent Mental Health (CAMHS) Rota – gaps are being filled by offering them as locums to trainees with all the Educational Supervisors, Guardian of Safe Working and Director of Medical Education ensuring there is no adverse impact on education and training. The use of locums may need to follow the Trust's 'acting down' Policy for gaps that can't be filled by trainee locums and as a results consultants may need to 'act down' (we have a number of gaps this year due to the coincidental completion and graduation from the rotation of 5 Specialty Trainees). The gaps will eventually be filled as trainees are recruited nationally. The CAMHS Service has also taken a longer term view regarding recruitment and retention, and the Director of Medical Education has worked with Health Education Wessex and Health Education England (HEE) to ensure the Trust will participate in the national CAP (Child & Adolescent Psychiatry) run-through training pilot

- Older Peoples Mental Health Rota – this rota is shared between Southern Health NHS Foundation NHS Trust and Solent. The unfilled shifts/ gaps are currently covered by locums and occasionally by Specialist Trainees 'acting down'. There are on-going discussions between the two Trusts and Wessex Deanery to find a more sustainable way forward and this will involve other systems including STP, and HEE national recruitment

2.3 Reporting against Core Indicators

NHS Trusts are required to report performance against a core set of mandated indicators using data made available to the Trust by NHS Digital. Target thresholds for indicators 1 to 3 are being met. The target threshold for indicator 4 is not being met and a summary of actions to be taken is provided. There are no target thresholds for indicator 5.

Indicator 1: The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

Measure:	Numbers of Service Users followed up within 7 days of discharge from inpatient care (Omnibus collection by Information Centre)											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	95%	100%	100%	100%	100%	98%	100%	100%	97%	100%	100%	100%	100%
YTD	95%	100%	100%	100%	100%	100%	100%	100%	99%	99%	99%	100%	100%

Indicator 2: The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period

Measure:	Percentage of Admission Gate Kept by CRHT (Including MHA assessments)											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
YTD	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Indicator 3: The percentage of patients aged (i) 0 to 15 and (ii) 16 or over re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period

Measure:	Percentage of patients aged 0 to 15 re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	5%	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
YTD	5%	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Measure:	Percentage of patients aged 16 or over re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	5%	0%	3%	2%	4%	3%	3%	2%	2%	3%	2%	3%	1%
YTD	5%	0%	1%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%

Indicator 4: The trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period

Measure: % of Patients Extremely Likely or Likely to Recommend Solent Services													
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	95%	75%	71%	88%	89%	86%	100%	91%	91%	88%	85%	91%	92%
YTD	95%	75%	73%	78%	81%	81%	83%	84%	85%	86%	86%	87%	87%

Data is shown in red as target thresholds have not been met however this is consistent with the national trend for Friends and Family Test (FFT) in Mental Health services. We continue to work hard to increase FFT feedback so the data is more representative and the service has improved results by 10% over the past 12 months using iPads in some areas. We aim to continue this improvement in the next 12 months and are currently exploring other ways of obtaining feedback.

Indicator 5: The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Indicator	2017-18		2018-19	
	Number	Percentage	Number	Percentage
Patient safety incidents reported	4452	N/A	4415*	N/A
Patient safety incidents resulting in severe harm or death	6	0.13%	2**	0.45%

*NRLS data is published every six months and the last published data was to the end of February 2019

** The number of severe harm or death incidents does not directly equate to the number of serious incidents (Learning from Deaths section). Many of the Trust's serious incidents are moderate harm incidents and are sometimes downgraded following investigation.

Chart 1: Incidents reported to the NRLS March 2018 to February 2019

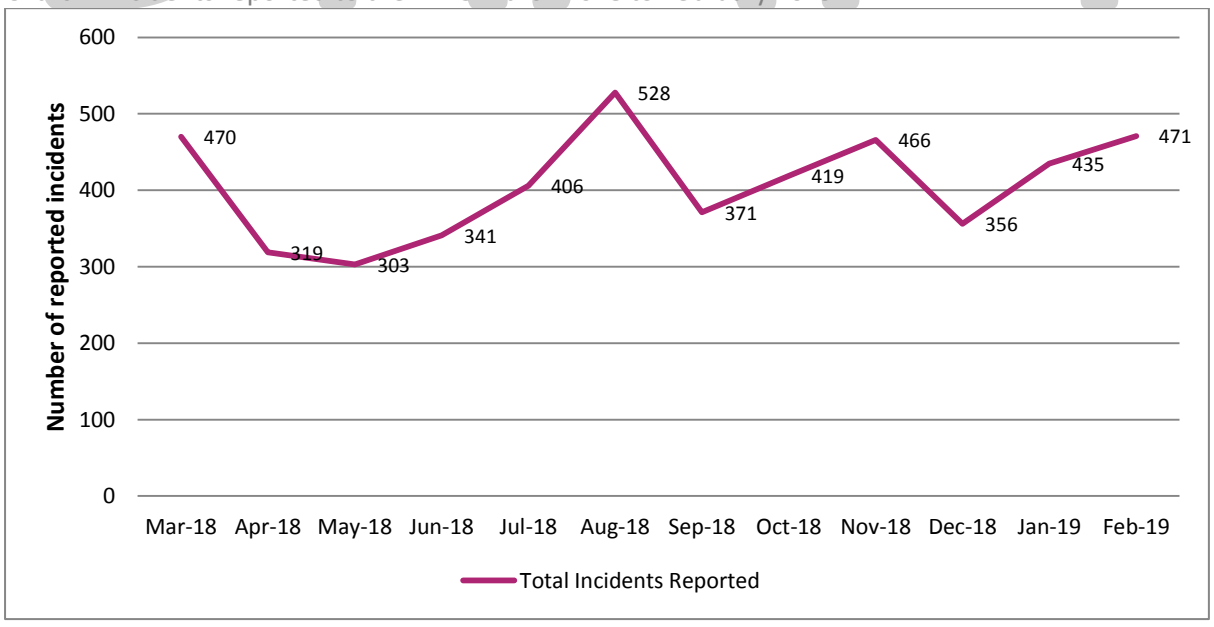
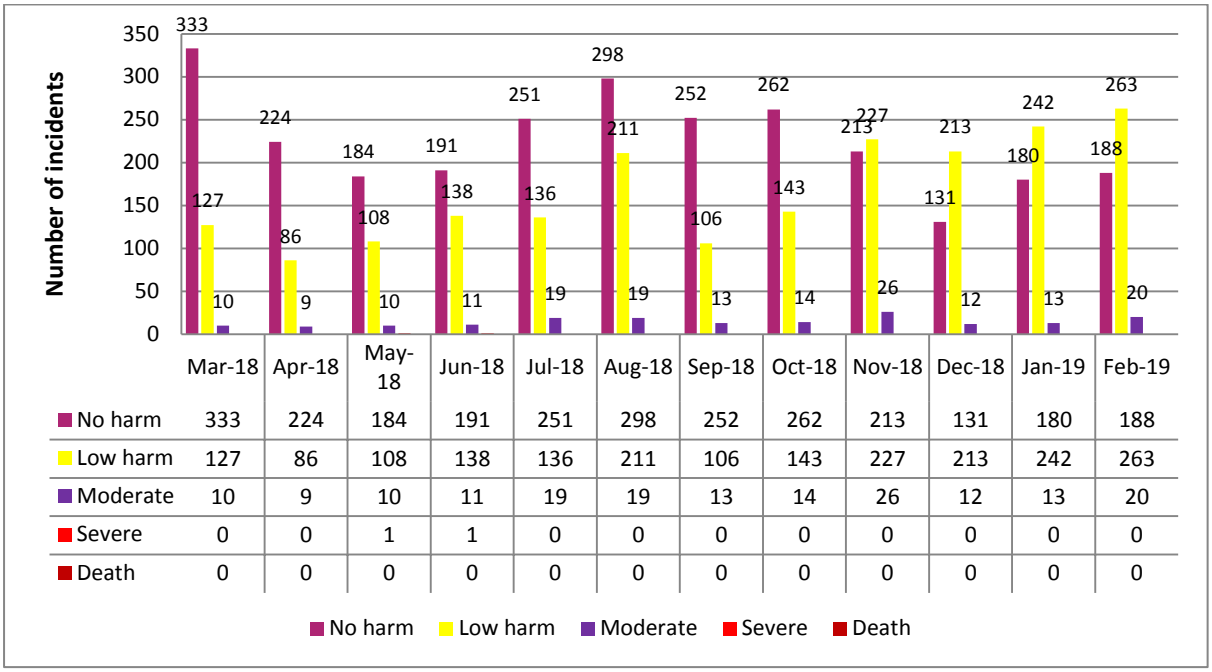


Chart 2: Degree of harm of NRLS reported incidents from March 2018 to February 2019



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
No harm	333	224	184	191	251	298	252	262	213	131	180	188
Low harm	127	86	108	138	136	211	106	143	227	213	242	263
Moderate	10	9	10	11	19	19	13	14	26	12	13	20
Severe	0	0	1	1	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0

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

- The number of moderate incidents relates mainly to category 3 and 4 pressure ulcers which were acquired in the care of the Trust.
- Of the two severe incidents, one relates to a patient causing major damage to the ward area which resulted in the evacuation of all patients on the ward. Several patients had to be relocated to other health care providers. The other relates to a patient who fractured their neck of femur while an inpatient.

Reducing Patient Harm

The figures highlight that the majority of incidents reported result in “no harm” or are “near misses”. There is a positive culture in reporting and staff are encouraged to report incidents and where an increase is seen it is seen as a positive increase in no or low harm incidents (none have been identified as severe harm).

Incidents are reviewed alongside other data such as compliance with assessments. Analysis is undertaken monthly to identify if there are any themes or trends and if identified this is highlighted to service leads and escalated via Quality Improvement and Risk (QIR) Group for future actions to be monitored.

Training is provided for incident reporters and reviewers which has improved the quality of data reporting and management. The Trust continues to work with staff to improve the reporting processes and make improvements to the electronic reporting system.

Duty of Candour

The Trust has implemented the statutory requirements of Duty of Candour and provides mandatory training and local guidance as per the Trust policy. When staff complete an incident form using the online reporting system, if Moderate harm or above is indicated the system prompts the reporter to consider if Duty of Candour applies. If a serious incident is declared, again the service is prompted to consider if Duty of Candour applies.

In their inspection last year, CQC identified that some staff were unsure of their obligations in relation to Duty of Candour and one of our quality improvement priorities for 2019/20 is to address this; in quarter 1 2019/20 the Trust will launch the updated "Being Open and Duty of Candour" policy which will enhance staff awareness of the importance of Being Open, in addition to how to meet the statutory requirements of Duty of Candour and when it applies.

Training packages and resources are being developed to support this as the Trust recognises that getting this right at first point of contact is crucial in supporting our patients and families/carers to ensure we embrace our Trust values and culture of "honesty" and "everyone counts" and seek to identify opportunities for learning when things have not gone the way we intended.

Family Liaison

In November 2018 the Trust recruited to the role of Family Liaison Manager (FLM), following recognition of the need for support of our bereaved families, at a time of great emotional distress. The aim of the FLM role is to ensure the Trust provides a consistent, autonomous person who will give unconstrained and appropriate support to bereaved families and carers, also assisting the Trust in consulting with and involving affected families.

The FLM fully walks through the processes, whatever they may be, with the family and supports them both at the time of the incident and during investigation, and in the future, should they need this.

The FLM encourages families to speak up and to be involved in investigations, to provide key information that may assist in a more rounded and holistic view/outcome of an investigation, as well as ensuring that staff are confidently and actively involving families and with regard to Duty of Candour.

The FLM is involved from the outset, starting at the Incident Review Meeting, where the FLM can input about support for the family and brings to that meeting the voice of the family.

Signposting for relevant services, counselling and FLM support is offered to all families and carers, by way of this role when a bereavement or serious incident happens and it is identified that there may be a role for FLM.

The FLM is also on hand to guide families through the Inquest process and also other health and social care systems as required.

Part Three: Other information

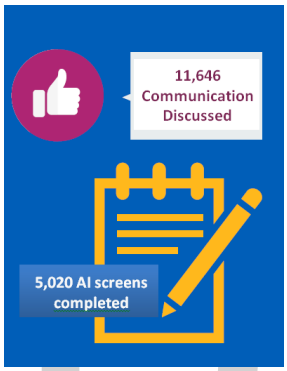
3.1 Quality Initiatives

This section provides information about other quality improvements and initiatives not covered elsewhere in this report.

Accessible Information (AI)

Identifying patients and carers communication and/or information needs

Accessible information (AI) screening has now been embedded into all electronic patient record systems across the Trust. The screens have been designed to meet the requirements of the NHS England Accessible Information Standard (DCB1605 Accessible Information).



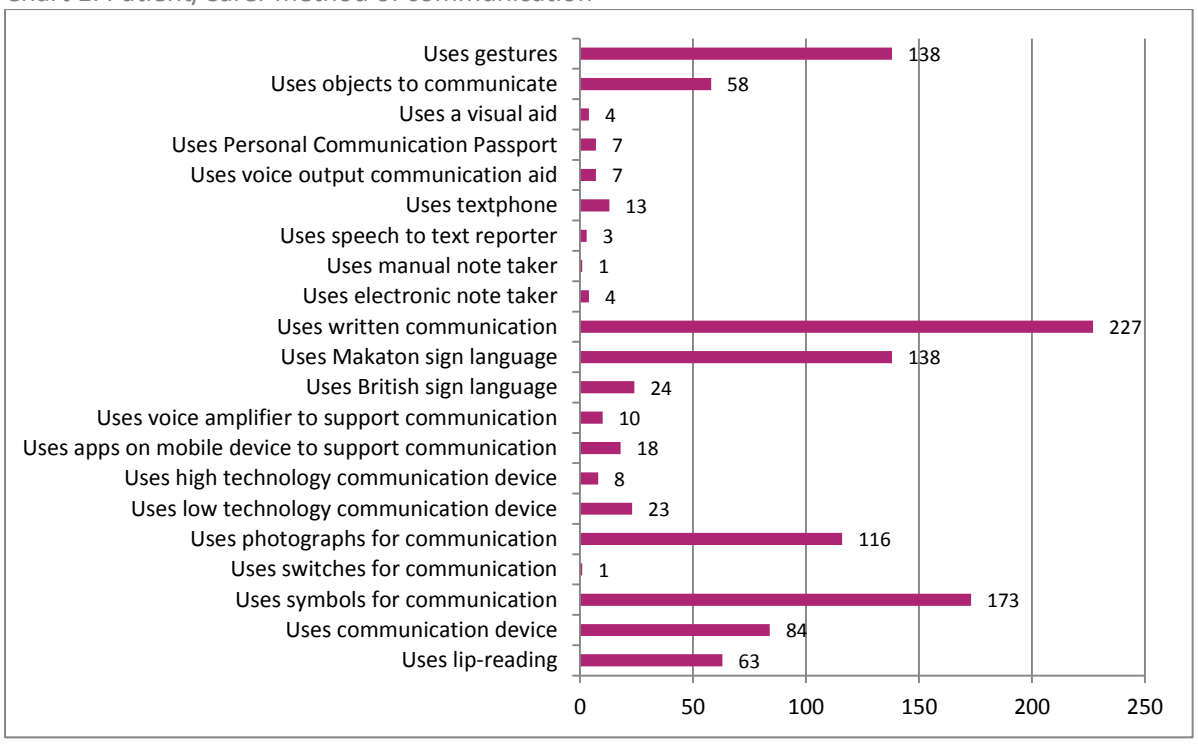
Accessible Information (AI) screening includes four key questions - how the person communicates; if they require any communication support; what format they need their information; and their preferred contact method.

As of February 2019, **11,646** discussions about communication and/or information needs have been recorded. Of these, **5,020** people went on to have a full accessible information screen completed. Through screening, **1,941** people with communication and/or information needs were identified, which equates to 39%.

To further understand the nature and prevalence of communication and/or information needs across our local population, additional data is presented in the tables below.

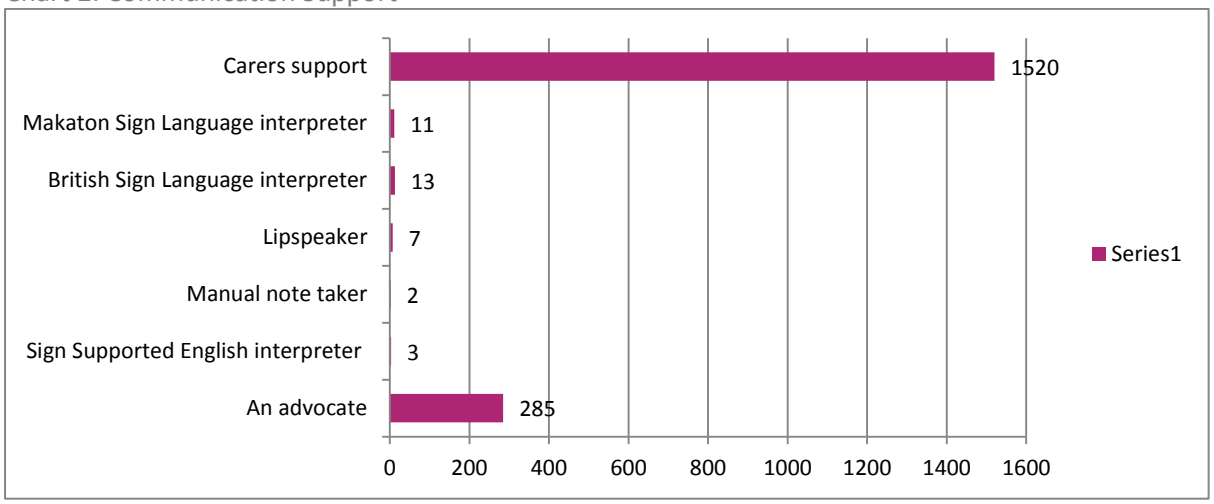
Chart 1 highlights the wide range of communication methods used by our patients and carers and the skills needed by our staff to support and facilitate inclusive communication approaches.

Chart 1: Patient/Carer method of communication



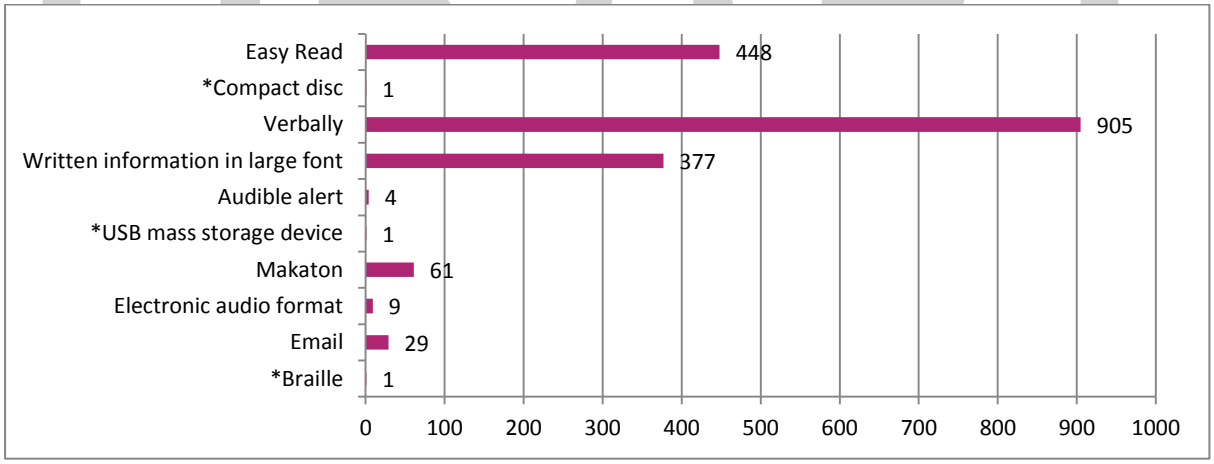
In addition to the information presented above, **1,114** people were recorded as using a hearing aid.

Chart 2: Communication Support



The information presented in Chart 2 illustrates that of those screened, 83% required the support of a paid or unpaid carer to support their communication and 15% required an advocate. Data on the number of people requiring a paid communication specialist e.g. a British Sign Language (BSL) interpreter remains low at only 3%. However, through our procurement records we know that a higher number of BSL interpreters have been commissioned; indicating that some services are still not recording this need within the AI screen.

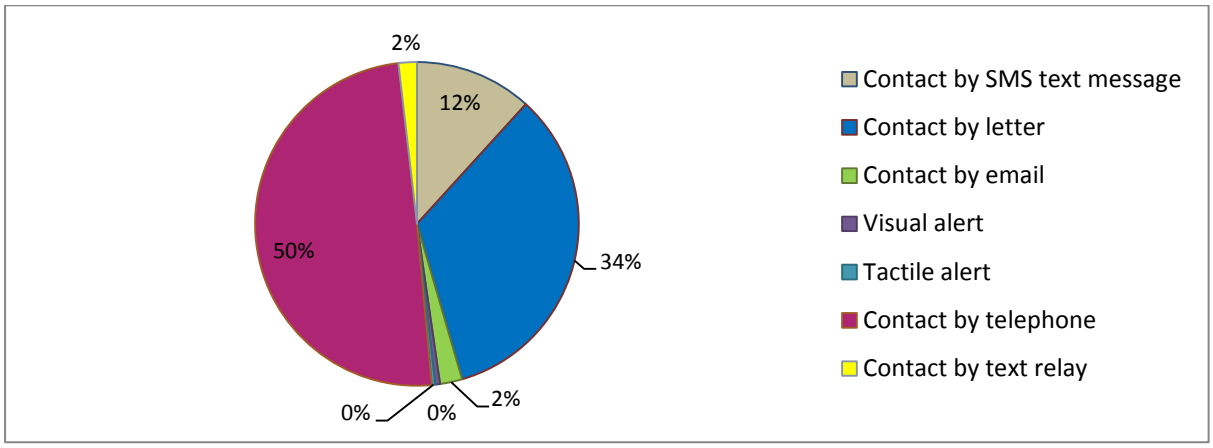
Chart 3: Format of information



*= only 1 person identified.

Of those screened, 900 people requested to have their information verbally, however this raises a concern about the person's ability to accurately retain and act on the health information given. The next highest requested formats were Easy Read and large font, both of which can be produced in-house.

Chart 4: Contact method



Of those screened, most people are still requesting contact via the traditional methods such as by telephone, letter, email and SMS text message (98% collectively). Only 2% of those screened required a more specialist contact method as illustrated above.

In-house communication training and support

Throughout 2018/19, 35 additional members of staff from 22 services across the Trust have completed the one-day AI workshop delivered by the Accessible Information Team. The workshop has been updated to include the Communication Access Symbol UK (see below) and is now co-delivered by a patient-lead that has first-hand experience of living with communication and information needs. Some staff supporting patients with complex communication needs have also been trained in Talking Mats™. The Trust has one accredited trainer for Talking Mats™ who delivers the training across the Trust bi-annually.

There is an established AI champion network, with over 50 members, that meets bi-monthly to lead change and share learning beyond the training. AI practice is further supported by a comprehensive AI SolNet page that hosts a range of tools to support the production accessible resources, ready to use Easy Read resources and information to support self-directed learning.

Communication Access Symbol UK – early adopters

Following a two-year national project run by the Royal College of Speech and Language Therapists (RCSLT), 2018 saw the launch of the new Communication Access Symbol UK. The symbol (pictured on the left) will be used to demonstrate that the service/team can support the communication access standards. Good communication benefits everyone and effective communication access for all is achievable through awareness, education and training.

Solent NHS Trust was proud to be selected as the first community and mental health NHS Trust nationally to register as an early adopter of the Communication Access Symbol. On the 8 March 2019, key staff from the Trust headquarters received the training and Highpoint become our first communication accessible location. As part of the early adopter phase it is hoped our in-house AI workshop will be Communication Access accredited which will support local implementation.

Co-produced accessible self-help guides for children with learning disability and mental distress

A collaborative quality improvement project was led by the Accessible Information Team to develop and evaluate accessible resources to support and promote self-management whilst families await

specialist interventions. Engagement events were conducted with parents, children and siblings who had lived experience of managing mental distress within the home environment. Baseline data from the Child and Adolescent Mental Health Service - Learning Disabilities (CAMHS-LD) was reviewed in relation to the range, frequency, intensity and cost of their interventions. A co-production model was then utilised to develop the accessible self-help guides.

Sleep was identified as the key topic for the on-line prototype. Parents wanted a demonstration video, which included professional guidance alongside stories from families with lived experience, as well as Easy Read documents. The impact on siblings and the need for a child friendly resource was highlighted. A range of children worked with the team in designing an animation to support good sleep strategies.

The 'Sleep Help' resources were launched in February 2019 and can be access via the Solent Healthier Together website: https://www.what0-18.nhs.uk/solent/camhs/sleep-help. The impact of the accessible sleep self-help resources will be fully evaluated over a 12 month period, through service user feedback and a review of CAMHS-LD activity data.

Inclusive Community Engagement Event and Accessible Annual General Meeting (September 2018)

For the 2018 Annual General Meeting (AGM) a number of steps were taken to ensure the meeting and event beforehand supported communication access. A summary of the action taken is presented below;

- Promotional resources about the event and AGM included an Easy Read leaflet/poster and sign-up form
- People were encouraged to register for the event. The online registration included four key questions about communication and information needs (aligned to the Accessible Information Standard) so the right support could be planned ahead of the event
- There was a registration desk where people were welcomed and their support needs checked.
- Rather than a traditional health fair, there was an interactive community engagement event that enabled people to explore our services through their senses. This led to a more shared experience, accessible to all
- Everyone received an accessible resource pack that will include a range of resources to support understanding including a dual format agenda, a visual floor plan to guide people through the event, a large print version of the Directors poster etc.
- To maximise the accessibility of the AGM presentation, there were BSL interpreters who signed alongside the Chairman's welcome and the review of the year by the Chief Executive, Chief Finance Officer and Chief Nurse. There was also an Easy Read summary of the presentation in the packs
- The open question and answer session was replaced by small group discussions. There was a table host and a communication facilitator on each table. A range of total communication tools were available to support the discussion and the facilitators ensured that everyone was listened to and had an equal voice. Key points from each table will be shared with the larger group and collated in an action plan

We plan to build on the success and feedback received when we hold our 2019 Annual General Meeting later this year.

Future Developments

In 2019/20 the focus will be on rollout of Communication Access Symbol UK across a range of clinical bases and further development of centralised advice and support for meeting patients and carers AI needs, including expanding our use of audiovisual information.

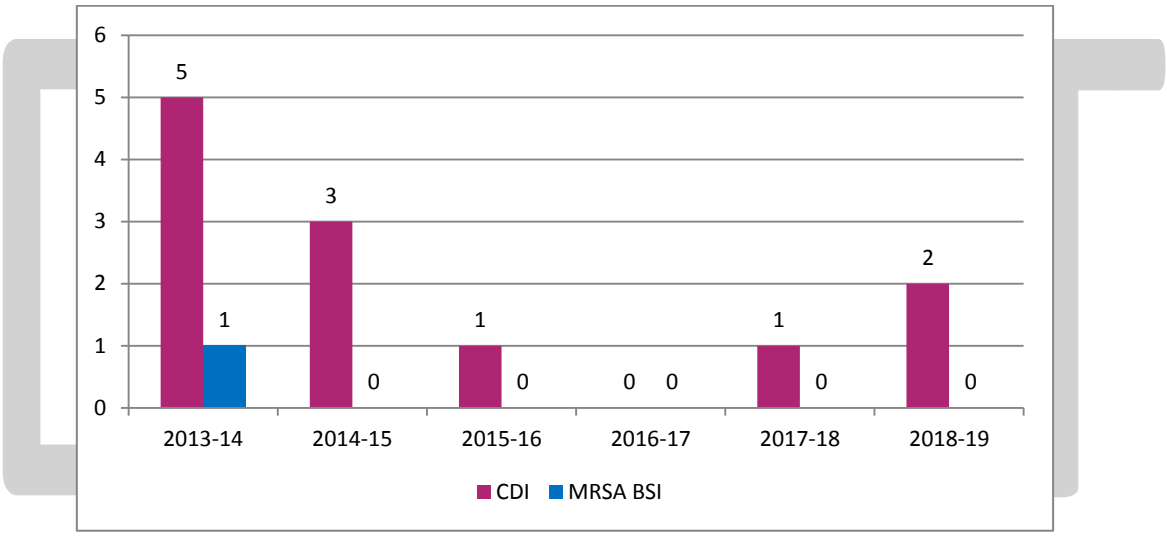
Following growing interest in our AI developments from other NHS Trust, we will scope the potential for national consultancy support to drive AI developments at scale.

Avoidable Healthcare Associated Infections (HCAI's)

Healthcare Associated Infections (HCAIs) can develop as a direct result of healthcare interventions or from being in contact with a healthcare facility. The term HCAI covers a wide range of infections including the most well-known such as Methicillin Resistant Staphylococcus Aurous (MRSA) and Clostridium Difficile Infection (CDI).

In line with the *Five Year Forward View* (NHS England 2014) the Trust has remained committed to a zero tolerance approach to any HCAI. If any such infections occur a full investigation takes place so that any learning can be shared and implemented. The following graph illustrates numbers of MRSA bloodstream infections (MRSA BSI) and cases of CDI that have occurred within the Trust since 2013 to the end of 2018/19.

Chart 1: MRSA and CDI infections 2013 - 2019



The numbers of reportable infections remain very low. In addition to this there have been no ward closures due to outbreaks of infection for in excess of two years.

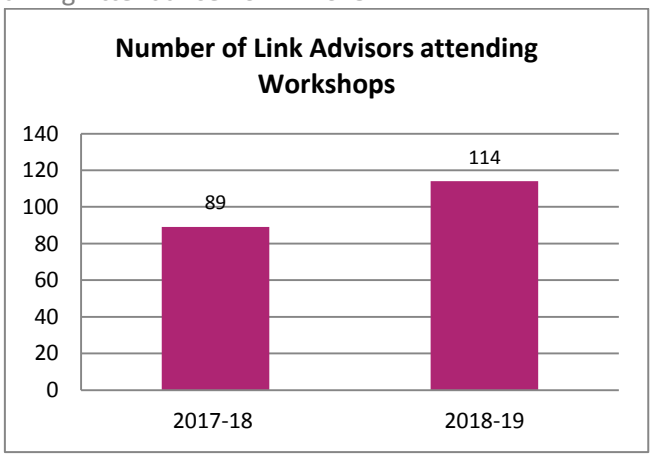
Over the past few years a range of specialist infection prevention projects have been undertaken for three local Clinical Commissioning Groups (CCGs) by the Infection Prevention Team (IPT) through a service specification. This model of collaborative working has been recognised as a positive factor in the constant drive to reduce HCAI across the local and wider health economy.

The ability to access microbiological results in real time and disseminate these to the appropriate healthcare professionals and ensure timely actions are put in place demonstrates compliance with at least four areas within the NHS Outcomes Framework Domains and Indicators (Dec 2010). To date this year, in excess of 700 community infections have been detected early and actions put in place to ensure the correct treatment is commenced in a timely way. This aims to protect those individuals developing more serious infections such as sepsis and reduce the possibility of onward transmission to others.

The IPT will remain focused on quality improvement and use a variety of tools and measures to monitor compliance with the Health and Social Care Act (2008). To help us achieve this we have developed a valuable resource known as infection prevention link advisors (IPLA). The IPT strongly support the role of the IPLAs within all clinical areas with visits, additional training and workshops.

147 IPLAs currently work across our organisation completing spot checks within their service areas as well as keeping staff compliant with hand hygiene competencies. This year we have seen a 28% increase in attendance at the workshops as illustrated below.

Chart 2: Link Advisor Training Attendance 2017 - 2019



There are challenges with regards to the continued emergence of resistant bacteria and growing resistance to antibiotics so it continues to be more important than ever to reduce the spread of avoidable infection with good and safe practice within healthcare. We will continue to push the infection prevention agenda and enhance this by working collaboratively with neighbour organisations.

Complaints and Concerns

The Trust's approach to complaints handling is based on the principles published by the Parliamentary and Health Service Ombudsman (PHSO). Their principles outline the approach the PHSO believe public bodies should adopt when delivering good administration and customer service, and how to respond when things go wrong. These principles are:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement

Training is provided for staff on a regular basis to ensure that anyone making a complaint is supported; receives honest, timely communication; and is clear about the actions we are going to take next as a result of our learning from complaints. The Trust encourages the staff closest to the people receiving our services to, wherever possible and with the service user's consent, deal with concerns and problems at the local level, aiming to ensure that issues are resolved the earliest stage possible and in a way that is responsive to the service user's needs and circumstances.

Timely intervention can prevent an escalation of the issues raised and achieve a more satisfactory outcome for all concerned. However, if the complaint is initially dealt with as a service concern[1], it does not prevent the complaint being escalated formally should the patient remain dissatisfied with the initial outcome.

1 We define service concerns as matters that can be resolved locally. A complaint follows a formal investigation process in order to gain resolution.

The following tables show the number of complaints we have received in the past 12 months, complaints received in comparison to previous years and categories of complaints:

Chart 1: Complaints received by month 2018/19

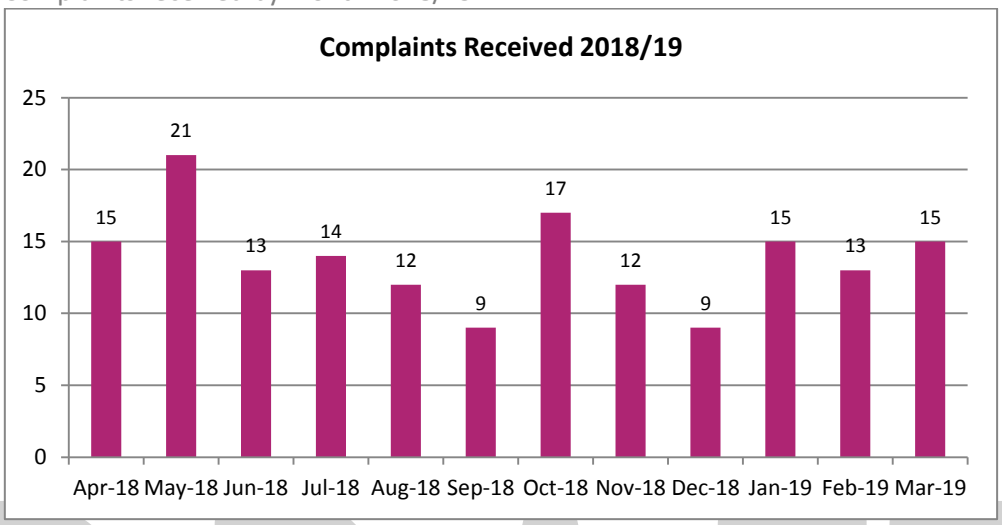
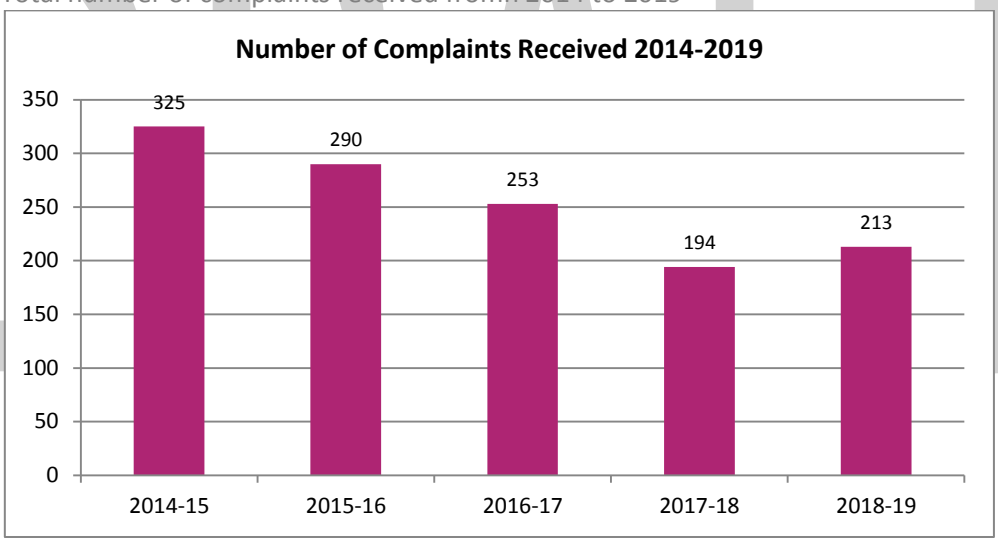


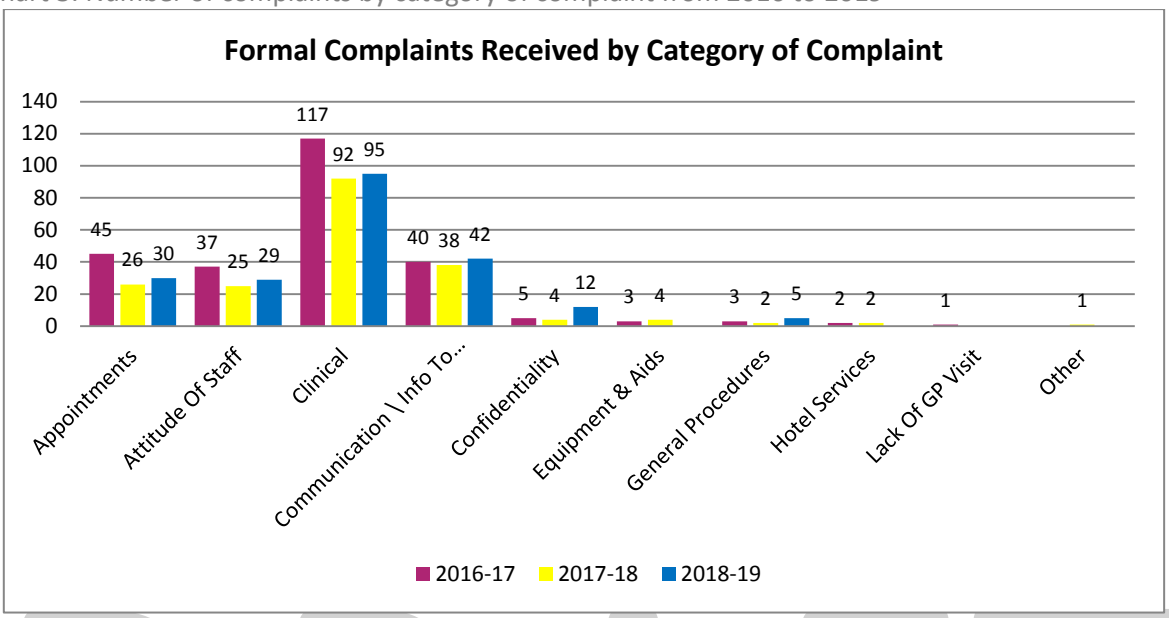
Chart 2: Total number of complaints received fromn 2014 to 2019



There has been an increase in complaints this year which we believe is due to the introduction of the Quasar system by South East Hampshire CCG. Quasar has a module that allows Primary Care services to feedback directly regarding other community services, making it easier to report concerns etc.

The table below shows the formal complaints received by type of complaint:

Chart 3: Number of complaints by category of complaint from 2016 to 2019



When a complaint is received, the team or individual it relates to are encouraged to consider learning and how to make improvements. These are discussed at a local governance level and any concerns regarding themes or trends are escalated. This will continue with the addition that changes can be tracked and monitored using the Trust Learning Framework and the electronic system which has now been fully implemented to manage complaints across the Trust. Below is a summary of learning and improvements identified to (March 2019):

Service	Learning and Improvements from Complaints
Primary Care	The Pain Team offer more advice and support to referring GPs to avoid inappropriate referrals
Primary Care	The service has updated the GP Surgeries website after it was identified that there was inaccurate information concerning new patient assessments
Primary Care	The Tip Toe team mobile number was provided to existing patients to enable communications when problems with the landline were identified
Primary Care	A new consultation room is being provided at one of the surgeries so there is greater access to a private space for patients
Sexual Health Service	The service is reviewing the appointments system in an attempt to improve access to the clinic after difficulties in access were highlighted
Sexual Health	The waiting time signage was improved to ensure patients are kept up to date and aware of delays
Sexual Health	Text message content was reviewed and now includes clinic dates and time so that patients can identify what the text relates to
Sexual Health	Test result management is under review and a new patient portal will be introduced in Q1 2019/20 to improve access to results
Adult Mental Health	Handover sheets are now printed on single sided paper to avoid future information governance breaches
Adult Mental Health	Reviewed the arrangements and process for clinical supervision.
Adult Mental Health	Reviewed and improved how they communicate with patients' who have difficulty articulating their needs and requirements
Adults Southampton	A direct referral pathway has been developed which ensures referrals are sent to the correct team
Adults Southampton	The Bladder and Bowel service have provided updated telephone numbers of another organisation to ensure that correct information is given to patients
Adults Portsmouth	The service provided additional information and training to GPs so there is a greater

Service	Learning and Improvements from Complaints
	awareness of what they can provide and avoid inappropriate referrals
Specialist Dental Service	Reviewed communication for patients' who do not meet criteria for treatment
Children and Families	Reviewed process when there is a delay between the appointment and a report being sent. Teams were reminded that if third party information is included in a report, consent must be given prior to sharing
Children's and Families	Processes introduced to ensure that when patients' are referred to other providers the demographics of the patient are correctly recorded
Children's and Families	Process and protocols have been reviewed for when consent is not provided for children to be entered into national programmes
Primary Care	The Podiatry Service now has full access to swab results, along with increased capacity, to review infected patients
Children and Families	Learning shared at a professional day to reduce delays in communication to families
Children and Families	Service currently reviewing the nasal flu spray parental consent form to make it clearer. Schools are being given follow up information about ensuring quiet rooms are provided for Nurses to undertake the triaging of consent forms
Sexual Health Service	Quality Improvement Project to be completed looking at access to the service. Outcomes will be reviewed once available
Sexual Health Service	Online booking process to undergo additional work and the introduction of an online, patient specific portal
Child and Family	Feedback given to teams regarding the importance of first contact with young people and families
Sexual Health Service	SMS text cancellation service to be implemented. Web chat facility for alternative signposting and advice for patients

As an organisation we are committed to learning from complaints to ensure that other service users do not have the same experience and we will continue to review this and if any themes or trends emerge, actions will be taken to address this and seek to understand why and if there is a need for a wider system and process review.

In 2019/20 the Trust will continue to develop and improve the Complaints process to support service users who complain. We are currently updating the Complaints Policy, which will introduce a change in approach by offering complainants an opportunity to meet with the service and discuss their concerns directly at the beginning of the process rather than the end. One service line has been successfully piloting this in 2018/19 and feedback has been positive. Complainants will continue to be offered a choice as to how they wish to progress, but it is anticipated that there will be a positive uptake on an earlier meeting and that complainants will find this a more satisfactory experience when things haven't gone as planned.

Community Engagement Strategy

In 2018/19 the Trust Board endorsed the Community Engagement Strategy including the establishment of a Community Engagement Committee to oversee its delivery. The Committee is chaired by Non-Executive Director and reports directly to Board. The aim of the strategy is to make community engagement a core part of how the Trust operates so that it becomes embedded in the culture and practice of the organisation at all levels.

By community engagement the Trust means the variety of ways in which it involves and works collaboratively with the full diversity of communities it serves, in order to improve the health and wellbeing of individuals from those communities. The Trust recognises there is no single way in which a community can be defined, it may include:

- characteristics - for example, identification with one of the protected characteristics[2] as defined by the Equality Act 2010
- location and place – for example, having a shared identity by virtue of living in a neighbourhood or area
- vulnerability and risk – for example, being homeless or lacking mental capacity
- socio-economic – for example, being unemployed or disadvantaged

All of the above may contribute to different individuals and communities experiencing health inequalities and other factors that can inhibit access to services, detract from the experience of using services and result in poorer health outcomes. Working with and involving different communities in the work of the Trust is a means to address these barriers and ensure that everyone who uses and needs the Trust's services, can fully access them and gain the benefits and health outcomes that they need.

Delivery of the Trust's community engagement strategy rests on four building blocks:

- Intelligent use of data and information
- Workforce and leadership development
- Fostering good relations with different community groups
- Involvement of community groups in service delivery, evaluation and development to improve health outcomes

These building blocks are designed to be developmental and will change and be revised as the delivery plan progresses. A Delivery Plan is in place and includes actions to ensure good governance and leadership so that the Community Engagement Strategy is aligned with other core functions of the Trust, for example equality, diversity and inclusion.

A data review to establish base line evidence is underway and due for completion in April 2019 with a report to the Community Engagement Committee in May 2019. The data review and evidence base, which covers patient experience, service utilisation and workforce will be used to inform the development of priorities for action under the Delivery Plan objectives.

Over the coming year the Community Engagement Committee will manage progress and reporting for the Community Engagement Strategy Delivery Plan. This will include prioritisation of community and service user groups for engagement; workforce development and leadership and building relations with the community and voluntary sector.

Dementia

The Trust has a Dementia Lead who works with Teams to ensure the needs of patients with dementia and related illnesses are considered and support the Trust in its delivery of the National Dementia Strategy. Achievements this year include:

- Provision of expert dementia advice on many estates and quality improvement projects which have enhanced patient experience for those with dementia
- Up-skilled teams to self-manage dementia developments in the future.
- Raised the Dementia profile in local services
- Implemented training and dementia champions, increasing knowledge and confidence in staff
- Established a Dementia Champion Network
- Trust presentation at the National Dementia Congress 2018

2 Protected characteristics are defined under the Equality Act 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

End of Life

The development of the Trust End of Life Policy and establishment of the End of Life Strategy Group has been a key focus for 2018/19. From the policy the Strategy Group has produced delivery framework and the strategy will be delivered in 2019/20 using a co-production methodology. An initial workshop has been held and further work involving local communities is planned for early 2019/20 to complete this work. The aim is to fulfill the six ambitions from the National End of Life Care Partnership.

The End of Life Strategy Group completed a review of the Gosport War Memorial Report and has commenced a programme of work to review current practice through staff survey and case note reviews. Good practice identified is shared across services and areas for improvement which have been identified to date and which will be a focus for 2019/20 are:

- Complete the review of the syringe driver checklist and guidance which is currently going through Trust governance processes
- Implement the 'ADIoS' software to support more proactive monitoring of controlled drug supply and usage
- Develop through the Matron's forum a toolkit of resources to facilitate improved professional assertiveness
- Continue to develop through our Learning Framework the sharing of learning and changes made as a result of learning from deaths

Learning Disabilities Improvement Standards (New for 2018/19)

People with learning disabilities, autism or both and their families and carers should expect high quality care across all services provided by the NHS. They should receive treatment, care and support that are safe and personalised; and have the same access to services and outcomes as their non-disabled peers. In June 2018 NHS Improvement published four standards and improvement measures NHS trusts need to meet; in meeting these standards we can demonstrate we are delivering high quality services for people with learning disabilities, autism or both.

A summary of our performance against each standard and improvement measure are below. The delivery of our new Learning Disability Strategy which includes achieving continual improvement against these standards is one of our quality improvement priorities for 2019/20:

Standard 1: Respecting and protecting rights All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act	
Improvement Measures	**Our Performance**
Trusts must demonstrate they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or both can access highly personalised care and achieve equality of outcomes.	The Trust seeks engagement with people with a learning disability and their carers in a number of ways: it has a strategy for producing accessible information; it has an adapted patient feedback process; a number of services have developed adapted responses to this patient group (e.g. sexual health services have worked with our learning disability service to develop a special clinic); "Shield", for people with a learning disability; specialist dental services have developed a feedback group of people with a learning disability to help them improve their service response; the recent AGM had provision for people who use Makaton to engage; there is expert by experience training available; the learning disability service has a range of engagement

Standard 1: Respecting and protecting rights All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act	
	processes that can be supported across other services
Trusts must have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services.	There is a patient flagging option within the Trust's electronic patient record system. Working is progressing to ensure that this is fully utilised and linked to care planning promoting reasonable adjustments
Trusts must have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations.	A monthly Learning from Death's panel is held and chaired by the Chief Medical Officer. The panel discuss any deaths which were reported as Serious incidents (SI), learning from any Coroner's court cases and Mortality review papers for each clinical division. The Trust has developed a Mortality dashboard which covers all services with the exception of Special care Dentistry and Sexual Health services. Teams identify through their Mortality review process cases which are appropriate for a clinical judgement review (also known as structured clinical judgement tool). The Trust has developed a learning database which monitors and tracks specific changes that need to be implemented to improve future outcomes (this is separate from action plans). This includes cases where learning has been identified form deaths. In line with this the Trusts Specialist Learning Disability service are fully engaged with the Learning Disabilities Mortality Review (LeDeR) programme
Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism or both.	This is monitored through Mental Capacity Act (MCA) and Depravation of Liberty (DoLS) audit processes
Trusts must have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.	The Trust promotes anti-discriminatory practice by providing reasonable adjustment options such as: • Providing accessible information to aid patient understanding • Providing staff with the appropriate skills and support to take an individualised approach to communicating with people • Involving family carers from pre-admission onwards • Involving family carers in care decisions as appropriate • Ensuring that staff have been trained in MCA and DoLS and know how to implement these policies • Ensuring there is a protocol in place which details when best interest decisions are required • Providing information for people with learning disabilities and family carers regarding their rights under the Mental Capacity Act • Having a flagging system highlighting a patient has a learning disability to help identify additional support may be required • Ensuring that reasonable adjustments are put in place regarding appointment times and length e.g. offers of first or last appointments of the day • Supporting staff to use Hospital Passports or

Standard 1: Respecting and protecting rights All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act	
	similar where these are in place • Ensuring staff know how individuals express pain and discomfort and act accordingly • Using good practice guidance on dysphagia and ensuring there is accessible information about food choices • Identify, analyse and learn from incidents involving people with learning disabilities

Standard 2: Inclusion and engagement Every trust must ensure all people with learning disabilities, autism or both and their families and carers are empowered to be partners in the care they receive	
Improvement Measures	**Our Performance**
Trusts must demonstrate processes that ensure they work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.	The Trust seeks engagement with people with a learning disability and their carers in a number of ways: it has a strategy for producing accessible information; it has an adapted patient feedback process; a number of services have developed adapted responses to this patient group (e.g. sexual health services have worked with our learning disability service to develop a special clinic); "Shield", for people with a learning disability; specialist dental services have developed a feedback group of people with a learning disability to help them improve their service response; the recent AGM had provision for people who use Makaton to engage; there is expert by experience training available; the learning disability service has a range of engagement processes that can be supported across other services
Trusts must demonstrate that their services are 'values-led'; for example, in service design/improvement, handling of complaints, investigations, training and development, and recruitment.	We ensure our clinical services have a strong focus on the Trust values through a number of processes such as: • Patient feedback • Analysis of complaints, concerns and compliments • Learning from adverse events • In its staff training and development opportunities • Within its governance structures • In its public engagement strategy
Trusts must demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers.	The Trust's Learning Disability services facilitate a number of such forums related to both service developments and/or clinical pathways using experts by experience. It is an expectation that all service development activity has a clear engagement strategy
Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families and carers throughout these processes.	Complaints, investigations, incidents and mortality reviewed are agenda items at all governance meetings which in turn report to the Quality Improvement & Risk Group and the Assurance Committee (Board sub-committee) There was 1 serious incident involving a person with a Learning Disability in 2018/19 which raised the following actions: • Raised awareness within the Community Team to use the accessible information template on S1.

Standard 2: Inclusion and engagement Every trust must ensure all people with learning disabilities, autism or both and their families and carers are empowered to be partners in the care they receive	
	• All team members to complete the mental capacity act training; this will help them to document consideration of mental capacity when planning care

Standard 3: Workforce All trusts must have the skills and capacity to meet the needs of people with learning disabilities, autism or both by providing safe and sustainable staffing, with effective leadership at all levels	
Improvement Measures	**Our Performance**
Based on analysis of the needs of the local population, trusts ensure staff have the specialist knowledge and skills to meet the needs of people with learning disabilities, autism or both, as well as those who support them.	All clinical areas have a "Learning Disability Resource Pack" that supports staff to deliver effective care. More formal training is under development and will be shared across the local TCP (SHIP). Autism training is currently being explored
Staff must be trained and then routinely updated in how to deliver care to people with learning disabilities, autism or both who use their services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.	The Trust is currently finalising a Learning Disability Strategy that reflects the Learning Disability national standards and directly addresses staff competence and confidence in supporting patients with a Learning Disability
Trusts must have workforce plans that manage and mitigate the impact of the growing, cross-system shortage of qualified practitioners with a professional specialism in learning disabilities.	Workforce plans are in place within the Trust's Specialist Learning Disability Services. This includes supporting apprenticeships, involvement in "return to practice" initiatives, review of skill mix, and, participation in the "Training Nurse Associates"
Trusts must demonstrate clinical and practice leadership and consideration of the needs of people with learning disabilities, autism or both, within local strategies to ensure safe and sustainable staffing.	A workforce plan is currently in place that reflects the clinical demands upon services

Standard 4: Specialist learning disability services Trusts that provide specialist learning disabilities services commissioned solely for the use of people with learning disabilities, autism or both must fulfill the objectives of national policy and strategy	
Improvement Measures	**Our Performance**
Trusts must have plans for the development of community-based intensive support, including treatment and support for people accessing mental health services and the criminal justice system.	The Trust's Specialist Learning Disability Service already has an Intensive Support Team which is effective in supporting those in crisis. A request has been made to the local CCG for funding of a focussed forensic practitioner role
Trusts use the care and treatment review (CTR) and care and education treatment review (CETR) to ensure a stringent assessment is made if admission is anticipated or requested, and that discharge arrangements ensure no individual stays longer than necessary.	The Trust's Specialist Learning Disability Service is actively involved in the CTR's/CETR's of its patients. It hosts regular meetings to review the care arrangements and discharge options of those patients
Trusts have processes to regularly review the medications prescribed to people with learning disabilities, autism or both. Specifically, prescribing of all psychotropic medication should be considered in line with NHS England's programme stopping over medication programme STOMP.	The Trust's Specialist Learning Disability Service have engaged with our Pharmacy service in the delivery of a STOMP initiative
Trusts providing inpatient services have clinical pathways that adhere to evidence-based assessment and treatment, time-limited interventions and measurable discharge processes to ensure inpatient episodes are as short as possible	The Trust has no specialist inpatient services

Standard 4: Specialist learning disability services Trusts that provide specialist learning disabilities services commissioned solely for the use of people with learning disabilities, autism or both must fulfill the objectives of national policy and strategy	
Trusts have governance processes for measuring the use of restraint and other restrictive practices, including detailed evidence-based recommendations to support the discontinuation of planned prone restraints and reduction in unwarranted variation in use of restrictive practices. They can demonstrate that alternative approaches are being deployed	The Trust has no specialist inpatient services

Patient Experience & Engagement

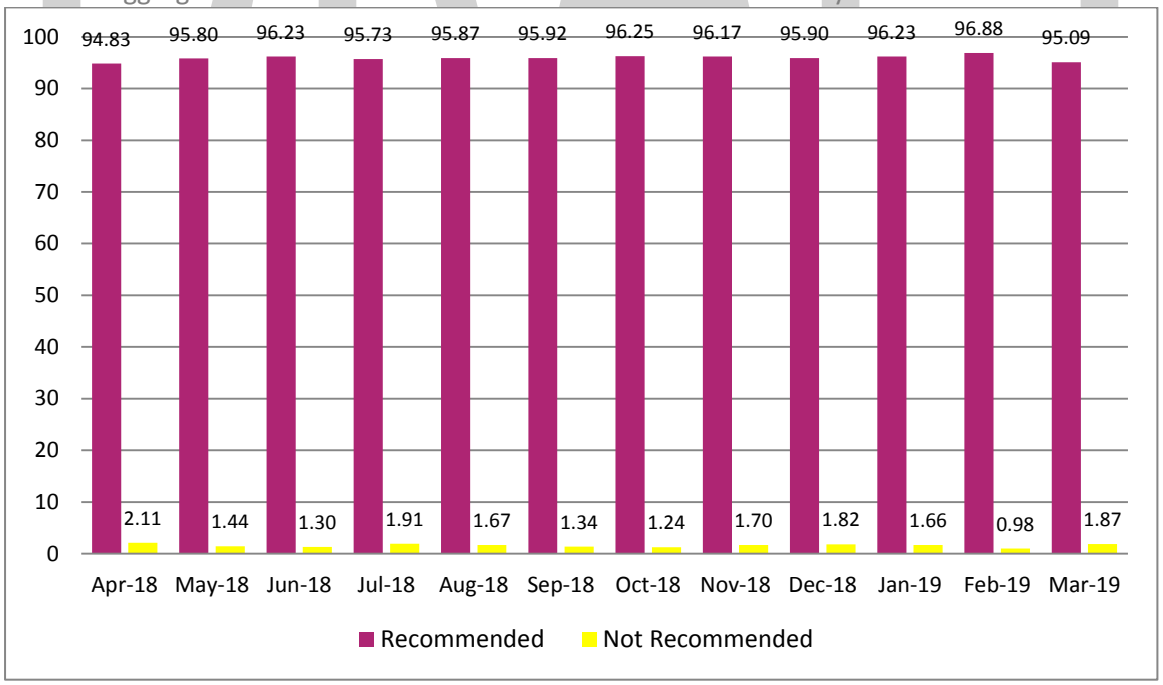
Patient Experience

Experience is one of the three domains in our Quality Framework and our experience goals for 2018/19 have been to ensure we learn from patient feedback and involve people in the development of our clinical services.

We bring together information from various sources including complaints and the Friends and Family Test (FFT), community engagement and patient, family and carer feedback to focus on learning and improvement and we showcase lessons we have learnt and improvements made in the form of 'You said, We did' posters, bulletins and newsletters.

Our FFT results throughout the year show a consistent positive level of satisfaction for the Trust overall with our internal targets of 95% and above who would recommend Solent services, and below 5% who would not recommend, being consistently met.

Chart 1: Aggregated results for Solent NHS Trust combined community and mental health services



A total of 25,119 FFT responses were received by Solent in 2018/19 compared to 18,560 in 2017/18. This is an increase of 6,559 and is attributable to work in our clinical services to increase levels of patient feedback including:

- The Sexual Health Service and teams in Primary Care and Childrens Services have introduced

email to capture FFT responses
- The Childrens Service is currently piloting the use of Android phones for capturing patient feedback
- Adults Services Southampton, Adults Portsmouth and the Dental Service have enrolled volunteers to capture patient feedback with other service lines exploring the same method

Our results compare favourably with national FFT results which are reported separately for Community Health and Mental Health services:

- Community Health – 97.05% would recommend, 0.97% would not recommend
- Mental Health – 89.66% would recommend, 3.15% would not recommend

Each of our clinical services reviews their own FFT responses to enable as near real-time feedback as possible, action planning and learning. The table below provides a breakdown of responses by service. The proportion of respondents recommending Solent for care exceeds the Trust target in all service lines except Mental Health Services; however results are consistent with national levels for mental health trusts.

Chart 2: FFT responses broken down by Service Line

Area	SMS/Text/ Smartphone App	Electronic tablet/kiosk at point of discharge	Paper/Postcard given at point of contact	Paper survey, sent to the patients home	Telephone survey once patient is home	Online survey once patient is home	Other
Overall	55	213	23092	0	0	1759	0

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Adults Portsmouth Services	97.69%	0.77%	1948	1517	386	27	8	7	3
Adults Southampton Services	96.93%	0.86%	4752	3532	1074	77	26	15	28
Childrens Services	96.44%	1.15%	4773	3756	847	70	33	22	45
Dental Services	98.28%	0.74%	1630	1334	268	10	6	6	6
Mental Health Services	84.88%	4.63%	800	446	233	61	20	17	23
Primary Care Services	93.40%	3.71%	3804	2923	630	78	54	87	32
Sexual Health Services	96.51%	1.23%	7412	5622	1531	137	47	44	31
Summary	**95.94%**	**1.56%**	**25119**	**19130**	**4969**	**460**	**194**	**198**	**168**

Although the quantitative FFT and survey results are encouraging it is free text comments from patients that provide the richest source of information. All free text comments are reviewed as even when quantitative results are positive and complimentary the comments may include suggestions of small changes that can be implemented to improve the experience of our patients. When we identify a change or improvement we feed this back to patients by displaying on Solent NHS Trust's website and by using the "You Said, We did" poster in patient areas such as wards, clinics and waiting areas.

Below are just a few examples of feedback from individual patients which has led to us reviewing our practice and making improvements:

You said: The chairs in the waiting room are scruffy and not appealing to sit down on.
We did: The League of Friends are to support us with the purchase of new chairs.

You said: The location is very far from home for us and would take one train, a bus and a walk by public transport, so we had to spend £30 on taxis.
We did: We currently offer clinics across the City and are in the process of developing a CAMHS leaflet which would indicate this was available to families accessing the service.

You said: I felt ill because of the heat in the surgery. It's far too hot to lie there having treatment. I have sweated so much. I don't know how staff work all day in that heat.
We did: Portable air conditioning units have been delivered to Gosport and an improvement in temperature has been reported. Our staff continue to monitor the temperature.

You said: Reception staff could be friendlier and more approachable. Medical staff I have seen have been great.
We did: All of our receptionists have now received training in Customer Care and we will be monitoring this through individual 1:1 meetings.

You said: The program is difficult to access. Our computer screen isn't suitable for using because it is too small for clarity. I felt that instructions were given too quickly and the sound was not clear, there was also no feedback on exercises i.e. to assess if I was doing them correctly.
We did: This patient felt they were not given enough time and in future we will ensure all patients on the face to face programme will be asked if they need any extra time to recover or undertake a particular exercise.

You said: I found the Physio to be too overpowering. She kept on at me and I said just go away.
We did: Following receipt of this feedback we carried out an internal investigation to understand exactly what happened. As a result our staff have been reminded of the need to flag difficult conversations they have had with patients in either team or individual supervision. The importance of this has been highlighted to enable the team to deal with potentially difficult situations in a timely way, but primarily to consider how care and treatment needs can be met if a patient declines treatment.

Demographic information

The data below provides a summary of the current diversity demographics for patient experience surveys. The data represents contacts rather than individuals.

Chart 1: Age of respondents

	Returns	0-17	18-24	25-40	41-60	61-75	76-85	86 or over	Prefer not to say
Total	21587	141	2,824	5,582	4,041	2,974	2,047	1,213	20

Chart 2: Sex of survey respondents

	Returns	Female	Male	Prefer not to say
Total	20830	13,555	7,234	41

Chart 2: Nature of disability of survey respondents

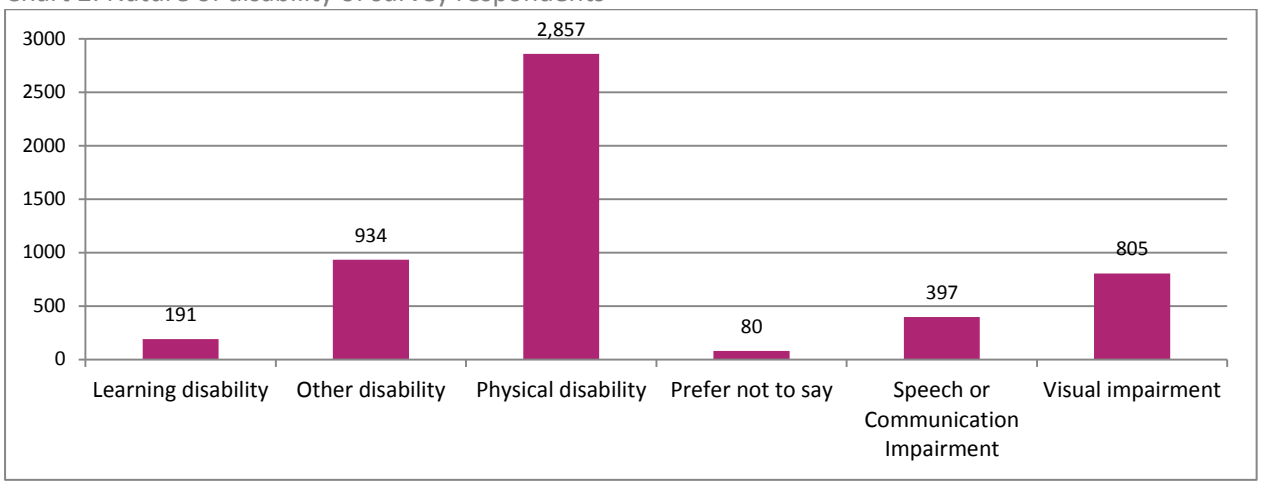
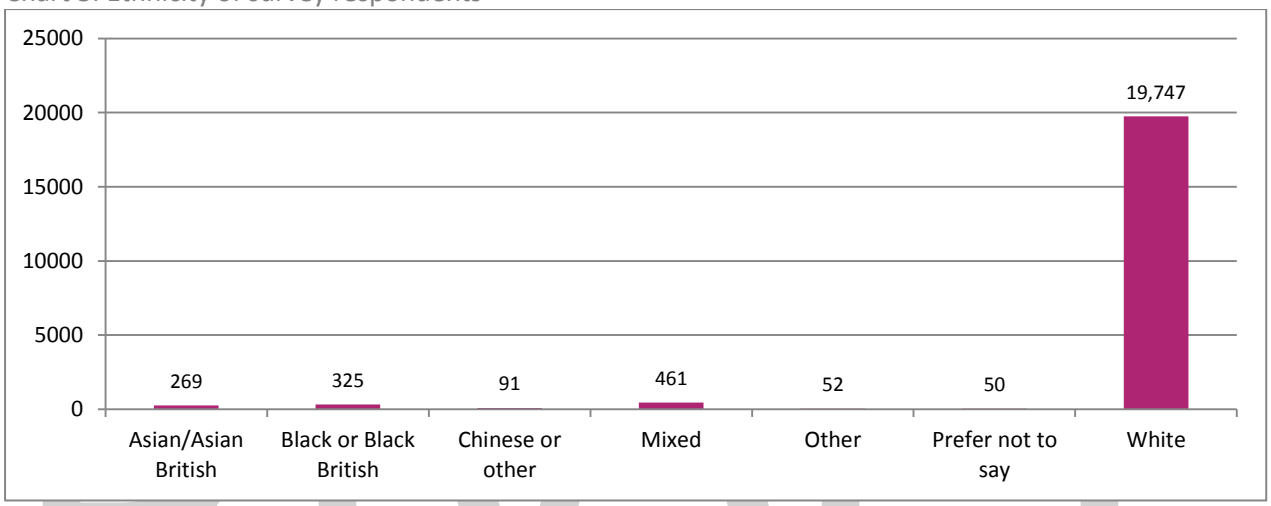


Chart 3: Ethnicity of survey respondents



Engagement

As part of our community engagement the following stories illustrate how engagement with patients and our wider communities has made a difference and provided many learning opportunities for us:

- The Side-By-Side group are a patient involvement group who are committed to working in partnership with the Academy of Research & Improvement. The group hosted coffee mornings in Portsmouth and Southampton as an opportunity to advertise and engage with the public about joining Side-by-Side. The coffee mornings were held at non NHS sites. Running small scale informal events at community (non NHS) venues is a good way to engage with patients and the public. The group found social media and internal communications to be useful ways to inform others of events, but we found that more importantly existing relationships and networks attracted people to attend. As a result more than 10 individuals have expressed interest in being part of Side-by-Side. The group is now looking at how it can make being involved as accessible as possible and support people to be engaged in a meaningful way. Through expanding and diversifying Side-by-Side the group anticipates that our patient population will be better represented in sharing a varied patient & public perspective

- The Family Nurse Partnership (FNP) Team wanted to establish if group sessions would be attended by the young mothers on their caseload, with an aim to decrease social isolation. The FNP Team distributed a survey to young mothers and held free engagement events at Non-NHS sites to enable informal discussion. The survey identified that young mothers and their children

were visiting public places such as parks and town centres but were not socialising with other people. Through the survey results and non-attendance at the engagement events, the FNP team learnt running group sessions is unlikely to decrease social isolation. The FNP Team are now aiming to look at different ways to engage with young mothers. Taking the time to hold patient engagement events has provided insight into what the young mothers do and do not want. Without this the Team could have wasted time and resources setting up a group which would not have been attended

- The Trust had received reports of negative comments relating to overhanging trees and potential harm/damage for residents opposite the St James Hospital site. We engaged with local residents through their Facebook page and were able to see where they may be experiencing problems that we could to act upon. As a result, the Estates team visited residents and offered to address their problems. In two cases, our gardening contractors removed trees overhanging a resident's property. This quick action and the resulting positive feedback ensured residents know where to come if they have concerns and that issues can be dealt with swiftly. This has had a positive impact on the Trust's relationship with the local residents

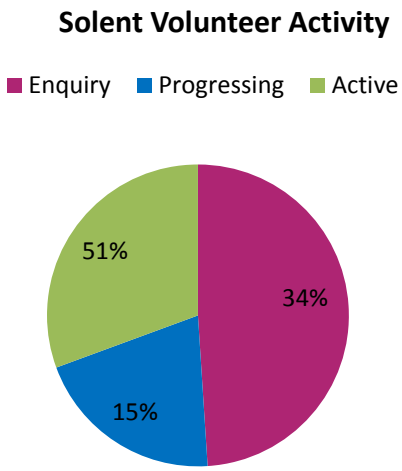
- Each year *Carer's Rights Day* brings organisations across the UK together to help carers know their rights and find out how to get the help and support they are entitled to. This year we wanted to raise the profile of informal carers with a focus on our staff who are carers. We did this by re-launching Solent's Staff Carers Pledge and we recognised that staff who are also carers may need additional support to maintain their health and well-being at work so we asked them to complete a survey. A network event took place in February 2019 to engage with staff who are informal carers to help us shape what support should be provided in the workplace (outcome of event to be updated in final version)

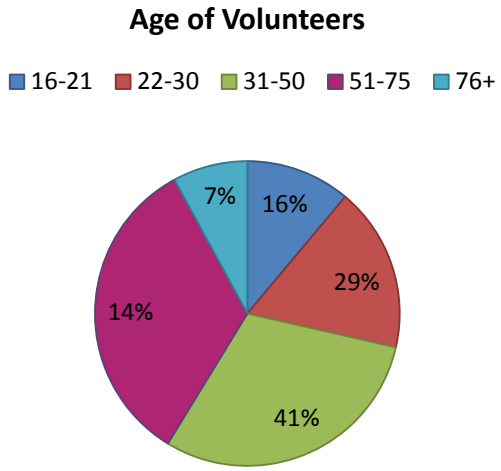
Volunteers

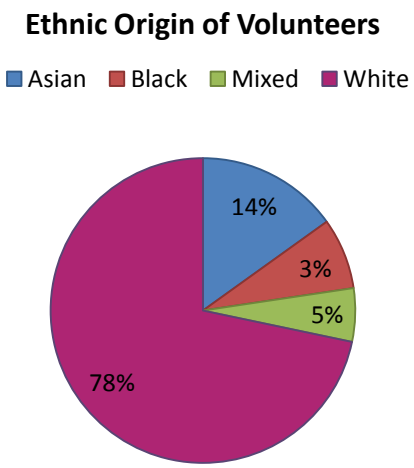
We recognise the important, and valuable, contribution volunteers make to our services, as well as enhancing patient care. Our Volunteer Service was developed to improve patient's experience of healthcare for the benefit of local people. As well as benefiting patients, many volunteers can gain vital volunteer work experience, it can also provide excellent opportunities to make new friends and be part of a team.

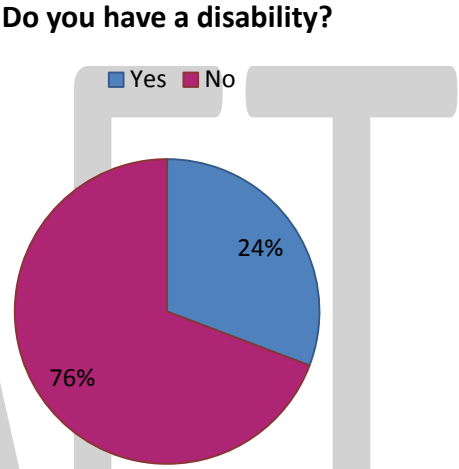
We advertise volunteer opportunities through our website including become a befriending volunteer to help people feel less lonely while in hospital, volunteer gardener, help guide patients and visitors around our hospitals/clinics/units as a meet and greeter, or there are 'volunteers by experience'. *Volunteers by experience* are volunteers who are recruited to share their own health / life experience to support others in a similar situation.

We currently have 146 volunteers enrolled with the Trust including 57 Solent volunteers and 89 League of Friends volunteers at St Mary's Community Campus. We collect demographic information about our volunteers to enable us to monitor inclusivity and diversity within volunteer roles. This information will continue to be monitored over the coming year to determine how closely our volunteer profile reflects our local population profile:









Examples of the great work our volunteers do are below:

- This year our Dental Service enrolled additional volunteers to help with meet & greet, talking to patients whilst they wait to be picked up by transport, assisting patients to fill in forms and encouraging patients to complete the Friends & Family Test (FFT) after their consultation, all of which enhance a patients experience of using our services

- The Patient Experience Volunteer supports with sorting, collating and bagging Friends & Family Test (FFT) and patient feedback. Volunteers also provide teams with the necessary information from Meridian

- A patient experience volunteer has recently joined Jubilee House to help staff capture feedback from patients and carers; they also identified a suitable area where *'You said, We did'* feedback could be displayed for patients, staff and visitors to view

- The Memory Café is an opportunity for carers of people with dementia to meet and socialise with others who understand their situation in an informal and friendly setting. Memory café volunteers help support the Admiral Nurses to provide such an environment

During December 2018 we signed up to the Helpforce/Daily Mail campaign. Helpforce is a charitable organisation that is committed to creating a better future in health and care through volunteering. The campaign asked people to pledge their time and give the NHS one day a month or three hours a week for six months. When the campaign closed at the beginning of 2019, 33,000 people had pledged. We are one of 160 Trusts who have come forward with volunteer opportunities and pledgers are in the process of being matched to Trusts opportunities. We look forward to welcoming new volunteers to the Trust in the months ahead.

Volunteers are valuable members of our team. Their contribution can make all the difference to the experience of a patient, and we thank all our volunteers for giving up their time to enhance other people's lives.

Patient Led Assessment of the Care Environment (PLACE)

The table below provides an overview of the scores achieved in the 2018 PLACE inspection and provides a comparison with national scores and the Trust scores for the previous year:

	Cleanliness %	Food Score %	Privacy, Dignity & Wellbeing %	Condition, Appearance and Maintenance score %	Dementia %	Disability %
National Average 2018	98.8	92.10	84.30	93.10	81.70	87.1
Solent NHS Trust 2018	**95.2**	**93.5**	**75.1**	**91.1**	**75.3**	**83.2**
Solent NHS Trust 2017	99	98	91	97	92	93

The decrease in overall scores was discussed at the PLACE feedback event hosted by the Trust and it was agreed the following had impacted negatively on our results:

- PLACE assessments are designed for acute Trusts therefore an appropriate response to some questions for many community services would be "not applicable". However, the only responses which can be entered are a yes or no or "pass" or "fail"; this results in some answers achieving a zero score on an area that is not relevant to the service
- The national Dementia Standards have been reviewed and updated and despite all actions being taken following recommendations made in the 2017 inspection, many Trusts reported a similar decrease in results
- The cleaning contract is under review nationally and following this inspection the Trust is considering other options to manage contract in future
- Some incorrect information had been reported by the assessors and which they did not highlight during the inspection. Therefore in some instances, this has resulted in negative recording

On a positive note, there is a higher than average score in the food category; our mental health sites achieved a higher than the national average for disability; an end of life care/rehabilitation site scored higher than average in the disability domain and privacy and dignity, and one site exceeded all national averages with the exception of the privacy and dignity domain.

We have made many improvements during the year and since the inspection including the following:

- Signage has been reviewed and updated
- Painting is to be updated to demonstrate a clear separation of the floor and wall

- Outstanding building/maintenance works for one area were escalated and resolved as a direct result of the PLACE inspection (in a non-Solent building).
- Orientation and dementia friendly clocks are in place
- Estates work including redecoration monies has been resourced
- A hearing loop system has been sourced to support a community clinic
- Alcohol dispensers have been placed in areas it was highlighted that they were absent
- Waste bins have been sourced to ensure all areas have the correct bins for general waste in addition to clinical waste
- Discussions have been held with the landlords of premises we are currently tenants in and the results shared. The Trust's estate teams will continue to review and monitor the progression of the action plans relating to premises concerns raised in the inspection

Clinical services monitor their progress on actions locally. Whilst some actions have been completed promptly, others require a more considered approach and in some cases the balance needs to be sought between patient safety and the environment. One example being our mental health wards where if they completed some of the actions the PLACE inspections recommended, it would create a ligature risk and hence impact on patient safety.

For the 2019 inspection, we will manage PLACE inspections in the same way we emulate CQC inspections. This will mean that a senior member of staff will accompany the PLACE assessors who are best placed to respond to any queries and support as required. It was also agreed at the feedback event that we would work collaboratively with Healthwatch to support the pre planning of the event.

Safeguarding

The Trust endorses everyone's human right to live their life free from abuse and harm.

Solent's Safeguarding team support the organisation to fulfill it's safeguarding duties and responsibilites, completing targetted work with specific clinical teams to embed safegaurding frameworks, such as making safeguarding personal.

The team provide expertise and promotes professional curiosity, challenge and collaboration. Staff are empowered to fulfil their safeguarding responsibilities through:

- Education
- Supervision
- Responsive and expert advice and support

Quarterly reports, demonstrating compliance with regulations, are submitted to the Safeguarding Steering Group, the Quality Improvement and Risk Group(QIR), Assurance Committee, the Board and the commissioners.

Solent NHS Trust is an active partner and is represented at the four Local Safeguarding Childrens Boards, (4LSCB), and four Local Safeguarding Adults Boards, (4LSAB), for Hampshire, Southampton, Portsmouth and the Isle of Wight and works collaboratively with partner agencies at a strategic and operational level.

Improvements during 2018/19

During this period the sSafeguarding team has implemented the following quality improvements:

- The provision of health navigators for the Portsmouth Multi-Agency Safeguarding Hub, (MASH). Intially this was for a fixed term contract but has now been extended and made into a substantive post
- The Trust Modern Slavery Statement, Referral to Social Care and Domestic Abuse pathways have been embedded in practice to suport and advise staff on the correct actions to take in these situations
- The Safeguarding Champions Forum with representation from all clinical services was established and works collaboratively to promote safeguarding within their clinical areas
- The Trust's Safeguarding Children and Adults policies have been reviewed and combined into a single Safeguarding Children, Young People and Adults at Risk Policy
- A Safeguarding Supervision Policy has been published to underpin newly stregthened safeguarding arrangements provided by the Safeguarding team. An electronic system for monitoring compliance with supervision standards was implemented in Q3
- A Safeguarding module has been introduced in the electronic patient record to ensure that safeguarding activity is recorded and easily accessable to all staff within the Trust
- Review of the Safeguarding Children and Young People - Roles and Competencies for Healthcare Staff (2019) and Adult Safeguarding - Roles and Competencies for Healthcare Staff, (2018), commenced to ensure all staff in the organisation are compliant with training requirements which will support improved safeguarding practices and improve outcomes for children, young people and adults at risk

The Safeguarding Adults – Roles and Competencies for HealthCare Staff, (2018) changed the requirements for staff who require Level 3 Safeguarding adults training, meaning an increase in the number of staff who required the training. This resulted in a drop in the training compliance for Level 3 Safeguarding Training which impacted on the Trust's overall compliance rate. A key priority for the Trust was to improve compliance with mandatory safeguarding training with a target of 90% at year end. The Trust's compliance rate has increased each quarter with a compliance rate of 87.72% at end of March 2019, the highest compliance since 2015.

Plaudits and Compliments

An independent author for a Safeguarding Children's review, (SCR), congratulated the Trust on the high standard of the internal management review the Safeguarding Team had submitted to inform the SCR process. The author commented that standard of objectivety and analysis was very effective and informative. One of Solent's commissioners also thanked the Safeguarding Team for their hard work and support to partner agencies, subsequently the team received Solent's Directors Choice Award for services to the Trust.

Safeguarding Children and Adults Reviews

The Safeguarding Team have fulfilled all requests for Safeguarding Adult and Child reviews during the year. An unusually high number of safeguarding children reviews were supported, whilst the quality of the reports and development of action plans was maintained.

Learning from all cases is shared with the clinical services and examples of key learning include the introduction of standard protocols for safe sleeping advice, which was developed as an outcome of a Children's thematic review, and work to start the development of a Transitions Protocol which was the outcome of an adult safeguarding review.

A pathway for sharing learning from Safeguarding Case Reviews and Safeguarding Adult Enquiries is being developed to ensure that learning is disseminated and easily accessible to all staff across the Trust, with the aim of informing service improvements.

Safeguarding Priorities and Quality Improvements for 2019/20

Plans for 2019/20 to improve the quality of safeguarding practice and which are in line with the Safeguarding Children and Adult Boards priorities have been agreed as follows:

- The safeguarding team will respond to 90% of requests for advice with one working day
- The safeguarding team will revise and develop the mandatory safeguarding training program provided to staff
- Embed Making Safeguarding Personal within adult services to allow adults' voices to be heard and listened to within safeguarding activity
- To further strengthen the Whole Family Approach to Safeguarding so that silo working is reduced and collaborative working is achieved

To provide quality assurance and to inform service improvements in 2019/20 the following audits and service evaluations will be completed:

- The quality and responsiveness of the safeguarding advice provided to staff
- The quality and frequency of safeguarding supervision provided to staff
- Quality of MASH referrals completed by Solent NHS Trust staff
- Evidence that the Whole Family approach is embedded into practice
- Evidence that Making Safeguarding Personal is embedded into practice
- Additional audits will be completed as requested by the 4LSCB and 4 LSAB

Same Sex Accommodation Breaches

The Trust has not had any Same Sex Accommodation breaches in 2018/19.

Tissue Viability

In June 2018, NHS Improvement (NHSI) published a report 'Pressure Ulcers: Revised definition and Measurement'. To support a more consistent approach to the definition and measurement of pressure ulcers at both local and national levels across all trusts, NHSI have recommended the use of the following definitions which are in line with the EPUAP (2016) classification system of categories, these are;

- Categories 1,2,3,4,
- Unstageable
- Suspected deep tissue injury

It has been agreed that these categories will be adopted across the country by April 2019. In order to prepare the Trust for implementation, a gap analysis was carried out by the Tissue Viability and the Quality and Professional Standards teams. This identified a number of areas that would need to be altered as a result and an implementation plan has been delivered, a summary of the actions taken are as follows:

- In December 2018, a revised Tissue Viability training programme was delivered to staff across Solent sites including community nurses, inpatient staff, children's nurses and urgent response. This has included training presentation, Pressure Ulcer Reporting Flow Chart and Pressure Ulcer recognition poster. An online presentation is being developed
- Incident reporting on Ulysses has been amended to reflect the additional categories of recording, i.e., the addition of unstageable and also suspected deep tissue injury which was not previously recorded by the Trust
- The Tissue Viability Policy, Pressure Ulcer Standard Operating Procedure, pressure ulcer review paperwork and care plans have been updated to reflect the changes

In January 2019, Pressure Ulcer reporting in Solent switched from 4 categories to the recommended 6 categories. The period from January to 31 March 2019 is viewed as a transition period and it is expected the new recording will be consistently applied from 1 April 2019 in line with the NHSI requirement to fully implement changes from this date.

In addition to the changes to the categories to be recorded, NHSI recommended the terms avoidable and unavoidable will no longer be used and the focus will be on the learning. The result of this will be that all pressure ulcer incidents will be investigated to support organisational/system learning. Instead of focusing on if the pressure ulcer was avoidable, teams will be required to assess level of harm which will be consistent with other categories of patient safety incidents.

The changes described will enable the Trust to benchmark against other areas of a similar population, helping us to improve quality and provide better outcomes for patients. This will be a key focus for us in the coming year.

3.2 Making a Difference

In addition to the Trust-wide improvements and initiatives above, each of our clinical services continually identifies ways in which their services can be improved. This section provides just a few examples of how our teams have worked to make a difference for patients, their families and carers in the past 12 months.

Some of the stories relate to changes and improvements across whole teams and services which have made a difference to many patients, other stories relate to how our staff have made a difference to individual patients.

Adult Services in Portsmouth

In September 2018 the Trust launched NEWS2 a national tool to help identify patients whose conditions may be deteriorating. The tool is based on a simple combined scoring system and involves allocating a score to physiological measurements which are already recorded when patients present to, or are being monitored in a hospital community and community health setting. The combined score is allocated to each measure with the magnitude of the score reflecting how much the parameters vary from the patient's normal range. The score is then aggregated and uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation. This tool combined with the staff member's clinical judgement helps determine the appropriate level of response needed to access appropriate and timely treatment and support for the patient.

Since the tool was launched in Adults Services in Portsmouth one of our registered nurses in our community nursing team visited a patient for a routine planned nursing care visit and recognised the patient's condition had deteriorated. The nurse used the NEWS2 assessment tool and this identified that the patient required immediate conveyance to the emergency department for immediate treatment. Had the tool not been used the urgency of the patients condition could have been missed and they may not have received the treatment they needed in a timely way.

As one of our priorities in Portsmouth for the coming year, we plan to ensure all of our staff are trained to use the NEWS2 tool and to refresh their competencies annually.

Adult Services in Southampton

In October 2018 we introduced a new pathway for Southampton City percutaneous coronary intervention (PCI) patients who should be seen within 14 days of their referral being received. Originally they were seen either at Bitterne Health Centre or Adelaide Health Centre but often not within 14 days as the clinics were already fully booked and this resulted in a delay in them starting their cardiac rehabilitation exercise programme.

We decided to offer patients assessment appointments at the cardiac rehab venue nearest their home address instead of coming to Bitterne Health Centre or Adelaide Health Centre. The rationale being that there are more staff at the cardiac rehab venues due to the number of patients attending. However, once the exercise component is finished staff still needed to be at the venue but could be free to undertake assessments. It also meant patients were able to visit the venue they would be attending in future and see some of the class taking place. If the venue wasn't convenient patients could chose an alternative.

Since October 2018 all Southampton City PCI patients have been booked in this way. This has resulted in an increase in patients being seen within the 14 days and our performance indicators confirm this. Patients are starting their cardiac rehab programmes earlier as PCI patients are usually

only in hospital for one night at the most, this helps with the support and advice they may not have had time to receive as an inpatient.

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Over the last year we reviewed the maintenance programme in pulmonary rehabilitation (PR). Patients attended the sessions after completing PR and were offered in accordance with our arrangement with the Clinical Commissioning Group. It had been noted that classes had become suboptimal due to several factors:

- Some patients health had deteriorated due to other co-morbidities and were no longer able to attend and participate to the evidenced based level of exercise, so were not getting the benefits
- Patients were not very motivated to take responsibility for their own exercise and self-management
- Some patients had been attending the sessions for a long period of time and this had resulted in:
    - Difficulting integrating new patients with a high drop out rate for new patients
    - Sessions were oversubscribed with new patients finding the sessions difficult to access
    - The sessions not being valued as a medical treatment of exercise prescription by some long-standing patients
- Staff had become less aware of other exercise options and did not sign post patients to other providers

A structured meeting with all staff and COPD consultants was held where the positive aspects and challenges of the current model were discussed. Other models were also reviewed including what happens in other parts of Solent such as the Portsmouth area.

As a result new "Next Step" classes have been launched. Patients come for 16 weeks and there is now a flow of patients through the service. We have improved our links with third party providers and supported Active Nations to set up breathability classes that patients can graduate to, and also attend alongside Next Step; we have increased our communications with the Saints Foundations and they are liaising with us regarding their service developments and how it might compliment the needs of our client group.

Child and Family Services

Our Speech and Language Therapy Team in south west Hampshire received a referral from a paediatrician at Royal Hampshire County Hospital to provide an in-patient service to their neonatal ward. This was unusual as we are not commissioned to work on a hospital site and children who need to stay in hospital are usually seen in Southampton however the Royal Hampshire hospital did not feel this was feasible for this particular family.

The referral related to a premature baby who was born at 23 weeks and who had chronic lung disease and unilateral vocal cord palsy. The baby was nasogastric tube fed and was nil by mouth due to aspiration.

An honorary contract was organised and the therapist visited the child on the ward where they were able to discuss her care with the paediatrician and nurses, and instructed the ward to increase the amount the child could take orally to 5ml. The therapist visited the ward three more times to check their advice was being followed and monitor whether it was still relevant.

The child was due to be discharged home with an NG tube, and the therapist had arranged to see her in the community however, she was not well enough to be discharged. Previously this would have meant she would have had a longer period without access to a therapy service however, we

were able to introduce orally fed purees in the hospital which she has taken to well and she made steady improvements.

Once the child was discharged home from hospital the therapist was able to see her at home, having already made a relationship with parents at the hospital and and was able to start her on more solids, and reintroduce liquids. Through her visits to the hospital the therapist was already in touch with the childs dietician and paediatrician, and able to discuss potential changes to her care in advance of her visits.

The therapist did encouter some challenges as this was not a service that had been provided before. She had to fit into how an acute ward operated, linked with different staff members who were all under pressure to care for several premature babies. Paediatricians were keen to push the child on, and the therapist needed to be firm about how safe they felt that was. The high number of staff on the wards meant that handover did not always include the therapists plan and she needed to explain this to senior nurses and make sure the information was somewhere prominent.

However this approach has been a success; the child had no more periods of aspiration where she needed resuscitation, but was able to successfully take a small amount. This means that parents could experience feeding her orally, which the child enjoyed, but they knew how to do this safely and when to stop. She was also now safely taking small amounts of puree and a larger amount of liquids, whilst in a safe environment.

A few weeks later the child was taking three puree meals a day and had begun to have some small snacks. Her parents were happy to try new foods under the therapists guidance and over time increasing the amount the child could take orally, so the amount given through her tube was reduced. This has been done in conjunction with the paediatrician and the dietician.

The family received support in safe feeding before leaving the hospital, and received support from the same therapist when they were at home. Parents felt comfortable contacting the therapist to ask about small changes to food and drink, and knew that that the therapist knews the challenges of the child and the family. The therapsist has also been able to organise a joint visit with the physiotherapist and plan one with the occupational therapist, reducing the time spent in appointments for the family.

The therapist's knowledge about premature infants within a hospital environment has increased and she has gone on to link with other hospital speech and language therapists to access clinical supervision. She is also proud to be part of the the success of joined up hospital and community care.

Mental Health

In 2018 we reviewed our in-patient care planning process and found that:

- The process for completing patient care plans was not truly collaborative and did not always demonstrate an understanding of patient needs or preferences
- In-patient wards had a high volume of care plans (from 12 to 21) for each individual patient
- The high volume of care plans means that nursing staff are not using these in order to truly lead patient care and it was difficult to ensure that care plans remained live and represented the patient's current needs at all times
- Many care plans had been created as a way of evidencing an assessment or task undertaken, rather than from a patient identified need. This means that the care plan process was not meaningful for the patient, with many not being appropriate to the patient's individual needs
- Care plan standards were not the same across the three mental health in-patient services

In-patient services recognised that a change to its current care planning process was required and set up a group to review the process. This group was comprised of ward based staff, managers of the services and colleagues within patient systems. The group wanted to ensure that:

- Every patient is fully engaged in both the assessment and care planning processes from the point of admission to the point of discharge
- Carers have an opportunity to engage formally in the care planning process and have their views recorded
- Assessments continue to be thoroughly undertaken and that this assessment continues to be demonstrated
- Care plans provide information that is easily understood by patients, carers and staff.
- Care plans are up to date to ensure that they truly lead the care provided to the patient
- At each point of change, the plan of care is agreed with the patient wherever possible. Where this plan of care cannot be agreed, this should be explained to both the patient and carer where appropriate
- Assessment and care plan standards must be the same across the mental health inpatient wards

The group then designed a care plan template which can be used with a patient and carer alongside the full assessment of the patient. The template includes:

- Inpatient Plan of Care
- Summary of Assessment
- Admission Objective and Patient Goals
- Staff Objectives
- Patient Objectives
- Interventions for my mental health recovery
- Interventions for my physical health wellbeing
- Interventions to manage my risk/safety
- Discharge planning requirements
- Patient Views
- Carers Views

For the patient this now means that:

- *I am spoken to about why I am in hospital and asked what matters to me and what would support me to be able to go home*
- *I am given information in a way that is succinct, makes sense to me and mirrors the reason I am in hospital.*
- *I am able to share this plan with my loved ones and it is clear to them why I am in hospital and what will change for me to be discharged home*
- *If I don't agree with any part the plan I am able to say so very clearly on the care plan.*
- *All of the staff on the ward know what support I need as they are able to easily assess this care plan*
- *The care plan is kept up to date as things change, which can be quite quickly in hospital, and both the staff and I know what those changes are at all times*

The outcome of this is that care planning process is simpler for both the patient and the service, and is led by the needs of the individual. The new care plans have been rolled-out in all of our in-patient areas and we have received positive feedback from patients and staff.

We now plan to extend this approach to our community services and this is one of our quality improvement priorities for 2019/20.

Primary Care Services

In September 2018 one of our podiatrists took part in a webinar organised and presented by Martin Fox a Vascular Specialist Podiatrist within the Manchester Leg Circulation Service. The webinar focused on the Academic Health Science Network North East and North Cumbria NHS (AHSN NENC) and the Northern England Clinical Networks Atrial Fibrillation programme "Diabetes Podiatry and Atrial Fibrillation (AF) – Save a Life, Stop a Stroke". The study involved a three month pilot when 45 podiatrists from North Durham, Darlington and Durham Dales, Easington and Sedgefield CCGs were trained to spot heart irregularities when taking foot pulse readings of diabetic patients in their annual foot screening. The study found that 1 new case of atrial fibrillationwas detected for every 500 people having their annual foot check and as a result it was recommended that podiatrists:

- Listen to the pulse with the Doppler for at least 30 seconds.
- Check the quality and regularity of the pulse
- If an irregular pulse is identified, explain clearly to the patient why you are referring them to their GP and that they will require further tests.

The Podiatrist reflected on learning from the webinar and put the study recommendations into practice. They began to feel and listen to the quality, rate and rhythm of the pulse, doing this for at least 30 seconds to 1 minute.

During a routine annual assessment of an 85 year old gentleman with no previous history of atrial fibrillation, the podiatrist identified an irregular pulse, they checked the patients medical history and questioned whether or not he had any symptoms; he did not. The podiatrist explained it was not for them to diagnose but that they had detected an irregularity that should be checked with the GP.

The podiatrist wrote to the GP explaining the findings of the assessment and asked the patient to book an appointment with the GP to follow this up which he. When the podiatrist saw the patient 6-8 weeks later he reported he had seen the GP who had arranged for an ECG and blood tests and subsequently diagnosed with atrial fibrilation. The patient has now been put on a beta-blocker and an anticoagulant and was most appreciative for the care and attention given to him.

Following this, the podiatrist gave a presentation to colleagues as part of the one of the Solent Podiatry Target (training) days. There was much positive feedback from the podiatry team after the presentation

Sexual Health Services

In September 2018 the service implemented "webchat" to support patients to self-manage their care, increase availability of appointments and to reduce number of concerns raised by patients about accessing the service.

The aim of webchat was to:

- Support patients to manage their own care
- To increase access for health promotion advice
- To increase availability of appointments for complex patients by reducing the number of low risk patients accessing appointments

The webchat starts with a number of electronic algorithms which aim to answer more general questions a patient may have about their sexual health. If this does not answer all of the patient's questions they can then access a nurse or health advisor via web chat to have a more in-depth discussion.

Since webchat went live in September 2018 we have seen a reduction in patient concerns regarding access; in quarter 2 there were 23 concerns and in quarter 2 after the introduction of webchat there were 12.

The Sexual Health service will continue to review the impact of webchat and in the coming year two of our improvement priorities aim to increae our our use of technology as a way of making our services more accessible by developing a new patient portal and an online platform for partner notification.

Special Care Dental Services

We have a 57 year old female patient who has been seen at one of our dental clinics since 2016. She is a bariatric wheelchair user and had previously attended in her own wheelchair which reclined to allow treatment to take place. In 2018 her reclining wheelchair became unusable and she attended in a wheelchair which does not recline. Due to her weight of 160kg, the patient could not be hoisted into the dental chair for treatment as she exceeded the safe working weight limit for the dental chair.

The clinician who had been treating the patient liaised with the team at the Royal South Hants (RSH) Hospital to arrange care using the bariatric facilities at the RSH. An appointment was arranged and transport booked. Unfortunately when the Ambulance crew arrived to collect the patient they found that her wheelchair did not have anchor points, making it unsafe to transport her. The clinician who was due to treat the patient telephoned the patient and it transpired she was awaiting a double lower limb amputation and she needed her dental extractions to be carried out before her surgery could take place. The clinician discussed the options for treatment with the patient and a joint decision was made to refer the patient for dental care under general anaesthetic at the Queen Alexandra Hospital which is closer to the patient's home and has facilities for in patient care. An urgent referral was made and the patient received her dental treatment in time to enable her other treatments to go ahead as planned.

The specialist dental service often treat patients with exceptional circumstances and many of our patients have multiple physical and/or mental health needs in addition to their dental health needs. The needs of this patient were particularly challenging and this case is a good example of how our staff maintain a patient-centred and quality focussed approach to coordinating and providing joined-up care which ensures the unique individual needs of every patient are met.

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Last year we designed an Accessible Information questionnaire for patients who attended the Paediatric Special Care General Anaesthetic list. We designed storyboards (easy read/pictorial leaflets) to support patients through this procedure. This included the themes:

- Visit to the dentist (for the assessment clinic)
- At the hospital/Fasting instructions (for the general anaesthetic)
- Care after my hospital visit (post-operative instructions)

Over a three month period we asked patients/carers/parents, at their hospital visit, to complete a patient questionnaire. During this time we received 43 completed questionnaires with the following results:
33/43 – felt that these leaflets were helpful
36/43 – wanted more leaflets like these to support them at the dentist

Some of the comments made:
“My daughter has autism and we sign to her as words confuse her so the pictures were good and she can see what is going on. Thank you”
“Social story was really useful as being Autistic it is nice to know what is going to happen…”
“…excellent…really helped and reassured us all…”

Our Accessible Information Lead has provided mini videos for staff to access Makaton signs and symbols to support our patients and our service is encouraging staff to introduce themselves using Makaton: *#Hello my name is…* This has improved our communication with and helped us better to understand the needs of patients who have accessible information needs.

Annex 1: Statements from commissioners, Healthwatch and Overview and Scrutiny Panel

The NHS Improvement letter dated 17 December 2018 *"Quality Accounts: reporting arrangements for 2018/19"* stated that Quality Accounts should be shared with commissioners and local scrutineers including the local authority Overview & Scrutiny Committee and HealthWatch organisations.

The draft Quality Account was sent to the following stakeholders on 29th March 2019:

Portsmouth City CCG
Southampton City CCG
West Hampshire CCG
Portsmouth HealthWatch
Southampton HealthWatch
Hampshire HealthWatch
Southampton City Council Overview & Scrutiny Panel

Responses received from stakeholders are set out the following pages.

Healthwatch Southampton Comments on Solent NHS trust Quality Account 2018/19

Healthwatch Southampton welcomes the opportunity to make formal comment on the draft of Solent NHS Trust Quality Account 2018/19. In Southampton, Solent NHS Trust provide in-patient care at the Western and Royal South Hants hospitals as well as providing GP practice surgeries, Child and Adolescent Mental Health Services (CAMHS), outpatient clinics and community services.

Our overall comment is that the account is well laid out, easy to read and as far as we can judge is complete and accurate with no serious omissions relating to services delivered in Southampton.

The statement on quality from the Chief Executive and the statement from the chief Nurse and Chief Medical Officer are a good introduction to the quality account. They are well justified in their comments about the CQC report; the Trust and its staff are to be congratulated on the overall rating of 'good' and particularly for its 'outstanding' rating for care

Last year we commented that it was disappointing that the coming year' priorities were not put in the context of progress made in meeting the priorities for improvement set out for the previous year's quality account. We are delighted that this has been rectified this year and that this report has an early section dealing with the progress against priorities for improvement 2018-19. This sets the priorities for improvement for 2019-20 into context and makes the report easier and more meaningful to read.

Without commenting in detail on each of the priorities established for 2018-19, it is clear that the Trust has made good progress overall and has maintained a focus on improving quality. We are very pleased to read of the progress made to embed a sustainable Community Engagement Strategy. The annual general meeting held in September was a good example of encompassing the accessible information standard; it was a pleasure to attend a well-thought-out event. We can attest to efforts to liaise with local healthwatch which is very welcome.

The priorities for improvement for 2019-20 are well set out. The idea for each of the clinical services to develop their own quality improvement priorities as well as identifying Trust-wide priorities is very sensible and makes it easier for the public to understand the purpose. It is appropriate for the priorities to be set around the Quality Framework domains of Safe, Effective and Experience. The format of 'Why we chose this as a priority and what it means for patients'; 'What we are planning to do'; 'Performance measures' and 'Engagement and consultation' is a very good way of presenting the priority and will make monitoring progress much clearer. We are particularly pleased that the Trust intends to monitor progress against delivery of each priority through governance meetings in clinical services and the Trust's Quality Improvement & Risk Group.

The specific proposals for Adult Services Southampton, Child and Family Services, Primary Care Services and Sexual Health are all supported and if successful will be very beneficial to patients. However, no mention is made of encouraging, developing and making use of Patient Participation Group (PPG) especially under Primary Care. We are aware that the Trust has a PPG group and would expect it to have a part to play in engagement and consultation for Primary Care Services.

The Trust-wide priorities are clearly important. We are pleased that the Trust will concentrate on improving their interaction with those with learning difficulties as 'Patients with a learning disability are more likely to have poorer health and die at a younger age than the general population. Duty of Candour is a simple and important concept but is not fully understood by everyone in the health service; it is right that the Trust has this as a priority. Similarly, we are pleased to see 'Freedom to Speak Up' guardians identified as a subject

requiring priority. The final priority ‘to support staff’ is very important. It is good that there has been continual improvement over the previous few years and we hope to see a further improvement in the coming year.

Part 3 of the quality account provides more detail and is helpful. The actions to implement the accessible information standard are welcomed. The Trust has made very significant progress with this important aspect. It is pleasing that the number of healthcare associated infections has remained very low. Learning from complaints is important and we are pleased to note that the Trust is offering patients an opportunity to discuss issues at an early stage of the process.

The PLACE feedback event demonstrated a commitment to improving the environment and we were pleased to be invited. Healthwatch Southampton has been involved for several years in the PLACE process in Southampton. It is very positive that the Trust has agreed to work collaboratively with Healthwatch to support the pre planning of the 2019 event.

We look forward to continuing an effective relationship with the Trust and will do what we can to help the trust achieve its objectives.

Harry F Dymond MBE
Chair Healthwatch Southampton

Steve Beale
Healthwatch Southampton

25 April 2019

NHS
Portsmouth
Clinical Commissioning Group
CCG Headquarters
4th Floor
1 Guildhall Square
Portsmouth PO1 2GJ

Tel: 023 9289 9500

By Email

25 April 2019

Sue Harriman
Chief Executive
Solent NHS Trust

Dear Sue,

We are pleased to be able to comment on the Trust's Quality Account for 2018/19.

Having reviewed the mandatory detail of the report we are satisfied that the Quality account incorporated the mandated elements based on available data.

We commend you on your CQC rating of good and outstanding for caring and consider this is well deserved recognition of your journey as a Trust over the last few years. The Trust recognises there are improvements that have to be made and we expect that you will be monitoring these areas closely over the next few months.

The Trust has made good progress on its 18/19 priorities. Of particular note is your QI programme, your approach to Learning from Deaths and Serious Incidents and that you remain a leader amongst Community Trusts in the area of research.

We were excited to see the launch of the Academy of Research and Improvement website but note that updates are no longer that current.

We welcome your bottom up approach from service lines to developing the 19/20 priorities and are pleased to see these are both smart and comprehensible to your staff. These priorities reflect a broad base of what is important for staff and patients and that service delivery and quality indicators are intrinsically linked. We look forward to seeing the progress on these areas in the coming year.

By implementing new ways of working between the Trust and the CCG we have been able to witness your quality assurance processes in action and look forward to working in partnership with you in 19/20 to ensure the best possible care for our patients.

Yours sincerely

Dr Linda Collie
Chief Clinical Officer & Clinical Leader, NHS Portsmouth CCG

NHS
Southampton City
Clinical Commissioning Group

NHS Southampton City CCG
NHS Southampton HQ
Oakley Road
Millbrook
Southampton
SO16 4GX
Tel: 02380 296904
www.southamptoncityccg.nhs.uk

26 April 2019

Sue Harriman
Chief Executive
Solent NHS Trust
Highpoint
Bursledon Road
Southampton
SO19 8BR

Dear Sue

Solent NHS Trust Quality Account 2018/19

As the lead commissioner Southampton City Clinical Commissioning Group (CCG) is pleased to comment on Solent NHS Trust's Quality Account for 2018/19. The CCG and the associate CCG of West Hampshire have continued to work with the Trust over the past year in monitoring the quality of care provided to the local populations and identifying areas for improvement.

The Quality Account is well presented and demonstrates the Trust's ambitious vision, values, and commitment to quality. It also shows the commitment to learning and making improvements where needed.

The CCG would like to congratulate the Trust on the positive results from both the national Staff Opinion Survey and patient Friends and Family Test. The CCG is pleased to note the overall rating by the Care Quality Commission (CQC) of 'good' and 'outstanding' given under the caring domain. It is also of note that the 2019/20 priorities have taken into account the findings from the CQC feedback and each clinical service has developed their own quality priorities with clear improvement measures.

The Quality Account provides details of progress made against the 2018/19 priorities and although they have not specifically been defined as 'achieved' or 'not achieved' within the report the updates on progress have been presented in a clear and understandable format. Further information on the impact of the initiatives on patients would be welcome. Details of engagement with key stakeholders including patients and staff is included, however the Quality Account would have been further strengthened through specific examples of patient stories.

The CCG is pleased to note that the Trust also continued with a number of other quality improvement activities during the year, which are to be commended.

Examples of note were:

- Improvements detailed as a result of local clinical audit initiatives
- Following recognition of the need for support for bereaved families the Trust's development of a Family Liaison Manager role
- Progress with implementation of requirements required to meet the NHS England Accessible Information Standard
- Details of learning and improvements in response to feedback from complaints and concerns.

The Quality Account continues to provide details of the Trust's learning from deaths reviews undertaken including areas identified for improvement. The Quality Account also includes the new

requirements for 2018/19 regarding details of ways in which staff can speak up and how they ensure staff who do speak up do not suffer detriment, as well as gaps in medical rotas.

The Trust should be congratulated on its successful community engagement event which involved discussions between members of the Trust Board and a wide range of stakeholders.

The CCG's opinion is that the Quality Account for 2018/19 meets the minimum national expected reporting requirements and provides details of levels of achievement.

Southampton City along with West Hampshire CCG look forward to continued close working over the coming year and the Trust ongoing commitment to work with system partners to further progress improvements in the quality of services and care provided to the people of Southampton and West Hampshire.

Yours sincerely

John Richards
Chief Executive Officer
Southampton CCG

CC: Stephanie Ramsey – Director of Quality and Integration / Chief Nurse
Carol Alstrom – Associate Director of Quality / Deputy Chief Nurse

Annex 2: Statement of Directors' Responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare a Quality Account for each financial year.

NHS Improvement has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporate the above legal requirements) and on the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account.

In preparing the quality account, directors are required to take steps to satisfy themselves that:

• the content of the quality account meets the requirements set out in the *NHS Improvement Letter 'Quality Accounts: reporting arrangements for 18/19" dated 17 December 2018* and the *Detailed requirements for quality accounts 2018/19*

• the content of the quality account is not inconsistent with internal and external sources of information including:

– board minutes and papers for the period 1 April 2018 to 24 May 2019

– papers relating to quality accounted to the board over the period 1 April 2018 to 24 May 2019

– feedback from Portsmouth, Southampton and West Hampshire Clinical Commissioning Groups dated 25 and 26 April 2019 respectively

– feedback from Southampton Healthwatch dated 26 April 2019

– the Trust Friends & Family Test results which are submitted to NHS England monthly and Staff Friends & Family Test results which are submitted quarterly

– the 2018 NHS Staff Survey Results published in February 2019

– the Head of Internal Audit's annual opinion of the trust's internal control environment dated 24 May 2019

– CQC inspection report dated 27 February 2019

• the quality account presents a balanced picture of the NHS trust's performance over the period covered

• the performance information reported in the quality account is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the quality account, 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 account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

• the quality account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality account.

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

By order of the board

.....Date ..... Chairman

.....Date ..... Chief Executive

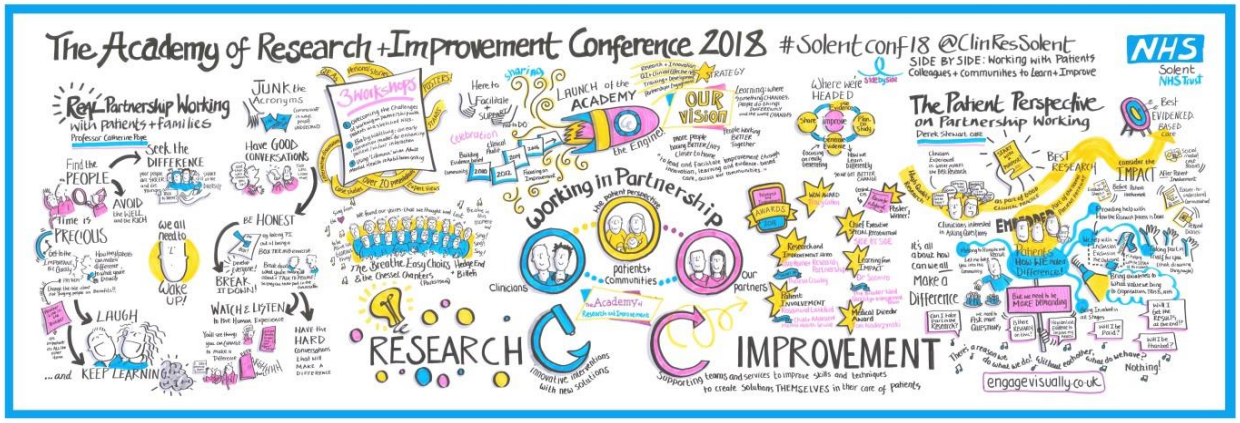
Academy of Research & Improvement: Annual Report 2018-19

Trust overview

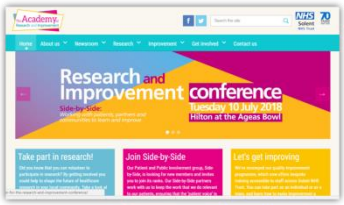
Activity in numbers

Research	Quality Improvement	Dragon's Den	Audits and Evaluations	
50 studies 2855 participants	350 staff trained 11 foundation days 2 practitioner cohorts 20 projects underway	10 projects in progress	14 national audits 2 national confidential enquiries	124 local audits and evaluations

Artwork generated from Research and Improvement conference 2018



Solent Academy of Research and Improvement



The Solent Academy of Research & Improvement was officially launched in July 2018, with an accompanying Strategy and website (www.academy.solent.nhs.uk). It aims to support learning and ongoing improvement across the organisation.

As the Academy moves into its second year the benefits of our innovative integrated model, combining research, clinical audit and quality improvement are becoming increasingly apparent. The natural synergies between these key functions provide numerous opportunities for sharing of knowledge, learning and cross-pollination of ideas for how we, as a Trust, can continue to innovate and improve.

The Academy supports a spectrum of activities, supporting skills development for those that with for and with us. A selection of the projects that have been undertaken through the Academy in 2018-19 are detailed in this report. A full list is given in the Appendices.

Research	Audit	Evaluation	Outcomes	Quality Improvement
Patient and Community Engagement	Innovation (Dragon's Den)	Sharing Learning	Favourable Event Reporting	Schwartz Rounds

The Strategy was developed in partnership with staff, patients, our Side by Side group and colleagues in partner organisations. It has four key priorities:

Patient and community participation

Patients, families and others who touch our services should play a central role in our learning and improvement. Supporting teams and patients to work in partnership is one of the key strategic priorities for the Academy. The last 12 months has seen the way Solent works together with patients and communities gain considerable momentum, particularly with the launch of the Trust Community Engagement Strategy.

A Patient's Included Conference

The theme of the 2018 Solent Research & Improvement Conference was 'Working in Partnership'. For the second year, the event was accredited as 'Patient's Included' and was co-designed by our patient group – Side by Side. Derek Stewart, a patient leader for research gave the keynote talk, and a number of patients presented on the day alongside clinicians. The Side by Side group ran a workshop on barriers and facilitators for good partnership working.

Patients as partners in Quality Improvement

All those participating in the QI programme are required to include the patient voice in their improvement – and teams on the Practitioner training include patient or family representatives.

Patients and families are involved in improvement projects in a variety of ways. For example, a mother of a child with autism is working along side a QI team to look at the referral pathway into the Child and Adolescent Mental Health Service; an experience based design approach is being used in one physio service to view access to the service through patient's eyes, by literally walking through the process with them. Patients in a vocation rehabilitation service have co-designed an outcome measure to help track and plan their progress; patient's experience of the pain pathway is being used to streamline appointments.

A Health Foundation Grant was also secured to co-design a patient specific module within the QI programme – this project is currently underway and is being carried out in

collaboration with Southampton Children's Hospital.

Patients leading improvement projects

In addition to having patient and public participation in quality improvement, two projects were service user led.

One looked at the plates used on the Brooker ward, for those with acute Dementia. Evidence shows that the colour and composition of plates can affect eating and therefore nutrition. The project was carried out with residents, families and staff, and a blue lightweight set of plates is now in use.

Similarly, a past client of our mental health services has designed small 'pocket-therapy' aids to support recovery and participation in different types of therapies. The printing and distribution of these booklets was supported by Dragon's Den funding.

Improving Access to Research

In research, we secured funding from the Wessex Clinical Research Network to develop promotional materials, and hold engagement events to extend our Side-by-Side group.

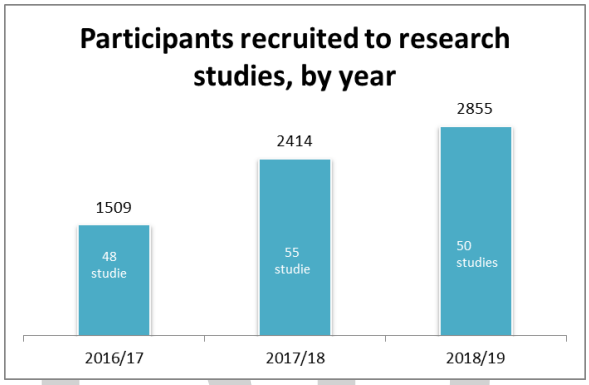
We also carried out an audit on diversity in research, which demonstrated that although we know anecdotally that research is typically less accessible to some groups (older adults, those who don't have home internet access, those who don't have English as a first language etc), we have limited evidence to demonstrate this. We are now collecting demographic data on all research participants and working with the national Health Research Authority (who approve all research studies in England) on widening inclusion criteria.

Valuing Lived Experience

Patients, with their lived experience, can support other patients in their health needs, through peer support or co-production of health services and health outcomes. A few services have peer support workers (for example the Recovery College in Mental Health and the Pain Service) and this is starting to extend. To support this aim, the ***'Valuing Lived Experience'*** network has been established for staff. This network supports managers and lead clinicians to share and learn from each other regarding the challenges and successes of involving patients through co-production or involving peer workers in delivering services.

Research

Solent NHS Trust continues to grow its research activity, recruiting 2855 participants into 50 studies in 2018/19. This is an increase of 18% on the previous year, making Solent the most research active Care Trust in the National Institute for Health Research annual league tables.



Solent NHS Trust conducts community-based health and social research across a range of specialty areas including infection, children, oral and dental health, mental health, dementia, genetics, musculoskeletal, health services, neurology, stroke and primary care. We host and lead trials as well as contributing to research studies being led by other NHS Trusts and Universities. This is important because there is a wealth of evidence that Trusts which are active in research have better patient outcomes and higher quality services. Research activity raises awareness of evidence-based practice, drives innovation and gives staff opportunities to learn new skills. It also often gives patients access to interventions, medications and treatment that might not otherwise be available to them.

A core component of our research is our community research partnership model, in which we work collaboratively with other care organisations to deliver studies. To date, we work with care homes (over 30), schools, colleges and community organisations. The care home research partnership was recognised this year with Solent winning the Nursing Times Award for Clinical Research Impact.

The following pages outline a selection of the research studies we currently have in progress.

Trust-wide research

Carriage rates and antibiotic resistance

This winter saw the third year of Solent's involvement in the important SMART study. We recruit people of all ages from the community and take samples of bacteria from the upper respiratory tract. This enables the research team to determine community carriage levels of common respiratory pathogens and the prevalence of antibiotic resistance. To date we have recruited over 2000 participants, across the full spectrum of age groups. This is contributing to a national programme of work on Antimicrobial resistance.

Adults Service Research

Vision in Parkinson's Disease

As well as the recognised effects on movement, patients with Parkinson's disease suffer from visual disturbance, even at the earliest stages. Yet little is known about how and where visual processing breaks down in

patients with Parkinson's disease. Solent recruited 16 participants to this study. Participants took part in psychological testing, blood tests and computer based visual tasks. They will complete follow up, undertaking these tests once a year for 4 years. The long-term goal is to increase understanding of visual breakdown and inform the development of effective treatments.

Accessing medicines at end-of-life

This study involves an England-wide survey of health care professionals, to capture important details about current practice in providing patients with access to end-of-life medicines, and views on what facilitates and prevents good practice in this area. A cohort of Solent's community nurses completed a short survey. We are now in the process of setting up phase 2 of the study which will help shape policy and practice.

Musculoskeletal

Ankle Recovery Trial (ART)

The purpose of the ART study was to compare two methods of managing ankle fractures after surgery using either a plaster cast or removable boot. This study was conducted in conjunction with a local Orthopaedic surgery department. Solent NHS Trust's research team co-ordinated the study, recruited 19 participants and provided the physiotherapy intervention. Formal results are awaited and will be used to guide future management of this patient group.

Sedentary Behaviour and Physical Activity in Osteoarthritis (OA)

The aim of this study is to better understand why some individuals with OA make an effort to be physically active, whilst the majority are physically inactive. Part of the study involves body composition analysis which participants have found interesting and informative. To date, Solent has recruited 13 participants to the study. The results will be used to identify effective practices to help inactive people with OA become more active.

Ageing

Falls in Care Homes (FinCH)

Care home residents are susceptible to falls and these are often associated with negative health outcomes. The purpose of the FinCH study is to determine the clinical and cost effectiveness of the Guide to Action (GtACH) process for fall prevention in care homes compared to usual care. The study involves a randomised controlled trial to gauge the impact of GtACH training for care home staff on the number and severity of falls in care homes. Solent NHS Trust recruited 86 participants for this study. Ultimately, the goal

is to identify strategies to reduce the number and severity of falls in care homes.

Memory Service Professional Practice regarding Assistive Technology

Due to the increasing number of people in the UK living with dementia there has been a growing interest in supporting people with dementia to live independently. One way to help support independent living is the use of assistive technology. This study aims to determine current practice of professionals working in Memory Services regarding the provision of information on, and access to, assistive technology for families living with dementia. Solent NHS Trust recruited 23 participants to this study. The findings will be used to find ways to better support memory services to enable people with dementia and their families' timely access to assistive technology.

Sense Cog KAP

This study is designed to investigate the impact of sensory impairment on cognition in older people with dementia. It is being conducted within care/nursing home settings. Solent NHS Trust has played a key role in assessing feasibility and setting up of this study, tapping into our Care Home Research Partnership. To date, the team has recruited more than 20 care homes and over 200 participants to the study. This includes care home managers, paid carers and family carers. The study will provide insight into issues and strategies for the management of sensory impairment amongst care home residents.

Adult Mental Health

The CAP-MEM Study

This study explores the cause and prevalence of memory problems in mental health. It assesses self-reported concentration and memory problems amongst people with a clinical diagnosis of a psychiatric disorder and a comparison group of healthy controls. To date, Solent NHS Trust has recruited around 200 participants to the study. This initial study will be used to establish the feasibility of conducting similar research amongst larger numbers of individuals in the future. Ultimately, findings will enable researchers to better understand the relationships between psychiatric diagnoses and memory and concentration problems, taking into account factors such as medication type and dosage.

The LIGHTMind Study

This is the third phase of a study to compare the benefits of cognitive behavioural therapy (CBT) to mindfulness therapy amongst patients seeking treatment for depression. Patients are recruited from Solent NHS Trust's

Improved Access to Psychological Treatment centre in Portsmouth. The study aims to determine which therapeutic approach provides the greatest benefit in terms of reducing symptoms of depression and minimising the risk of relapse. The trial is ongoing and, to date, Solent has recruited 13 participants into the study.

Sexual Health

HIV Prevention Study

PrEP Impact is a high profile national trial looking at people who are at high risk of acquiring HIV and involves them taking medication to reduce their risk. Solent NHS Trust offers participation in this trial at our three sexual health service hubs. Interest in the trial has been high and, to date, we have recruited 146 participants. Our role includes regular follow up visits and collection of samples to determine successful avoidance of infection.

Accelerated Partner Therapy (APT) Chlamydia Trial

The LUSTRUM study is a randomised controlled trial to measure the effectiveness of APT to identify and treat the partners of patients diagnosed with chlamydia. Solent NHST Trust is recruiting patients from sexual health clinics in Southampton and Portsmouth. To date we have recruited 86 patients to the trial. Our sexual health nurses deliver the intervention and collect outcome measures. If the intervention is shown to be effective, it will help to reduce rates of chlamydia by reducing incidents of reinfection.

Research with Children

The E-SEE trial

In an attempt to combat the public health challenge presented by behavioural problems and mental illness this study examines a program designed to promote social and emotional wellbeing in young children. This study aims to investigate whether the Incredible Years programme is effective in enhancing children's wellbeing at 20 months of age compared to usual care. The Solent NHS Trust team recruited 83 participants to the study and provided 10 week block parenting courses. If the programme is found to be successful it has potential to benefit the long-term health of the families involved.

The Pre-Appt Study

Children accessing therapy services often have a variety of long-term conditions and rely on their parent's willingness to engage with services. Across the country, there are wide variations in content of materials sent to families ahead of their first appointment and it is unclear whether materials encourage families to engage with therapy services. This study aims to compare and contrast pre-appointment materials to determine whether they can be standardised in a way which improves parental engagement. The Solent NHS Trust research team liaised with 8 local children's therapy services and submitted

materials to be assessed for this study. The results will provide insight into current practice across England and guidance around the content, tone and look of materials to increase parents' willingness to engage with therapy services for their child.

Cost of Autism Diagnostic Assessment

Nationally, there has been a significant increase in referrals for possible Autistic Spectrum Disorder (ASD), and this is putting a strain in diagnostic services. This multi-centre observational study aims to find out the amount of clinician time taken to assess a child for possible ASD and from this calculate the resulting costs to the NHS. Solent NHS Trust recruited 72 participants for this study. It is hoped that by understanding the complexity of assessment and costs, this will inform appropriate resourcing of assessment services and improve patients' experience.

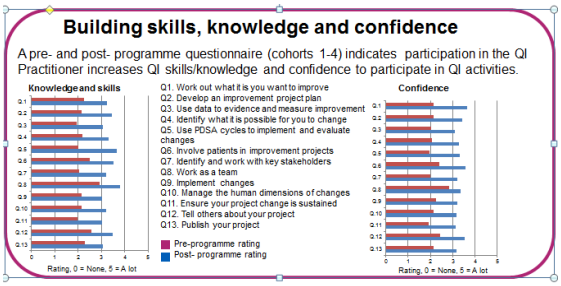
Quality Improvement (QI)

QUALITY IMPROVEMENT PROGRAMME

The Academy's Quality Improvement (QI) Programme, launched in July 2016, is designed to support individuals and teams to develop the skills and capability to successfully identify and implement QI projects within their workplace. The growing success of the initial offer of a six monthly QI training programme for teams of staff has resulted in the successful launch this year of a stepped QI training programme comprising of four key elements:

1. **Introduction to QI:** this short introductory session provides teams with a brief overview of QI.
2. **Foundation day:** this day long training provides an introduction to key QI methods. It is available to all staff and includes support to carry out small scale QI projects within the workplace.
3. **QI Practitioner:** this brings teams of staff and patients together to participate in learning days on key QI topics whilst they carry out improvement projects over 6-8 months. Teams also receive individual facilitation and support.
4. **QI Leaders:** newly launched in 2018, this year long programme is open to staff who have experience of successfully delivering QI projects and who want to develop their ability to lead QI activities across the Trust.

This year ***over 350 staff, external partners and patients have participated in Solent's QI training***. Those attending the training report better knowledge and increased confidence on how to make improvements.



QI Programme Key Deliverables in 2018/19	
INSERT ICON	11 foundation training days
INSERT ICON	22 foundation day projects have successfully completed and 15 projects are underway
INSERT ICON	2 Practioner courses, 12 teams
INSERT ICON	8 QI Practitioner projects have successfully completed and 12 projects are underway
INSERT ICON	8 members of staff recently joined the newly launched QI Leaders.
INSERT ICON	Optional Master Classes delivered by external speakers and open to all Trust staff have been run regularly throughout the year

This year has also seen a number of projects presented at local and national conferences. Additional activity to support dissemination of project outcomes is planned. Increased patient engagement in QI projects is planned for 2019. This will be supported by a specific QI training programme for patients and the public; development of this programme is currently underway.

QI Foundation Projects

Examples of some of the QI Foundation projects which are underway or have been completed are:

"Safeguarding Vulnerable Patients" - Special Care Dental Services, project complete

Patients seen within the Special Care Dental Service who did not attend (DNA) or were not brought (WNB) to a dental appointment, may not be followed up adequately and 'fall between the cracks'. Aims for the project included:

1. For 100% of all WNB patients to be followed up with the re-engagement process.
2. To increase the awareness and engagement all staff members, within the dental team, with the WNB/DNA procedure and ensure they understand its relevance to safeguarding.
3. To standardise the WNB/DNA process across the East Area of Solent NHS dental service.

These aims were achieved by engaging both patients and staff in the development and adoption of a flow chart for missed appointments and disengagement.

Patients are now followed up in a standardised way across the East Area of the service, with 78% of staff using the new flow chart. The number of patients seen within 9 weeks of a missed appointment was increased by 50%. Dental nurses and receptionists, who book the majority of dental appointments, had little or no confidence that DNA/WNB patients were followed up in an appropriate

manner. Following the implementation of the new flow chart these confidence levels improved from 36% to 93% for the Nursing staff and 0% to 85% for the Receptionists.

"Standardising Microscopy" – Sexual health services, project complete

The aim of this project was to standardise an approach to microscopy which could be rolled out across all Sexual Health Services in Solent. Initial audit data and findings were shared at Education Days. A process was agreed and added to the Microscopy field of the IT system INFORM. A microscopy training tool was developed which included competency sign off.

"Standardising Community therapy provision for 0-4yr children with complex needs" - SW Hants Children Therapy Team, project complete

The team had identified that there was inequity in the access to therapy provision for children aged 0-4yrs with complex needs across the SW Hants area Children's Therapy services operates. The aim of the project was to ensure that 100% of children aged 0-4 Years would have the same access to therapy provision available to them. Patient and staff satisfaction relating to the current service provision was gathered across the SW Hants area. Information was gathered regarding what type of activities should be offered and this was used to review the service provided and identify possible improvements. Two new "6 weeks' groups" commenced in Eastleigh and Hedge End on the 11th September 2018, referrals were accepted from children across the whole of SW Hants. These groups were evaluated and the second round of "6 week groups" took place in January/February 2019. Staff who would be involved in the role out of the project across SW Hants was invited to attend training in preparation for the expansion of the project. In March 2019 two further groups start in Totton and Winchester/Andover. Development of a 'Handbook for group setup' is being created for staff to use when setting up a new group.

"Improving the management of the Urgent Waiting List" - Community Therapy Team East, project complete

The team highlighted that there was an issue with their current Urgent Waiting List and that this was increasing in number and causing stress and anxiety for staff. A patient questionnaire was developed to gain some patient views around the current waiting time for physiotherapy. The questionnaire also looked at the perception of "Urgent" need and how long patients were willing to wait. Staff opinions were sought to understand the problem measure the current level of stress and explore any ideas for improvement. The

team identified that a new triaging system could help manage the urgent waiting list and so developed a new set of triage questions. This has led to a reduced waiting time on the Urgent List from 13 weeks to 3 weeks and 3 days, a reduction of 73%, meaning that the project's aim has been achieved.

"Improving the confidence in staff to facilitate and lead ward activities for patients" - Oakdene Ward AMH, project complete

Oakdene Ward runs activities for patients to engage in throughout the day to aid their rehabilitation. Some staff were reluctant to facilitate or lead these activities due to lack of confidence. Despite a wide range of staff engagement activities the outcome from this project did not achieve the original aim set out. However there are clear learning points when a project does not go according to plan. The team have now identified that the problem highlighted is more complex, including staff opinion surrounding job roles and the possible overlap between historic "nursing roles" and "therapy roles." In order for the original aim to be achieved the team now realise further work will need to be completed to understand the barriers that are currently in place affecting staff willingness to lead and facilitate ward based activities. Engaging staff more fully in the original "understanding the problem" could have improved the outcome of this project and the learning from this will be shared and used in future projects.

"Grow Your Own" - Central Community Independence Team, Project complete

The demand for a Comprehensive Geriatric Assessment (CGA) was greater than capacity available. This led to concerns that GP tasks were not being completed in a timely fashion thus impacting patient wait times for rehabilitation. There was little career progression for therapists in the Community Independence (CIS) team and this was seen to be impacting on staff recruitment & retention. The aim of the project was to develop a therapy role with extended skills within the CIS team to ensure 100% of medically referred patients receive the right care at the right time (CGA Within 2 weeks). Outcomes included an increase in the number of CGA's being completed, patients who have had a CGA, stay in hospital on average 7 days less than those who have not. Patients admitted to the acute trust by Central CIS had a reduction in bed days. There has been a decrease in the number of tasks being sent to GP's and 100% of tasks outlined by the therapist were completed showing that GP's recognised their expertise. Staff reports that patients' rehab was being affected whilst they

were waiting for a CGA has reduced from 45% of patients being affected to 7%.

QI Practitioner Projects

"Emergency appointments in podiatry" - Podiatry Service West

There are up to 50 emergency slots across the podiatry service each week. Due to clinical and staffing pressures these slots were frequently being booked for planned appointments, which was impacting on quality. The aim of this project was for 100% of emergency patients to be seen by the right clinician at the right time by January 2019. In order to understand the problem the team process mapped new patient and follow up appointment pathways, validated their list of clinics, identified all specialties and analysed the variation in their emergency appointment data using statistical control process charts. They then pooled their waiting lists for all routine and follow up appointment slots across all Southampton and West Hants clinics, adjusted the number of emergency appointments slots available per day to account for variation, introduced 7 day embargoed emergency slots, increased the length of each emergency appointment slot from 30 minutes to 45 minutes and introduced telephone triage slots to confirm the need for an emergency slot. Results show there has been a reduction in the number of times when emergency slots are booked for planned appointments. For this project, understanding variation using statistical process control and reducing queues into the appointment system were critical factors in improving patient flow.

"Right patient, right results" - Sexual health services

The Sexual Health Services take many hundreds of specimens a year, which are sent to a laboratory for analysis. Staff were concerned that there had been a number of errors in the process of labelling and logging specimens. This could give rise to serious incidents in which patients may be given incorrect results. Therefore, the aim of this project was for 100% of patients to have their specimens labelled and logged correctly. The team mapped their process for labelling and logging specimens, conducted an observational walk through of the environment and worked with their wider team to identify potential causes of errors. Changes tested and adopted included implementation of a new process and Standard Operating Policy, new logging sheets, flow charts displayed in specimen logging areas, and a programme of staff training. The process has now been successfully spread service wide. Data show there have been fewer specimen labelling and logging errors and these have all been successfully identified and rectified prior to the specimens being sent to the laboratory.

The team are currently producing a podcast on the process to support a range of staff learning needs. Process standardisation and extensive testing using plan-do-study-act cycles has been a key to the success of the project.

"Changing health outcomes for overweight and obese children through better engagement with their families" - Children's healthy weight team,

This project sought to achieve by June 2018, an increase in engagement between the school and school nurse team with parents/carers of children identified as obese at their Year R National Child Measurement Programme (NCMP) screening. A multi-agency project team focused on two schools in Portsmouth with the highest obesity rates. All parents of year R children at these schools were invited to attend a focus group to explore this issue. The findings of the focus groups, at which 12 parents attended, were that 30% of the parents had no understanding of the NCMP, 100% of the parents thought that childhood obesity was an important issue and understood the health implications associated with obesity, 83% of parents thought the NCMP post-measurement letter was easy to understand that that the language used and information the letter contained was clear. Changes implemented by schools and the school nurse team to support children and their families to maintain a healthy weight included timely distribution of the pre-measurement letter; SMS reminders to be sent by the school to parents the day before the measurement, promoting the role of the School Nurse and translation of information into other languages.

"Improving complainant and staff experience of local resolution meetings" - Complaints team (corporate services)

Local Resolution Meetings (LRMs) are being encouraged as an early step in managing a complaint. This project sought to improve complaint and staff experience of LRMs. The team interviewed a number of complainants, staff and advocates, using an experience based design approach to understand their experience of participating in an LRM. They also reviewed the complaint investigation process and flow, and analysed data to identify the number of LRMs and time to completion. Changes made included revision of the Complaints Policy so that the complainant is routinely offered the choice to meet the service, staff training on holding LRMs is now provided and guidance for staff on LRMs has been developed and is available on the intranet.

"Improving missed medication doses reporting" - Adult Mental Health inpatient wards

Staff were concerned that there were occasions when medication cards showed that patients were missing medication doses. Missed medication doses can have a negative impact upon patient recovery and well-being. Therefore, a data collection sheet to capture the number of 'blank boxes' on medication charts was developed for us on the four inpatient wards.. The results showed how many medication administrations had not been recorded but there was no way of knowing if these were missed doses or not. In order to understand the problem and identify potential solutions the team consulted staff, shadowed medication rounds, raised awareness at team meetings and handovers, gathered feedback from patients and completed a fishbone cause and effect diagram with staff on each ward. Staff identified they wanted a second person to check the medication cards and this was tested and implemented on each ward. The team also held meetings with ward managers to agree standards for managing non-compliance with policy, leadership teams communicated with nursing staff about the issue of non- compliance, non-compliance and associated risks were escalated via the Mental Health Governance structure. Data showed that over a six month period some wards made significant sustained improvements whilst other wards had further work to do. Further feedback from staff indicated they felt there now needed to be "people management". A plan was agreed for handing this improvement activity over to services for embedding into practice and monitoring is continuing through a variety of forums.

"Reducing rates of non-concordance with home oxygen therapy for patients with Interstitial Lung Disease (ILD) and Chronic Obstructive Pulmonary Disease (COPD)" - Home Oxygen Therapy Service, Adults Portsmouth

The Home Oxygen Therapy team were concerned that under or over use of home oxygen was a common occurrence amongst their patient group. Such under or over use has potential to negatively impact upon patient quality of life. Data analysis showed that the greatest amount of non-concordance was in those patients with ILD and COPD. Therefore, this project aimed to reduce rates of non-concordance with home oxygen therapy for patients with ILD and COPD. Consultation with patients identified the current method of providing verbal information regarding their home oxygen therapy prescription didn't fully support their needs. Following this the team worked collaboratively with patients to develop a home oxygen therapy information leaflet which also included a prescription sheet for the clinician to complete with the patient. This is currently being tested with patients.

"Improving patient education on the risk of herniation" - Stoma Care Service, Adults Southampton

Patients with a stoma are at risk of developing a hernia as a complication of surgery. The Stoma Care Team realised they could influence outcomes through providing education to all patients undergoing surgery. Therefore, the project's aim was to improve the pre-operative information provided to patients on the potential risk of hernia formation and on the preventative steps they could take. The team developed a survey seeking feedback on the way information is currently given, the timing of its delivery and the preferred delivery method. Attendees at 2 stoma support groups participated in the

survey. Based on the feedback the team have designed a short patient education video which is currently being tested in clinic. The team are developing plans to use the video as part of their care pathway, potentially prior to discharge from hospital, as survey respondents identified this as an ideal time to reiterate the information. They are also exploring the feasibility of sharing the video on the Trust's intranet and internet and the Stoma Care Service's Facebook page to increase accessibility.

Clinical Effectiveness

Our clinical effectiveness activities include clinical audits, service evaluations, the development of clinical outcome measures and the dissemination and review of NICE guidance.

In all these activities we are looking to identify areas of concern and evidence of effectiveness, from which we make plans for improvement.

Planning for Improvement

We are required to produce an annual plan for our audits and evaluations. This has traditionally been done by service lines in isolation.

Last year, we launched a trust wide improvement planning together event which we repeated, with improvements, in January this year. This year we included patient and public representatives meeting with teams from each of the service lines and corporate services.

Each team was provided with:

- results of a staff improvement ideas survey
- key themes from patient experience reports, incidents and complaints
- details of audits and evaluations marked for re-measurement

A video was also produced for this event to promote good practice and share examples of improvement from the previous year.

Draft plans from each team were discussed around the room to promote joint working.

One of the key themes identified, discussed and planned at this event was processes for maintaining standards by reviews of electronic patient records.

Clinical Outcome Measures

Last year we conducted a scoping survey to identify and build a database to track clinical outcome measures use in the trust.

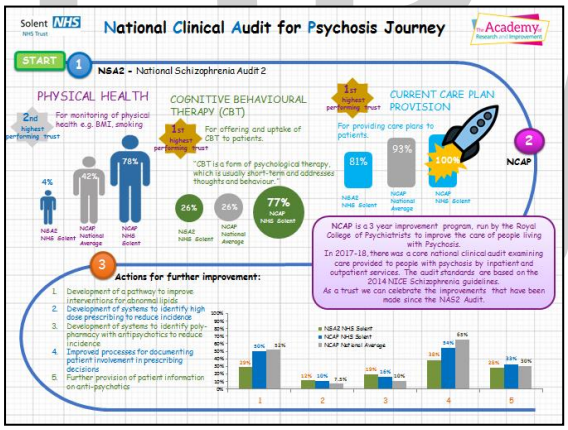
Examples of projects to design and implement outcome measures into clinical service are:

- A co-designed (patient and clinician) set of outcome measures in the Vocational Rehab Service
- Roll out of an outcome measure for the physiotherapist service in Portsmouth
- Development of outcome measures with young people for the Child and Adolescent Mental Health Service

National Audits

During 2018-19 we participated in 16 national audits, submitting over 2,000 cases.

In one example of a repeated national audit, the National Clinical Audit of Psychosis, we submitted 88 cases and shared results across the trust in a range of formats including video and info-graphics. The info-graphic below shows key findings and actions for improvement.



Local Clinical Audits and Service Evaluations

During 2018-19 we conducted 124 local audits and evaluations.

The examples of repeated audits and evaluations below show how the cycle of repeated measurement and action can lead to improvement.

Completion of care plans in mental health (re-audit).

Four audits were completed between January to June 2018. Between the first and last audit there was improvement in all areas measured:

Standard	Improvement
Care Plan in place	30%
Current and in date	60%
Relevant to episode of care	40%
Documentation of capacity	60%
Documentation of consent	40%

Recording parental consent in specialist dentistry (re-audit).

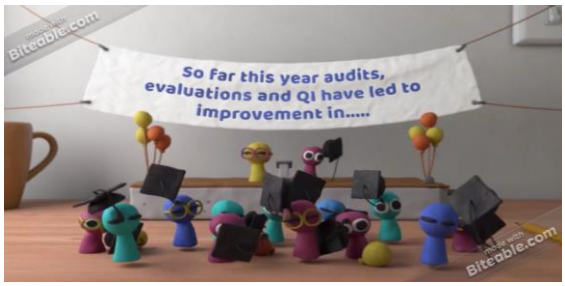
The compliance reported in this audit (87%) shows continued improvement since the previous audit (83%) and a run of improvement since the audit started in 2015.

	Dec 2018	Dec 2017	June 2017	Jan 2017	Dec 2015
Overall compliance	87%	83%	65%	44%	39%

Wound assessment in adult services (re-audit).

158 patients with wound care plans were audited of which 137 (87%) had a TIMES wound assessment which exceeded requirements and showed an improvement

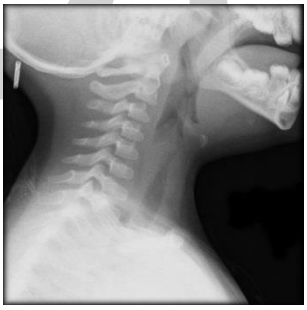
from 80% in the last audit and 65% in the previous year's audit.



Complication rates of vasectomies in Sexual Health (re-evaluation).

This evaluation showed that the occurrence of complications had been overestimated. Re-coding using clear definitions gave an overall complication rate for Solent vasectomy department of 0.79% (12/1525 operations) which is within the limits quoted in the evidence and an improvement on the previous rate of 5.8%.

Radiological investigation in non-accidental injury of children (re-audit).



The audit looked at 79 patients under 2-years old with suspected physical abuse following community paediatric examination, from 2013-18.

84% of under two year-olds had a skeletal survey when physical abuse was suspected (increased to 100% in 2018). Children under 1 year were significantly more likely to get a skeletal survey (94%).

89% of follow-up skeletal surveys were carried out (100% in the last 4 years) which is impressive as much of the published literature reports high attrition rates.

Planning for transition of young persons to adults (re-audit).

There was an improvement from 42% in 2014 to 62% for a plan of transition starting at the appropriate age. Information in the health care plan had also significantly improved with, for example, including young person' views increasing from 47% to 55% and inclusion of a list of professionals increasing from 33% to 100%.

Post-op complications following Podiatry nail surgery (re-evaluation).

The number of patients lost to follow up before wound healing improved by 3.7% to 13.3%. Post-operative infection rates improved by 19% to 13.3% whilst delayed wound healing improved by 6% to 33% patients.

Nutritional screening in adult services (re-audit).

100% (37) of patients were screened for malnutrition status within 24 hours of admission - this showed an 11% improvement from 2017-18 Qtr. 3 and 7% improvement from 2018-19 Qtr. 1; 92% overall had this repeated weekly.

The inpatient wards have consistently demonstrated the appropriate use of food and fluid charts when the patient's MUST score is medium or above.

End of life medication records in adult services (re-audit).

The audit gives a clear picture of the EOL medication prescribed & administered to patients and shows improvement from previous audits. More records contained information regarding disposal of no longer needed medication, than found in previous audits (91% compared to 56% last year).

Pressure Ulcer Prevention and Management in adult services (re-audit).

Improvements were noted in ulcer categorisation, use of at risk care planning and Waterlow score, advice to patients and carers, equipment provided, MUST use and onward referral with compliance ranging between 93% and 100%. Range of improvement was between 5% and 35%.

Infection prevention and control in specialist dentistry (re-audit).

The lowest level of compliance was 96%. Areas of good practice were: prevention of blood borne virus exposure (18 clinics - 100% compliant); use of personal protective equipment (19 clinics - 100% compliant); management of dental medical devices (18 clinics - 100% compliant).

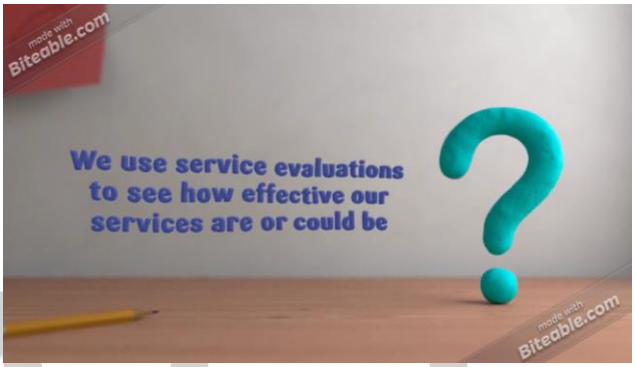
Adoption medical reports (re-audit).

The overall quality has considerably improved. Of 27 standards, 24 are now 100% compliant. The overall average compliance increased from 87% to 97%. The lowest level of compliance increased from 27% to 60%.

Improvement was specifically seen in: availability of information from Social Care; stating if immunisations are up to date; inclusion of comments on emotional and behavioural issues (from 27 to 90%), vision & hearing; details of head circumference; information about hereditary and family risks.

Service Evaluations

The examples below illustrate how service evaluations can help us understand how our services work now and how they could work in the future.



Musculoskeletal (MSK) telephone triage service compared to GP telephone calls (evaluation).

This evaluation compared the effectiveness of a newly established MSK telephone triage service with GP telephone calls. 51% of MSK patients speaking to a GP duty team were given on the day appointments, compared to 9% from the MSK telephone triage. For GP duty team, 33% were given a prescription compared to 9.5% from MSK. Only 9% of patients were given only advice by the Duty Team, compared to 40% within MSK. MSK telephone triage appears to saves time on appointments, prescriptions and provides more advice than the GP duty team. 54% of patients made no further contact with the GP

surgery or MSK Triage service for the same problem within the following 3 months.

Epilepsy passports for children (evaluation).

21 people (including 4 patients and 10 caregivers) responded to a survey. The majority perceived the epilepsy passport to be useful. Caregivers mainly recognised its helpfulness in emergency situations, whereas health care professionals identified its potential for improving communication between teams.

Factors affecting drop out from emotional coping skills and dialectical behaviour therapy in mental health services (evaluation).

No significant differences (e.g. symptom severity, demographics) were found between dropouts and completers of these forms of therapy. Substance-use was not found to be a significant predictor of dropout, contrary to previous research. Interpretation of the results suggested that psychological assessment should address the likely impact of behaviour and mood on patient ability to attend therapy. Assertive engagement may be valuable for people struggling with chaotic behaviour and low mood. Motivational work may also be benefical to try and increase inital engagement with therapy after being placed on a waiting list.

Patients views on the acceptability of e-prescribing in Sexual Health (evaluation).

1281 service users took part in this survey. In general, most participants preferred to either be given the medication by a doctor (20%) or collect it at a pharmacy (34%). However, for chlamydia treatment and contraceptive pills, many (45%) chose 'home delivery' as their preferred method. When asked directly, around 83% of participants were willing to receive antibiotics and contraceptive pills by post. For medication by post, most (76%) participants were not concerned about the confidentiality, but 44% would be concerned about the medication delivery if they were absent.

Preferences for video consultations in sexual health (evaluation).

246 service users completed a paper based survey. 70% of patients preferred face-to-face consultations at the clinic as the first point of contact; 73% were willing to use live web chat services and 58% video-consultations. Only 40% reported that artificial intelligence chatbots would be acceptable. The findings demonstrate the importance of human interaction in SH services and the potential for inequity of provision if services are too focused on digital provision.

Dragon's Den – Innovation

In Solent, staff and patients are able to bid for small scale innovation grants to test new ideas within their services. Bidding is invited four times a year, and grants are worth up to £10,000. There are currently ten projects underway across the Trust. For example:

Pillowcase to position the arm post stroke (Neuro rehabilitation service, Southampton)

To help patients, carers and staff position an arm correctly post stroke, a physiotherapist has designed a pillowcase that shows where the arm should be placed. The pillow sits under the arm – the innovation fund is supporting the development of a prototype and a range of cases to test.

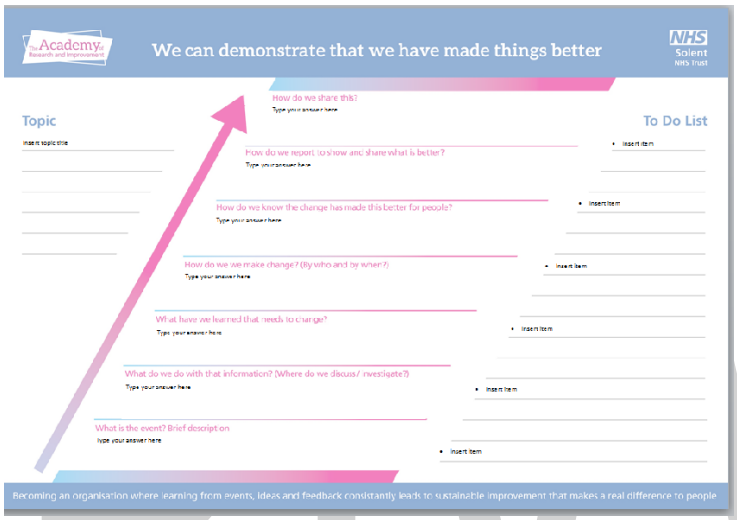
Pedometers to support increased exercise for those in receiving therapy for mental health illness.

Often, people with mental health illness also have physical health challenges. In one service in Portsmouth, they are trialling pedometers with service users, and supporting within therapy, to try and increase levels of activity.

Learning

One of the strategic goals of the Academy, and the Trust, is to share learning and improvement. At the core of this is supporting a model that focuses not on what tasks have been done per se, but on what improvements these have led to, and what has been learned.

To facilitate this, a number of activities have got underway in 2018/19. A learning framework has been produced with a range of staff from across the organisation. This aims to help change the focus to has changed or been learned following events or actions.



One example where this is now happening effectively is via our reporting on clinical audit and evaluation – this now focuses on changes and improvement between audits rather than on long action plans. All audits and improvement projects now also have one page summaries to help other teams and patients easy read about and learn from them.

A learning zone is being created on the intranet, and a process to support learning from positive events has been piloted and is being implemented across the Trust.

The Academy is now moving into its second year, with a range of projects planned. For on-going updates, please see www.academy.solent.uk or follow us on social media (@solentacademy).

Solent NHS Trust

Call 0300 123 3390

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Highpoint Venue, Bursledon Road, Southampton, Hampshire SO19 8BR

Item 6.1

Presentation to		X	In Public Board Meeting		Confidential Board Meeting							
Title of Paper	Governance Updates – including: - Declarations of Interest - NHSI Provider Licence Compliance Annual Declaration											
Author(s)	Rachel Cheal – AD Corporate Affairs and Co Sec.			**Executive Sponsor**		Sue Harriman, CEO						
Date of Paper	17th May 2019			**Committees presented**		----						
Link to CQC Key Lines of Enquiry (KLoE)			Safe		Effective		Caring		Responsive	X	Well Led	
Well Led KLoEs	**W1** Leadership Capacity & Capability	X	**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities					
	W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation					
Action requested of the Board			**To receive**	X	**For decision**							
Link to BAF risk	BAF # ---------- Concerning ---------- or		X	N/A								
Level of assurance *(tick one)*	Sigificant		Sufficient	X	Limited		None					

The following governance documentation has been reviewed and updated;

1. **Declarations of Interest** - it is good governance to formally note on an annual basis the declarations declared by Board members. These can be found within pg 48 of the Annual Report. Board members regularly update these; the register is held by the Company Secretary's office and contemporary updates are available via our public website.
2. **NHS Provider Licence Compliance Annual Declaration**

The requirement

In April 2017, NHS Improvement introduced a new requirement on all NHS Trusts whereby each Trust is asked to **self-certify in accordance with the NHS Provider Licence** on an annual basis.

Although NHS Trusts are exempt from needing the provider licence, directions from the Secretary of State require NHSI to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. The Single Oversight Framework (SOF), bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

Solent NHS Trust, is therefore required to self-certify annually that we meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that we have complied with governance requirements.

Since our original declaration in May 2017, it was agreed that for good governance, on-going compliance be incorporated within the wider SOF requirements, captured within the In Public Board Performance Report, rather than solely considering the requirements on an annual basis.

In April 2018, Trusts were informed that there is no requirement to return the completed self-assessment to NHSI, as previously, but instead Trusts must however, **publish their self-certifications via their websites** and complete their self-certifications by the following dates:

- Condition G6(3) by 31 May
- Condition G6(4) by 30 June
- Condition FT4(8) by 30 June

NHSI will conduct spot audits on a select number of NHS Trusts (and FTs).

A template has been provided by NHSI to capture Trust responses on a 'comply or explain' basis, which has been adapted for internal use to capture assurance.

There is no set process for assurance or how conditions are met, which is reflective of autonomy - each Trust is therefore required to determine how compliance is met (or otherwise). NHSI requires each **Board to formally 'sign'** in agreement of compliance against the conditions.

Providers are required to have effective systems and processes in place to ensure compliance; to identify risks to compliance and take reasonable mitigating actions to prevent those risks/or compliance failures.

A copy of Solent NHS Trust's compliance with these conditions are found in Item 6.2 (a copy of the full Licence Conditions for G6 and FT4 are found in Appendix 1 of Item 6.2)

Board Recommendation

The Board is asked to:

1. Note the **Declarations of Interest** as included within the Annual Report and note that contemporary updates are published on our public website

2. Confirm its agreement with the responses outlined against each of the **Provider Licence requirements; or provide alternative responses as agreed**. Representatives of the Board (the Chairman and the CEO) are asked for formally sign in agreement.

<u>Assurance Level</u>

Concerning the overall level of assurance the Board is asked to consider whether this paper provides:

- Significant, sufficient, limited or no assurance

And, whether any additional reporting/ oversight is required by a Board Committee (s)

Self-Certification 2018/19 – NHS Provider Licence – May 2019

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

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	*Confirmed	<u>For 2017/18</u> The Trust achieved a £0.7m surplus against an agreed deficit control total of £1.5m. External Auditors issued an unqualified Value for Money opinion and an unqualified opinion concerning the Trust's financial statements for the year 2017/18. <u>For 2018/19</u> We achieved a £1.4m surplus, against a stretch deficit plan of £0.4m; the original plan had a deficit of £1.0m. During 2018/19, Solent received £3.5m of Provider Sustainability Funding, as awarded from NHSI (£1.5m as per the original plan and an additional £2.0m for performing marginally better than plan). Our efficiency target (Cost Improvement Plan) was £7.7m, of which £6.1m was delivered; the balance was achieved by other measures. Internal control processes has been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls. The Board is not aware of any other departures from the requirements of this condition.	Concerning CQC compliance: We continue to address actions and monitor compliance with requirements made following our CQC report (Feb 2019).

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. Concerning Board level capability – All positions are substantively filled and qualifications, skills and experience are taken into consideration together with behavioural competencies as part of recruitment exercises for any vacancy. Established escalation processes allow staff to raise concerns as appropriate.	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Signed on behalf of the Board of Directors;

Signature

Title

Date

Signature

Title

Date

Appendix 1 – details of full relevant Licence conditions:

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
    (a) the Conditions of this Licence,
    (b) any requirements imposed on it under the NHS Acts, and
    (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
    (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement (Monitor) a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHS Improvement (Monitor) in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
(a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement (Monitor) from time to time; and
(b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
(a) effective board and committee structures;
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:
(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.
8. The Licensee shall submit to NHS Improvement (Monitor) within three months of the end of each financial year:
(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and
(b) if required in writing by NHS Improvement (Monitor), a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.