# Agenda
# Solent NHS Trust In-Public Board Meeting

Monday 3rd June 2019 09:30am – 13:40

Mary Rose Room, Haven Community Centre, The Salvation Army, Lake Road, Portsmouth, PO1 4HA

| Item | Time | Dur. | Title & Recommendation | Exec Lead / Presenter | Well Led Domains |
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| 1 | 09:30 | 5mins | **Chairman's Welcome & Update**<br>• **Apologies to receive**<br>*To receive* | Chair | - |
| | | | **Confirmation that meeting is Quorate**<br>*No business shall be transacted at meetings of the Board unless the following are present;*<br>• *a minimum of two Executive Directors*<br>• *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair* | Chair | - |
| 2 | 09:35 | 30mins | **Patient Story**<br>*To receive*<br>*End of Life Story* | Chief Nurse/Chief People Officer | W7 |
| 3 | 10:05 | 10mins | **Board reflection on patient story and discussion** | Chair | W7 |
| 4 | 10:15 | 5 mins | ***Minutes of Last Meeting and action tracker**<br>*To agree* | Chair | - |
| 5 | | | **Register of Interests & Declaration of Interests**<br>*To receive* | Chair | - |
| 6 | 10:20 | 5mins | **Matters Arising** | Chair | - |
| 7 | 10:25 | 5mins | **Any Other Business** | Chair | - |
| 8 | 10:30 | 10mins | **Safety and Quality First and Feedback from Board to Floor Visits,** *including six monthly Board to Floor update report – to receive* | Chief Executive / Chief Nurse | W3 |
| **Strategy & Vision** | | | | | |
| 9 | 10:40 | 30mins | **Chief Executive's Report**<br>*To receive* | Chief Executive | W1-W8 |
| **10 min Break** | | | | | |

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| 10 | 11:20 | 30mins | **Performance Report** - *including*<br>• Business Plan Review<br>• Operational Performance<br>• Quality Performance<br>• Financial Performance<br>• Workforce Performance<br>• NHSI Single Oversight Framework<br>• Research Performance<br>*To receive* | Executive Leads | W5, W6 |
| 11 | 11:50 | 10mins | **Proposal regarding the future approach to the Trust's Performance Report**<br>*To receive presentation on day* | Director of Finance | |
| 12 | 12:00 | 15mins | **Delivery of the Academy of Research & Improvement Annual Report**<br>*To receive*<br>*Supplementary paper available on request:*<br>• ***Item 12.3 –*** *Annual Report Appendix – Full list of research, QI and evaluation projects by service line* | Chief Medical Officer | |
| 13 | 12:15 | 5mins | **Learning Disability Strategy**<br>*To approve* | Chief Nurse | W3,W6 |
| 14 | 12:20 | 10mins | **CQC Follow Up Report**<br>*including web-link to Full Report*<br>*To receive* | Chief Nurse | W1-8 |
| 15 | 12:30 | 5mins | **Professional Engagement and leadership six monthly report**<br>*To receive* | Chief Nurse | |
| 16 | 12:35 | 10mins | **Health and Safety Annual Report and Statement of Intent**<br>*To agree* | Director of Finance | W5,W6 |
| **Reporting Committees** | | | | | |
| 17 | 12:45 | 5mins | **Charitable Funds Committee Minutes & Chairs update**<br>*To receive a verbal update from 23rd April 2019 meeting* | Committee Chair | W4 |
| 18 | 12:50 | 5mins | **Assurance Committee**<br>*To receive Chair's exception report /update from 23rd May 2019 meeting* | Committee Chair | W4, W5, W6, W8 |
| 19 | 12:55 | 5mins | **Audit & Risk Committee**<br>*To receive a verbal update from 24th May 2019 meeting*<br>*Supplementary papers available on request including:*<br>• ***Item 19.1*** *- Clinical Audit 2019-2020 Plan and Progress report on 2018-2019 activity*<br>• ***Item 19.2*** *- Internal Audit Plan* | Committee Chair | W5 |
| 20 | 13:00 | 10mins | **People and OD Committee**<br>*No meeting held since last Board. Next meeting 13th June 2019* | Committee Chair | W1-8 |

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| 21 | 13:10 | 5mins | **Community Engagement Committee (CEC)**<br>*To receive update from 3rd May 2019 meeting* | Committee Chair | W7 |
| 22 | 13:15 | 5mins | **Finance Committee (non- confidential)Chairs Update**<br>*To receive update from 24th May 2019 meeting* | Committee Chair | W4 |
| 23 | ---- | --- | **Complaints Review Panel**<br>*No meeting held since last Board. Next meeting 4th June 2019* | Committee Chair | W5-6 |
| 24 | ---- | --- | **Governance and Nominations Committee**<br>*No meeting held since last Board. Next meeting 12th July 2019* | Committee Chair | W4 |
| 25 | 13:20 | 5mins | **Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update**<br>*To receive verbal update from 30th May meeting* | Committee Chair | W5, W6, W8 |
| **Governance matters** | | | | | |
| 26 | 13:25 | 5mins | **Committee Annual Reports**<br>*To receive*<br>• *Governance and Nominations Committee*<br>• *Assurance Committee*<br>• *Audit & Risk Committee* | Corporate Support Manager | |
| **Any other business** | | | | | |
| 27 | 13:30 | 5mins | **Any other business & future agenda items** | Chair | - |
| 28 | 13:35 | 5mins | **Reflections – lessons learnt and living our values** | Chair | - |
| 29 | 13:40 | --- | **Close and move to Confidential meeting**<br>The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows:<br>"that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960) | Chair | - |

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


***Date of next meeting:***

- *5th August 2019 – In Public Board*
- *7th October 2019 – In Public Board*

# Action Tracker

Action 4.2

| Overall Status | Source Of Action | Date Action Generated | Minute Reference/ Additional URN | Action Number | Title/Concerning | Action Detail/ Management Response | Action Owner(s) | Latest Progress Update |
|---|---|---|---|---|---|---|---|---|
| On Target | Board meeting - In Public | 01/04/2019 | 2.5 | AC000687 | BOD1 - Patient Story - Mental Health In Patient Follow Up Story | JA to send a copy of the patient story video to the Board for information. | Jackie Ardley | 21/05/2019<br>Circulated to the Board. |
| On Target | Board meeting - In Public | 01/04/2019 | 10.3 | AC000688 | BOD1 - Performance Report - Quality | JA confirmed that the benchmarking of pressure ulcers will not be possible due to changes in recording measurements. Reporting will start afresh from 1st April following which will be benchmarked month on month. SH requested that further narrative is provided in future reports to explain the position. | Jackie Ardley | 21/05/2019<br>This is to be included within the ongoing Chief Nurse Report. |
| On Target | Board meeting - In Public | 01/04/2019 | 13.2 | AC000689 | BOD1 - Report 18/19 Flu Campaign for Employees | SE asked how the Trust's Flu Vaccination rate achievement compares with other organisations. HI confirmed that the Trust performed well. It was agreed to circulate a comparison report when received. | Helen Ives | 16/04/2019<br>A comparison report was circulated to the Board for information. |

# Minutes

## Solent NHS Trust In Public Board Meeting

**Monday 1st April 2019 09:30am-13:05pm**
**Kestrel 1 & 2, 2nd Floor, Highpoint Venue, Bursledon Road, Southampton, SO19 8BR**

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| **Chair: Catherine Mason, Trust Chair (CM)** | |
| **Members:**<br>**Sue Harriman,** Chief Executive (SH)<br>**Andrew Strevens,** Director of Finance (AS)<br>**Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA)<br>**David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN)<br>**Jackie Ardley**, Chief Nurse (JA)<br>**Helen Ives**, Chief People Officer (HI)<br>**Mick Tutt,** Non-Executive Director (MT)<br>**Jon Pittam,** Non-Executive Director (JPi)<br>**Francis Davis,** Non-Executive Director (FD)<br>**Mike Watts,** Non-Executive Director (MW)<br>**Stephanie Elsy,** Non-Executive Director (SE)<br>**Dan Meron,** Chief Medical Officer (DM) | **Attendees:**<br>**Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC)<br>**Jayne Jenney,** Corporate Support Manager and Assistant Company Secretary (JE)<br>**Jo Perry**, Professional Lead Mental Health Services (JPe) (item 2 only)<br>**Graeme Matthews,** Modern Matron, Adult Mental Health (GM) (item 2 only)<br>**Kayode Osanaiye,** Clinical Director, Adult Mental Health (KO) (Item 2 only)<br>**Sadie Bell,** Head of Information Governance (SB) (item 12 only)<br>**Apologies:**<br>No apologies were noted. |

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| **1** | **Chair's Welcome & Update, Confirmation that meeting is Quorate** |
| 1.1 | CM welcomed all attendees to the in- public meeting and highlighted being proud to commence her role as chair following the CQC 'good' rating and 'outstanding for caring' rating recently achieved. |
| 1.1 | The format of the meeting was explained. |
| 1.2 | No apologies were noted and the meeting was confirmed as quorate. |
| **2** | **Patient Story – Mental Health In Patient follow up story** |
| 2.1 | JA introduced Jo Perry, Graeme Matthews and Kayodi Osanaiye to the Board. JA explained the reason for their attendance to update the Board on actions taken and lessons learnt following a complaint raised by Mrs G, the wife of a Limes patient, regarding his care. |
| 2.2 | The Board watched part of a video that explained the experience of the patient and his wife. Opportunities were given to reflect and understand actions taken with regards to each issue highlighted. |
| 2.3 | It was noted improvements have been made in relation to care plans and patient information to ensure awareness of individual needs. |
| 2.4 | It was noted that training on the care of deteriorating patients has been introduced, consisting of a mixture of taught and computer based training. |
| 2.5 | JA to send a copy of the whole video to the Board for information. **Action: JA**<br>KO informed the Board of Mrs G's positive return to the service following improvements made. |

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| 2.6 | JA asked how the service initially felt when the complaint was received. GM reflected on his initial feeling of defensiveness however acknowledged improvements made as a result. |
| 2.7 | JoP informed the Board that the complaint was received a significant time after the patient was with the service and that some improvements had already been made. It was noted that a positive reflection exercise has been undertaken on identified improvements. |
| 2.8 | GM reported being present during Mrs G's return to the unit and that the feedback received had a positive impact on staff attitude that was timely for the CQC visit during the same week.<br>KO highlighted this to be a testimony to the Trust's CQC achievement of 'outstanding' for caring. |
| 2.9 | SH commented on the leadership reflection and learning and the acknowledgement of mistakes being a positive activity for the CQC to witness. |
| 2.10 | CM enquired as to why Mrs G waited so long before making a complaint. JoP reported Mrs G to be a member of a Carers Group and the complaint was progressed with another member of this group. |
| 2.11 | FD asked if consideration should be given to the timeliness of patient feedback requests. JoP provided assurance of existing communication opportunities, explanative posters on display and of work in progress to develop relationships as a leadership team. FD asked if carers can be assisted with the completion of required paperwork. JoP confirmed support available.<br>KO highlighted continued improvements in sharing learning with doctors. |
| 2.12 | SE queried the use of the video as a learning tool across the Trust. JA confirmed the video is to be shared with teams and reported on further similar learning videos to be developed. |
| 2.13 | JPi asked if the Board can be assured of mitigations in place to avoid future incidents with medicines management. JoP shared her confidence and informed the Board enhancements made in relation to medicines management assurance processes. GM also informed the Board of the Medical Team's involvement in ward reviews going forward.<br><br>A good result achieved by the service following a physical health audit was noted.<br>KO also informed the Board of further improvements being explored with regards to medicines management. |
| 2.14 | The Board discussed the circumstances surrounding the complaint – it was acknowledged that communication was a key component. |
| 2.15 | CM reported that she had the opportunity to watch the whole video and found it be excellent. CM thanked KO, JoP and GM for presenting to the Board. *KO, JoP and GM left the meeting at this point.* |
| **3** | **Board reflection on patient story and discussion** |
| 3.1 | The Board reflected on the video and further discussion. SH referred to Mrs G's attendance at the Board last summer and praised the learning work undertaken by the service. |
| 3.2 | CM commented on being heartened by the opportunity taken to learn from the complaints received and acknowledged how easy it is to be defensive. |
| 3.3 | FD emphasised the importance of services effectively liaising with carers. |

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| **4** | **Minutes of Last Meeting and action tracker** |
| 4.1 | The minutes of the February meeting were agreed as an accurate record subject to the following amendments:<br>• Item 14.3 - to read '16% of Portsmouth City were not white British and 23% of Southampton City were not white British'.<br>• Item 10.8 – add '£' sign in front of forecast outturn 400K |
| 4.2 | The following actions were confirmed as complete: 641, 642, 643, 631, 633 and 635. |
| 4.3 | Action 631 – Providing newspapers to Brooker<br>After discussion with the League of Friends they have indicated that they would prefer to fund alternatives. JA to discuss with local newspaper outlets other options for funding prior to seeking support from Trust funds. **Action: JA**<br><br>JA also confirmed that the Trust provides both male and female patients with personal items. |
| 4.4 | FD commented on the need for further discussion at the Charitable Funds Committee regarding the supply of newspapers. |
| **5** | **Register of Interest & Declaration of Interests** |
| 5.1 | There were no further updates to report. |
| **6** | **Matters Arising** |
| 6.1 | Item 10.10 – E-Rostering<br>CM requested an update with regards to the E-Rostering risk discussed. The Board was informed that the People and OD Committee receive regular updates which are reported on to the Board. |
| **7** | **Any Other Business** |
| 7.1 | No further business was requested. |
| **8** | **Safety and Quality First and Feedback from Board to Floor Visits** |
| 8.1 | There were no urgent matters of safety to report. |
| 8.2 | Board to Floor Visits<br>Musculoskeletal Service, Portsmouth<br>MT briefed the Board on his recent visit with Jill Young, Primary Care Professional Lead.<br>Differences were noted between Portsmouth and Southampton services, in particular a triage process in Portsmouth to refer urgent concerns. The service was noted as being well received by some GP surgeries.<br>MT highlighted discussions with junior clinical and administrative staff who were appreciative of training opportunities. Admin staff enquired about equal access to extra training and career progression considerations. Continued IT issues were noted however improvements were acknowledged. Safeguarding was discussed openly and was confirmed not to be an issue. |
| 8.3 | CM asked if appraisals are conducted for administrative staff and this was confirmed. |

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| 8.4 | HI informed the Board of discussions held at a career development session during part of a recent senior leadership away day. |
| 8.5 | FD reported on his recent visit to Newtown and Nicholstown surgeries and of positive adjustments made due to facility challenges and language issues. FD highlighted good practice achieved despite receiving no extra resources. **The Board noted the update.** |
| **Strategy & Vision** | |
| **9** | **Chief Executive's Report** |
| 9.1 | SH welcomed CM to her first Board meeting as Trust Chair.<br>CQC<br>SH highlighted the excellent CQC results achieved and suggested that Board members read and reflect on the full report. It was noted that an inspection of the Dental and Sexual Health Services is expected imminently and they are being supported through the Trust preparation programme. |
| 9.2 | Flu Vaccination<br>SH reported on the significant efforts made to achieve the CQUINs target of 75%. An achievement of 73.5% was noted. |
| 9.3 | Veteran Update<br>SA's leadership and passion to engage Solent and partners was acknowledged. A further briefing will be provided during Confidential Board. |
| 9.4 | Operational<br>It was noted that the Executive team are to work with Primary Care to consider PC networks from a geographical and political perspective. It was reported that a paper is being developed for future sharing.<br>Two significant areas for learning identified by the CQC were noted and it was confirmed that actions have been undertaken with the expectation to be embedded by August 2019. |
| 9.5 | System Updates<br>In response to Portsmouth and SE. Hampshire system pressures, it was noted that additional beds have been provided within the Spinnaker gym facilities and assurance was provided that the position is constantly reviewed. |
| 9.7 | TMT<br>SH briefed the Board on matters discussed at the recent TMT meeting, 27th March including progress on the draft Operational Plan, the review of a comprehensive risk report and the Board Assurance Framework.<br>STP and the wider system implications were also discussed.<br>SH explained the risk pyramid detailed in the report. |
| 9.8 | Regarding Health Visiting - JPi reflected on a high profile child death case reviewed in court last year and of his concerns regarding time lags by agencies. SA confirmed that health visitor timescales have been reviewed and the local authority has agreed to 14 days post birth visits. It was confirmed that arrangements will continue to be monitored. FD enquired if targets are universal. DN explained targeting arrangements and highlighted an incident dealt with by a full partnership approach associated with a child death. |

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| 9.9 | SE relayed her thanks for the work that attributed to the CQC results and suggested that the report should be formally reported to the Board as a separate item. It was agreed that a follow up report on progress be presented to the June meeting together with a link to the full report, available on the CQC website. MT confirmed that the report was presented and discussed in detail at the Assurance Committee. |
| 9.10 | The Board discussed the sustainability of the CQC results and future Trust ambitions.<br>Consideration was given on future CQC reporting and discussions with the Board. Current reporting pathways were clarified.<br>AS reminded the Board of a focus on and preparation for the expected CQC visits to Dental Health and Sexual Health. |
| 9.11 | CM briefed the Board on her recent visit to St Mary's new Block B and suggested others take the opportunity to visit.<br>**The Board noted the CEO report and further updates.** |
| **10** | **Performance Report** |
| 10.1 | <u>Care Group – Portsmouth</u><br>SA had no further matters to bring to the Board's attention. |
| 10.2 | <u>Care Group – Southampton</u><br>• DN informed the Board of progression with insulin funding. It was noted that two thirds of actual costs have been recognised.<br>• Ongoing issues with Primary Care workforce were highlighted. It was noted that a new approach is being worked on for consideration.<br>• The Behavioural Change contract was noted to have ended on Friday 29th March. A significant improvement in CAMHs West performance was highlighted.<br>• DN reported that the specialist dental Isle of Wight mobilisation has gone well and waiting lists are improving.<br>• DN highlighted emerging risks with Dental Nursing in the West. |
| 10.3 | <u>Quality</u><br>• JA informed the Board of a review being undertaken by the CQC on Mental Health guidelines.<br>• The Board was informed of work in progress with the Communications Team for a cervical screening campaign to encourage staff.<br>• JA explained the meaning of the new pressure ulcer reference 'unstageable' and highlighted changes to recording measurements from 1st April 2019. JA provided assurance of work in progress to ensure service awareness and understanding of what the measurements are.<br>SH asked how the new approach to pressure ulcer recording will impact on benchmarking. JA confirmed benchmarking will not be possible. It was noted that reporting will start afresh from 1st April and thereafter will be benchmarked month on month. SH requested that further narrative is provided in future reports to explain the position. **Action: JA** |
| 10.4 | The Board was informed that prior to formal approval being sought at a future Board meeting, a briefing will be provided at a Board workshop regarding the Learning Disability Strategy. |

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| 10.5 | JPi enquired as to what the Board needs to consider with regards to pressure ulcer reporting. JA explained the two levels of ulcer reviews and confirmed that the Board will receive reports containing clear narrative on avoidable ulcers that will include learning outcomes. |
| 10.6 | <u>Finance</u><br>• AS informed the Board of his confidence in the Trust achieving the forecast outturn. It was noted that new financial budgets are to be discussed during Confidential Board.<br>• Robust challenge was noted to have been sent to NHS Property Services on Friday 29th March regarding information on rate rebates. Further information is also being sought from local authority. |
| 10.7 | <u>Workforce</u><br>• HI highlighted an improvement in agency spend however explained expected changes to the position due to the need for a medical locum to cover Adult Mental Health retirements and long term sickness. CM asked if a substantive solution was planned and this was confirmed. MT confirmed a recent successful appointment of an overseas medic who is yet to start.<br>• HI reported on discussions held with NHSi regarding agency ceilings and how they are set. A request to consider recalculating was also declined although NHSi have acknowledged the difficulties experienced. MW asked how much of the issue is due to off framework agency spend. HI confirmed that Solent have a higher off framework spend due to the size of the Trust and associated limited buying power. HI commented however on being hopeful of an improvement through the STP Collaborative Bank Programme and a more standardised framework rate.<br>• HI highlighted the need to monitor the increase in absence rates and turnover rates.<br>• HI explained that Solent have a high proportion of staff nearing retirement age compared to acute trusts and therefore need to consider how the nature of roles can be adapted to enable people to work longer. |
| 10.8 | CM enquired about the Trust's achievement at the recent 'Firm in House Recruitment Network' ceremony award. HI confirmed that Solent did not win however were a winner of the Online Recruitment Awards 2019 previously held. |
| 10.9 | <u>Single Oversight Framework (SOF)</u><br>CM highlighted an update required to the year 2016 detailed on the second sentence of section 5.1. The Board considered the SOF and category level. It was agreed to seek to achieve category 1.<br>**The Board received the Performance Report.** |
| **11** | **Staff Survey Results 2018** |
| 11.1 | HI circulated a copy of staff survey results received from Listening into Action, the organisation responsible for the analyses of results. Solent was noted to be the top of the league for Mental Health and Community Trusts which is a credit to teams and staff. |
| 11.2 | HI briefed the Board on the areas where performance has dropped and it was confirmed that discussions are to be arranged with leaders and reported back to the Quality Improvement and Risk Group (QIR). |
| 11.3 | It was noted that the reduction in the Learning and Development score is being addressed and was discussed at the Employee Engagement Sub-Committee. |

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| 11.4 | HI informed the Board that the survey suggests the Trust to be compassionate and inclusive in leadership which is in line with the NHS framework.<br>FD asked if the Trust can be benchmarked against other similar geographies which could give a different perspective of analysis. In response it was confirmed that this could be considered, if feasible and value adding. |
| 11.5 | The Board discussed the scatter map and how the Trust compares to other organisations.<br><br>CM commented on Facilities Management's lower engagement and performance and asked if this is being addressed. HI confirmed there to be an extensive transformation programme in progress supported by HR and the Communications Team and noted there to already be improvements in engagement and response rate as a consequence.<br><br>CM asked if interim pulse checks are carried out in addition to the staff survey. It was confirmed that there are no arrangements in place for FM and Estates. HI reported on involvement in a national group where it has been suggested that a different survey is conducted for these service areas. |
| 11.6 | MW asked if each service have their own actions plans as a result of the survey. HI confirmed this to be the case. **The Board received and noted the report and outcomes.** |
| **12** | **Information Governance Briefing Paper** |
| 12.1 | CM welcomed SB to the meeting.<br>• DN explained IG reporting requirements to the Board. DN reported on the strong performance achieved being a good reflection on the work of SB and the IG Team.<br>• DN highlighted that the Trust is in a better position compared to last year with the training compliance toolkit.<br>• It was noted that the implementation of GDPR regulations has gone well and a favourable opinion has been received from Internal Auditors, PWC.<br>• DN informed the Board of the support of SB within the STP with regards to data sharing at system level within the STP. .<br>• DN highlighted breaches, providing assurance that all have been investigated. Breaches are regularly reviewed by SB and DN and although there has been a slight increase in numbers, no trends have been identified.<br>• The Trust was reported to have a stronger reporting culture which is to be encouraged. |
| 12.2 | • SB confirmed the submission of the toolkit.<br>• IG training was noted as achieving the highest level of compliance of 97%, in the last financial year. SB informed the Board of be-spoke training arranged and of a generally good culture within the organisation of staff wanting to undertake the training.<br>• SB commented on cyber security being a continued risk to the organisation and of the inclusion of social engineering awareness within training.<br>• Freedom of Information and access requests were confirmed as compliant. SB reported on work with the Senior Records Officer to improve coping methods as a result of a significant increase in access requests received. |

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| 12.3 | SE asked if systems are tested by external organisations. SB confirmed that tests are carried out by NHS Digital with a further test due at the end of April. Assurance was provided that no issues were identified during the last penetration test conducted. It was noted that testing is to be reviewed at the ICT Group. |
| 12.4 | SB briefed the Board on a review being undertaken on the retention of data on network drives and of significant work in progress to decommission the 'S' (shared) drive. |
| 12.5 | RC asked if FOI information provided has ever been challenged by the requestor and any referrals subsequently made to the ICO as a consequence.<br>SB informed the board that no referrals have been made to the ICO or adverse publicity experienced as a consequence and that a coordinated approach is made with other NHS Organisations via a Local IG forum, to ensure consistent responses to blanket requests.<br>FD asked if local authorities are included in the network group. SB confirmed this to be the case.<br>**The Board noted the Information Governance Briefing Paper and further update.** |
| **13** | **Report on 18/19 Flu Campaign for Employees** |
| 13.1 | HI informed the Board of the Trust's achievement of 73% against a target of 75%. CM commended the excellent results achieved. |
| 13.2 | SE asked if the Trust is responsible for setting the target. HI clarified that the target is set externally as part of the Trust's CQUIN. An expected target increase for next year was also noted.<br>SE asked how the Trust's achievement compares with other organisations. HI confirmed good Trust performance and it was agreed to circulate a comparison report when available. **Action: HI** |
| 13.3 | JA commented on the low numbers reported within the Estates Team and explained the reluctance of staff to receive the vaccination. |
| 13.4 | SH explained the process of CQUIN targets and consideration being given this year by the Trust. The Board discussed flu vaccines and the compliance achieved.<br>**The Board noted the Flu Campaign for Employees Report.** |
| **Reporting Committees and Governance matters** | |
| **14** | **Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs Update** |
| 14.1 | MT highlighted there to have been a significant turnaround of lead staff within Mental Health however provided assurance of continued competence and support during changes. |
| 14.2 | MT briefed the Board on matters discussed at the Committee.<br>• A low number of breaches of the 24 hour threshold for 136 assessments were noted. The Committee heard how the Trust is considered favourably compared to other mental health providers and AMPs choose to use the Portsmouth 136 suites rather than Southern suites.<br>• The Committee discussed restraint. The prevention of violence and aggression training was also noted as progressing. MT clarified that practitioners now understand levels of intervention, what constitutes restraint and how it is recorded going forward.<br>• A 92 day seclusion was discussed and reasons explained. |

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| 14.3 | MT reminded the Board of the Mental Health Act training, provided by Paul Barber on 30th May and encouraged attendance. |
| 14.4 | SA commented that the transferring of patients to appropriate accommodation can be subject to consideration resulting in wrong decisions sometimes made. DM acknowledged this to be a risk however provided assurance that the Committee will continue to monitor.<br>**The Board noted the Committee exception report.** |
| **15** | **Audit & Risk Committee** |
| 15.1 | JPi reported that the Committee received a Freedom to Speak Up report in order to identify themes. The Committee also acknowledged the tight deadlines for accounts approval.<br>**There were no further material updates to report and the Board noted the Audit and Risk Committee exception report.** |
| **16** | **People and OD Committee** |
| 16.1 | • MW informed the Board of discussions held regarding staff survey results.<br>• The Committee received a request for a decision on nursing apprenticeships. SH confirmed further discussion is to be held at the Executive meeting.<br>• It was agreed that the E-rostering system be included into the workforce plan to address issues. |
| 16.2 | CM referred to the inclusion of EDI sub-committee meeting minutes and suggested they were reported to the POD Committee for reporting onto the Board by exception going forward. The Board supported the suggestion and it was agreed not to provide to future meetings.<br>**The Board noted the POD update and EDI minutes.** |
| **17** | **Finance Committee (non-confidential) Chairs Update** |
| 17.1 | FD informed the Board that the March Committee agreed to the trial of the Social Value Act. Any further matters are to be reported to the Confidential Board. |
| **18** | **Assurance Committee** |
| 18.1 | The exception report was noted and there was nothing further to report. |
| **19** | **Complaints Review Panel** |
| 19.1 | SE confirmed the ratification of the Complaints Policy. There were no further matters to report. |
| **20** | **Charitable Funds Committee Minutes & Chairs update** |
| 20.1 | *No meeting held since last.* FD highlighted that the advert for honorary director is live. |
| **21** | **Governance and Nominations Committee** |
| 21.1 | No meeting held since the last Board. |

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| **22** | **Freedom to Speak Up Quarterly Oversight Meeting – Terms of Reference** |
| 22.1 | JPi informed the Board that the ToRs were reviewed at the last meeting and one final change was agreed to item 8.1 to state that the chair of the group should be a NED and not CEO.<br><br>Following discussion regarding the frequency of the Assurance Committee, it was agreed that the F2SU Lead Guardian will be openly invited to attend each meeting and a representative will attend when not available.<br>**The Board approved the Terms of Reference** |
| **Any other business** | |
| **23** | **Reflections – lessons learnt and living our values** |
| 23.1 | FD commented that whilst he supports the decision not to provide EDI minutes directly to the Board going forward, consideration should be given on reporting and discussions that impact patients and carers.<br><br>The Board discussed pro-active patient and carer engagement and acknowledged the role the Community Engagement Committee has in this respect. |
| 23.2 | SH reflected on the meeting and commented on occasions of sub conversations. SH requested that discipline is maintained to focus on discussions. SH also reminded members to refrain from the use of technology during the meeting. |
| **24** | **Any other business & future agenda items** |
| 24.1 | No further business was discussed and the meeting was closed. |
| **25** | **Close and move to Confidential meeting** |

Item 8

**Board Report – In Public Meeting**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Title of Paper** | **Board to Floor Visit Update** | | | | | | |
| **Author(s)** | Moira Black | **Executive Sponsor** | | Jackie Ardley, Chief Nurse | | | |
| **Link to CQC Key Lines of Enquiry (KLoE)** | Safe | x | Effective | x | Well Led | x | |
| | Responsive | x | Caring | x | | | |
| **Date of Paper** | June 2019 | **Committees presented** | | | | | |
| **Action requested of the Board** | To receive x | | For decision | | | | |
| **Link to BAF risk** | BAF: #57 | Concerning: Quality Governance or N/A | | | | | |

| **Level of assurance** *(tick one)* | Sigificant | | Sufficient | x | Limited | | None | |
|---|---|---|---|---|---|---|---|---|

## Purpose

The purpose of this paper is to provide a brief overview of the Board to Floor visits, in the period October 2018- March 2019.

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

## Background

In Q3 of 2018-2019, Board to Floor visits were undertaken in a different format. This enabled Board members to support the core service teams and units in the pre and post CQC inspection period running concurrently.

All executives visited clinical areas across the organisation to facilitate, enable, and to provide a direct source of access for staff to request information or specific actions needed.

In Q4 2018-2019, there was only one Board to Floor visit out of the three which had been planned. This was due to unavoidable short notice non- availability of members to attend the visits at the planned time. The process of undertaking these visits and necessary attendees has now been reviewed and updated.

**Examples of actions undertaken as a direct result of these visits.**

| Service Line | Actions completed |
|---|---|
| CYP | PAT testing review of all equipment in the Special Schools was undertaken with any out of date /near date equipment serviced in a timely manner. |
| Adults Portsmouth | Jubilee House: internal re-painting was undertaken, and an escalation of "Dump the Junk" took place with the assistance of the Estates Department |
| Adults Southampton | Fridge replacement at the Western Hospital. |
| Mental Health | Repainting of a wall after a patient incident<br><br>New and ongoing ligature assessments followed up by Estates staff to ensure compliance<br><br>Repairs to the roads directly outside Maples unit were undertaken |
| Sexual Health | New (non fabric) chairs supplied to clinics, as requested. |
| Specialist Dental Service | The collection of FFT data was discussed and staff felt that patients are discouraged to complete this due to the amount of forms that need to be filled in during their visits. Although the scores for the team are good, the return rates were low. The potential use of an tablet/IPad in the reception to collect data area was discussed<br><br>As a result of the visit, two Ipads were delivered to the service and are currently in use, with the evaluation expected in the next quarter. |
| Primary Healthcare<br><br>MSK Services<br><br><br><br>Nicololstown Surgery | <br><br>Career progression and access to training opportunities for administrative staff and access to CPD opportunities was raised this has been taken up by service<br><br>Organisation of a deep clean of Nicholstown surgery as an identified action from a compliance visit. |

## Conclusion

These visits have provided welcome opportunities to have open and honest conversations between front-facing staff and Board members, and to describe good work as well as the challenges that services face.

Board members have also described the immense value to these informal but structured visits; it has afforded insight into the daily workload of the services, and an opportunity to effectively escalate any locally-unresolved issues which may support the service.

Going forward, the documentation and scope of these visits has been changed at the request of the services. This has ensured that all types and grades of staff rather than purely clinicians have the opportunity to meet with Board members; this broad spectrum look has ensured that multiple voices are heard and reviewed. The new format has been undertaken in Q1 with great success and will be reported on in the next Board report. The report will take a different format which will include actions and outcomes from visits.

## Board Recommendation

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

Assurance Level

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)

Item 9

# CEO Report – In Public Board

Date: 28th May 2019

Where appropriate we have indicated alignment to our key strategic risks as outlined within the Board Assurance Framework (BAF) and / or our operational risks register.

## Section 1 - Our Performance

This is covered in full within the integrated performance report, however highlights are also provided below under updates from our Care Groups.

## Section 2 – Strategic Update

### Quality Matters

#### Nursing Conference 2019


On Friday 10th May 2019 we celebrated nursing by holding our Nursing Conference event *'Partnering with patients: Shaping the nursing workforce in response to the changing nature of healthcare'* where keynote speakers including Andrea Sutcliffe, CEO Nursing and Midwifery Council presented and service users shared their stories about how Solent staff made a difference. We also held our inaugural 'Nurse of the Year Awards' where we received 47 nominations from colleagues, patients and carers - which were shortlisted to 11. Our worthy winners were:

- Runner up: Emma Ives – Diabetes Nurse
- Runner up: Claire Campbell – Child and Adolescent Mental Health Service Nurse
- Winner: Vanessa Bull – Learning Disability Nurse

I was so proud and humbled by the stories and passion shared by colleagues and was delighted to be able to celebrate the nursing profession in recognition of International Nurses Day.

Our celebrations were also acknowledged within the Nursing Times https://www.nursingtimes.net/news/workforce/celebrating-international-nurses-day-in-every-which-way/7028973.article

#### Falsified Medicines Directive (FMD)

We are currently unable to meet the requirements of the Falsified Medicines Directive (FMD) which came into force from February this year, due to the necessary systems not being in place nationally - most prescribed medication packs do not yet have the barcodes which require scanning and the software solution for pharmacy systems is not yet ready. Once these matters have been resolved, we will move forward at pace towards implementation.

### Wheelchair Update

The Trust continues to work with collaboratively with Clinical Commissioning Groups (CCG's) and Hampshire Wheelchair Services (Millbrook) to keep a focus on the issues for patients and families in relation to the provision of wheelchairs. A review of all patients on the Trusts database has been undertaken which has been cross referenced with Millbrook data and validated to ensure that all patients within our services are on the waiting lists. This will support waiting list management and we have offered our support to any CCG led waiting list initiatives. (BAF#63 – Indirect Commercial Relationships)

## Workforce Matters

### NHS Pensions Scheme

There is a significant workforce issue for members of the NHS Pension Scheme who are affected by the annual or lifetime allowances concerning their pension savings for those in a registered pension scheme within the UK. Changes in the new pensions' tax regime have resulted in a number of workforce risks including; requests for reduced contractual hours, as well as reluctance to take on additional work or management responsibilities. Whilst this has not caused an issue for us at Solent to date, we are working closely with system partners on possible solutions, consulting with NHS Employers and engaging with NHSI/E. (BAF#55 – Workforce Sustainability)

## Capital update

The new NHSE/I Chief Financial Officer wrote to all Trusts on 7th May 2019 to ask for support in helping to collectively manage capital expenditure across the NHS in 2019/20 as the plans submitted in April show planned spend being in excess of the national limit.

We were asked to review our plans for affordability and robustness and resubmit our plans on 15th May; it was also made explicit that revised capital plans could not be greater than those previously submitted. As we do have sufficient cash for the schemes proposed and the plans are either related to key risks within our backlog maintenance programme or are required for transformation purposes, and have been through a rigorous governance process, we will not be revising downwards our plans. However, given the national picture, progress and the approval of the Outline Business Case (OBC) for the Southampton Bed Optimisation Project may be delayed, despite being approved as part of the Wave 4 Capital Schemes; this scheme is predicated on receiving national Public Dividend Capital (PDC).

(BAF#53 – Financial Sustainability and #27 - Estates)

# Section 3 - Operational Matters

## Southampton and County Services

### Adults Southampton

As previously reported, in the Southampton city area we have seen a significant rise in patients needing the support of our community teams with administering insulin. Working alongside our Commissioner colleagues some additional resource has been allocated to this area, sufficient to cover around two thirds of the growth in community workload, while a cross system group has been established to redesign the diabetes pathway in order to formulate new and sustainable approaches to managing this condition. Whilst this does generate financial risk, the service remains safe. (BAF#59 – Business as Usual: Demand and Capacity)

Domiciliary Phlebotomy service is now up to date on referrals, have a fully recruited team and have also fully adopted electronic patient records – as consequence the contract performance notice has been lifted. (BAF#59 – Business as Usual: Demand and Capacity)

### Primary Care / MPP service line

Sustainability within our primary care workforce and GPs in particular remains an on-going challenge. With the support of our COO (Southampton), our primary care transformation team have formulated an approach aimed at internal re-organisation and transformation to augment and deliver primary care services into the future this

includes how the Solent GP practice in Southampton will integrate and operate within the emergent PCN structure. The service remains safe. (BAF#55 – Workforce Sustainability)

### Children and Families (West)

Given the continued estate challenges with the Eastleigh and Southern Parishes geography, the estates team continue to investigate suitable alternative locations, and are now exploring a strong potential option. In the meantime, we continue to work in interim sites for group work locations in both Chandlers Ford and Hedge End and continue to lack adequate estate for clinical work. (BAF #27 – Estates)

The previously reported recovery of performance for our Child and Adolescent Mental Health Service (CAMHS) West service continues; there remains work to do in this important area to ensure sustainability and resilience, with some additional non recurrent investment coming to an end in early summer, the impact of which we are working hard to mitigate. (BAF#59 – Business as Usual: Demand and Capacity)

### Sexual Health Services

We are actively seeking a new location for service delivery in both Winchester and Eastleigh due to the current estate being suboptimal. We continue to work in these locations albeit the facilities are not as good as we would wish for staff or patients. (BAF#59 – Business as Usual: Demand and Capacity and BAF #27 - Estates)

Quality and operational outcomes across our Sexual Health services continue to indicate an extremely high standard of service delivery, but the service does currently face a significant financial deficit which necessitates an ambitious efficiency plan without impacting on delivery. (BAF#53 – Financial Sustainability)

## Portsmouth and SE Hampshire Care Group

### Appointment of Deputy COO and Director of Transition

Following a process of assessment and interview, we have appointed Suzannah Rosenberg as Deputy COO, and Director of Transition to the PSEH Care Group (this latter role in recognition that all our roles and organisations are evolving and that there will be further transition in the city as a result).
Suzannah will continue to lead on mental health commissioning for the city and as SRO for the Integrated Care Partnership Mental Health Programme. This is an exciting and innovative approach that further removes borders between organisations and functions and will support the approach we would wish to see increasingly in the Integrated Care Partnership.

### Portsmouth Adults

Jubilee House – An Internal Quality Review (IQR) was conducted at Jubilee House on 4th April 2019. A number of areas of improvement were identified and an Improvement action plan put in place, over seen by the Chief Nurse. Focused leadership and improvement continues in Jubilee House alongside a transformation programme examining options for the future provision of intermediate care services.
(BAF#57 – Quality Governance, Safety and Professional Standards)

Speech And Language Therapy (SLT) waiting times - increased referrals of non-urgent cases from care homes has resulted in a demand capacity imbalance and 13 non urgent cases waiting over 18 weeks.
All new referrals are sent an acknowledgment letter / choose and book letter following triage which specifically says to contact the service if there are any new concerns in the interim to being seen. A copy of the letter also goes to the referrer so they can also make contact if concerned. Of the 13 long waiters only 2 are waiting for an appointment. The Service is currently piloting a care home project to improve competency within care/homes with the aim of reducing referral rates and release clinical capacity to improve wait time. (BAF#59 – Business as Usual: Demand and Capacity)

## Portsmouth Mental Health

Information Governance (IG) Breaches - Talking Change/Improving Access to Psychological Therapies (IAPT) service has experienced an increased rate of IG breaches over the past 18 months. Although incidents in isolation have a low impact criterion there is a concern that collectively learning had not been implemented.
Consequently the service has undertaken a series of training sessions and IG colleagues have conducted an assessment of working practice on site. Improvements to administration processes and work place environment are underway to reduce the risk.

Vacancies and agency (M1 Position)
There are currently 10 Whole Time Equivalents (WTE) band 5 nurse vacancies in inpatient services. The majority of these vacancies remain filled with block booked Trust inducted agency staff.
3.8 WTE's have been recruited although most do not start until September. The recruitment campaign continues. Agency spend related to manage more acutely ill service users has been a significant factor in cost pressures. The service is ensuring clear monitoring of acuity of patients in the year ahead to inform financial discussions with commissioners
(BAF#55 – Workforce Sustainability)

Medical Staffing - The service continues to experience pressure in medical staffing including both trainees and consultant staffing. Mitigation is in place albeit relying on locums and consultants stepping down to cover rotas. Engagement with medical staff to fund appropriate mitigation continues.
(BAF#55 – Workforce Sustainability)

Waiting time pressures

- Psychological Therapy- The average waiting time in the past quarter is 29 weeks with some waiting 44 weeks for trauma services. Service users have access to interim general (rather than specialist) support and cases are reviewed for risk on a weekly basis. This is not a new situation and has been discussed with commissioners over some time. It is agreed that a further options paper is now produced to be reviewed by commissioners and providers in the context of prioritising spend in the city.
- OPMH community- Referrals are varying widely currently- although March was very high, the numbers have reduced again. We are actively trying to accommodate patients waiting over 6 weeks for a variety of interventions including assessment - all are triaged and prioritised so we believe the risk to be low. Service users are being allocated to any available gaps (rather than keeping to locality) and also are being seen at home where appropriate. We expect the position to improve.

(BAF#59 – Business as Usual: Demand and Capacity)

## Children and Families (East)

COAST/Children's Community Nursing (CCN) - Recent staffing issues have necessitated urgent action to keep the service safe and staff wellbeing protected. The original plan to reduce operating hours has been overtaken by a need to close the service for the next few months. Discussions with commissioners, referral agencies and the Acute Trust have happened and the impact will be monitored as part of a service redesign focused on population need and workforce sustainability. There is acknowledgement by stakeholders of the unavoidable decision that needed to be made. The most likely impact is an increase in Emergency Department attendances and calls to the GP triage service, both of which will be monitored.
Access to Services:
Waits for some services in Children and families Care Group are longer than we would wish or is deemed best practice. Full detail is provided in the Performance Report in this Board pack. In each case actions are being taken to mitigate the risk to Children and their families and to reduce the wait time itself.
In summary:

- Musculoskeletal (MSK) 0-12- the service is unable to see all children on urgent case load and patients are breaching the routine waiting list. Service are completing capacity / demand analysis which is indicating that

demand far exceeds capacity.

- Child and Adolescent Mental Health Service (CAMHs) waits -there is an increased demand for the service with a reduction in the trained workforce. Focussed work on remodelling the service delivery in both cities is underway.
- 0-19- Health Visitors who are undertaking the new model of ECHO delivery are required to support the Universal delivery. However the Health Visitor workforce is currently reduced due to short term staff sickness, and some vacancies. Plans to mitigate this risk include revision of the Healthy child programme offer, transformation planning processes to remodel the universal offer, and, wellbeing support for staff.
- Children paediatric medical service (CPMS) - Waiting time pressures continue resulting in looked after children not receiving their initial or review health assessments in a timely way. Action planning to address continues with a focus on improved processes, and skill mix review of clinical staff to improve capacity. It should be noted that the capacity of the medical staff is not the main cause for breaching the statutory time requirements. External factors including late notifications and out of area placements are significant factors.
- CAMHS Neurodevelopmental waiting list- Continued high referral rates have caused an ongoing challenge in meeting the demand for specialist neurodevelopmental (ND) assessments. The numbers of children now on the waiting list is 190 with 137 over 18 weeks and small numbers waiting 52 weeks. The service have now allocated additional dedicated capacity to ND assessment and modified their access pathway as an initiative to clear the backlog and create a more sustainable service, although this may take up to 12 months to clear the waiting list.

(BAF#59 – Business as Usual: Demand and Capacity)

## Finance

Subject to audit, the Trust achieved an adjusted surplus for 2018/19 of £1.4m, following an additional £2.0m of Provider Support Funding. This compares to a planned deficit of £1.0m, meaning that we improved our underlying position by £0.4m. This is an excellent achievement, particularly in the context of significant cost pressures across the health economy.

The month 1 results show a deficit of £0.6m, which is marginally higher than plan. The deficit in month 1 has been primarily caused by the one-off payment of £0.4m in additional salary to those at the top of salary bands.
(BAF#53 – Financial Sustainability)

## Estates

The redevelopment at St Mary's continues to be on track.

The Outline Business Case for the Southampton Bed Optimisation remains with NHS Improvement for approval. This case depends on receiving PDC.
(BAF #27 - Estates)

## ICT

The Solent ICT Team are working to enhance the Trust's ICT solution over the next 18 months with the following initiatives planned:

- Upgrade our main external network data connections to the latest Health Service and Care Network (HSCN) by September 2019, which will provide much greater resilience and bandwidth across our estate
- Deploy our new flexible and more efficient Managed Print Service across the organisation by September 2019
- Upgrade the operating system on our computers from Microsoft Windows 7 to Windows 10 by February 2020, and
- Upgrade our version of Microsoft Office to Office 365 by September 2020.

## Complaints and Serious Incidents

### Complaints

In March 2019 the Trust received 15 formal complaints and 19 in April (the increase is within a normal variation) however, we will be moving to the use of a Statistical Process Control Report from next month to support trend analysis and learning. The complaints are broken down by service line within the Chief Nurse commentary of the Board Performance Report.

Similar to previous months the themes related to concerns about quality of clinical care received, concerns regarding communication, concerns regarding staff attitude, access to appointments and arrangements to support safe discharge.

### Serious Incidents

During March six serious incident investigations were registered and three in April. The categories are detailed below and further detail can again, be found within the Chief Nurse commentary of the Board Performance Report.

| Category | March numbers | April Numbers |
|---|---|---|
| Unexpected Death | 1 | 0 |
| Pressure Ulcer | 3 | 0 |
| Medication Error | 1 | 1 |
| Safeguarding Vulnerable Adults | 1 | 1 |
| Sub- Optimal Care of the Deteriorating Patient | 0 | 1 |

# Section 4 - Systems Update

## Portsmouth and South-East Hampshire Systems update

System OPEL status fluctuated during March and April, with Portsmouth Hospitals Trust (PHT) being at OPEL 4 on five occasions during this time; although this was generally resolved within 2-3 days. The immediate cause of escalation was fluctuations in demand – especially Ambulance activity, which showed a greater rise in South East Hants than elsewhere in the South Central region and increases in social care delays.

This much lower level of OPEL 4 days overall in Winter 18/19 appears to be related to the provision of thirty additional care spaces by increasing therapy and nursing staffing in the Portsmouth Rehabilitation and Reablement Team (PRRT), the continuation of the Community End of Life Team and additional transitional home care capacity. Jubilee and Brooker Units also created nine additional “surge” beds, by reducing their length of stay.

The focus of pathway ‘flow’ improvements is now switching to admission avoidance schemes as system leaders participate in the “Humanising Healthcare” population health programme, which aims to identify the “vital few” patients who are the biggest users of urgent and emergency care and design interventions to prevent their need for frequent admissions.

Southern Health NHS Foundation Trust and Solent held a joint Multi-agency Discharge Event (MADE) on May 2nd – with the theme of reducing Delayed Transfers of Care (DTOCs) in Acute Mental Healthcare. This contributes to the system plans to eliminate out of area mental health placements and create a common mental health bed base in PSEH.

## Hampshire & Isle of Wight Sustainability & Transformation Partnership (HIOW STP)

At the last Executive Delivery Group of the STP a number matters were considered:

A CEO led working group of the HIOW STP has produced a ‘Roadmap’ for the transition from STP to the creation of an Integrated Care System (ICS) by April 2021 in line with expectations of the NHS Long Term Plan.

### Digital Innovation Hub (DIH)

On Tuesday 7 May 2019 the national Digital Innovation Hub expressions of interest process was launched. Building on the strong tradition of research and digital development in Wessex, the STP is intending to bid. Solent CEO is a member of the DIH working group, which is Chaired by UHSFT CEO Paula Head.

### Hampshire and Isle of Wight Long Term Strategic Delivery Plan

We still await the publication of the national guidance on LTP delivery plans (in accordance with the framework within the NHS Ten Year plan) but anticipate this before the end of May 2019.

### Vision and Values

It was agreed on the importance of refreshing the STP Vision as part of the reset, strategy development and ICS roadmap. A working group will be established to help develop the process by which a vision is created and vision, values and key success measures for the ICS are defined.

### Transforming Workforce

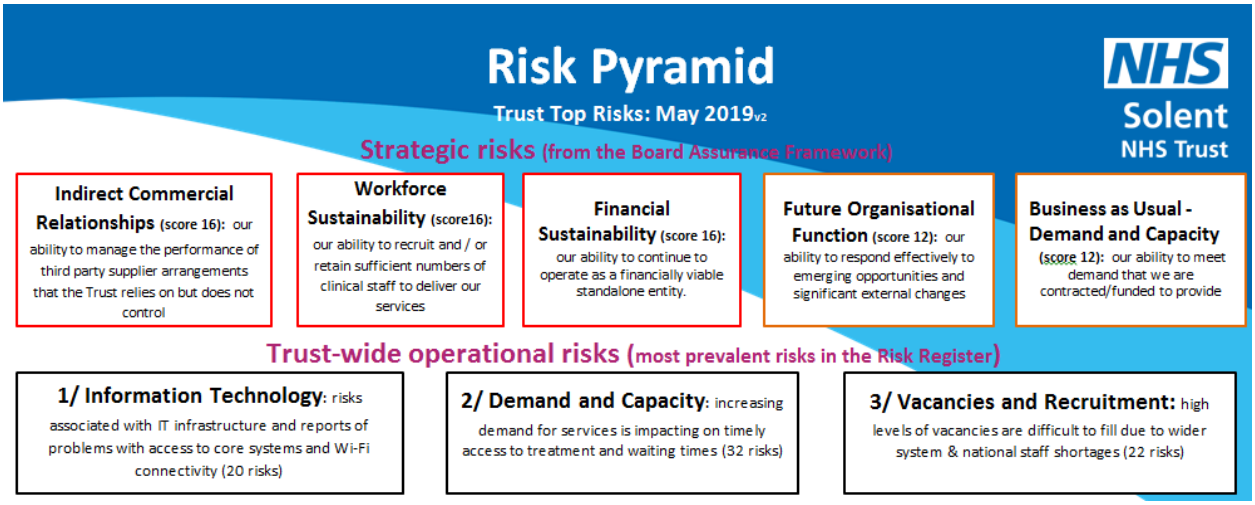
Sue Harriman CEO Lead Workforce, Sandra Grant Programme Lead Workforce and Ruth Monger Health Education Wessex presented the workforce transformation programme. Areas of focus for pan-HIOW workforce transformation in 2019/20 were considered with further debate ad confirmation of the priorities scheduled for the June 2019 Executive Delivery Group (EDG).

## Section 5 – Update from Trust Management Team (TMT) meeting

A verbal summary of the business conducted at the 29th May 2019 meeting will be provided at the Board meeting.

## Section 6 – Board Assurance Framework and Operation Risk Register

As summarised within our Risk Pyramid our top strategic risks, as captured within our Board Assurance Framework (BAF) and top operational risks are as follows:




Regarding the operational risk register, items of note are:

1. Three Directorates continue to have wheelchairs as one of their top 3 risks in the risk pyramid (Adults Portsmouth, Adults Southampton and Child & Family Services).
2. The risk associated with the Hampshire Liaison & Diversion Service staffing has been removed as the service has transferred to another Trust.

The risk register is a dynamic tool used daily by the service lines.

# Section 7 – Other matters to report

## Sealings and signings

### Sealings

| Reference | Description |
|---|---|
| 74 | Sale transfer – Oakdene |
| 75 | Adelphi House Lease renewal |

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

| Reference | Commissioner | Description |
|---|---|---|
| CPRO_0155 | NHS Portsmouth CCG | Main CCG contract for Portsmouth, 2019/2020 – new contract |
| CPUR_0009 | Solent Orthotic Services | Provision of Paediatric Orthotics to Children in special schools and community – new contract |
| Ecm_8748 | Southampton CCG | Variation to merge our Current Alternative Provider Medical Services Contracts (Portswood, Adelaide, Nicholstown surgeries) to become one surgery "Solent GP Surgery" |
| CPRO_0155 | NHS Portsmouth CCG | Main CCG contract for Portsmouth 2018/19 – variation to revise the finances |
| CPRO_0004 | Portsmouth Hospitals NHS Trust | P2P agreement, variation to include the provision of a band 5 theatre recovery nurse |

Item 10

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Presentation to** | X | In Public Board Meeting | | Confidential Board Meeting | | | | | |
| **Title of Paper** | Trust Board Performance Report – April 2019 | | | | | | | | |
| **Author(s)** | Alasdair Snell | | | **Executive Sponsor** | Andrew Strevens | | | | |
| **Date of Paper** | 24/05/2019 | | | **Committees presented** | TMT | | | | |
| **Link to CQC Key Lines of Enquiry (KLoE)** | X | Safe | X | Effective | X | Caring | X | Responsive | X | Well Led |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | | **W2** Vision & Strategy | | **W3** Culture | | **W4** Roles & Responsibilities | | |
| | **W5** Risks and Performance | | **W6** Information | X | **W7** Engagement | | **W8** Learning, Improvt & innovation | | |
| **Action requested of the Board** | X | **To receive** | | **For decision** | | | | | |
| **Link to BAF risk** | BAF #59 concerning Demand and Capacity | | | | | | | | |
| **Level of assurance** *(tick one)* | Sigificant | | Sufficient | X | Limited | | None | | |

The purpose of this paper is to provide a bi-monthly overview of performance against the NHS Improvement Single Oversight Framework, key contractual requirements, business plan and operational indicators of quality, our workforce, finance and service hotspots.

**Board Recommendation**

The Board is asked to receive the report.

**Assurance Level**

Concerning the overall level of assurance the Board is asked to consider whether this paper provides: sufficient assurance.

# Table of Contents

# 1.1 Business Plan End of Year Report 2018/19

## Corporate Portfolio Management Office (CPMO)

By Aaron Scott and Matthew Rowsell

*Portfolio Support and Assurance for Solent NHS Trust*

# 1. Executive Summary

The 2018/19 business year for Solent NHS Trust ran a total of 61 Business Objectives across 14 Service Lines and Corporate Teams with over 300 milestones in total for completion. All Business Objectives were focussed on 3 core Trust priorities of providing great care, being a great place to work and delivering great value for money, whilst largely contributing to the delivery of the five-year Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) and the Portsmouth Integrated Care Partnership (ICP).

**Provide great care**

Rated good overall by CQC and outstanding for caring.

**Great place to work**

Rated first in class by Listening into Action for staff engagement.

**Deliver great value for money**

Delivered a £1.4m surplus.

In relation to the detailed business plans, 54% of objectives have successfully been achieved in full.

# 2. Quarter 4 Summary

## 2.1 Business Objective Progress

Business Objectives are given a colour status of either in order to provide a quick reference to the health of the objective. At the start of 2018/19, it was projected that 61 Business Objectives should be achieved by the end of the year. As a result, this means that there are no green objectives as all objectives are either completed (blue) or outstanding (red or amber).

- **14 Objectives (23%)** are highlighted as **amber**, indicating that they have at least 1 milestone outstanding at year-end, however this delay will not be detrimental to the overall success of the objective.
- **14 Objectives (23%)** are currently rated as **red**. This means that the objective has 1 or more milestones outstanding that have a significant impact on achieving the intended outcomes of the objective.
- **33 Objectives (54%)** have successfully met all their milestones and the Business Objectives are now complete (shown as **blue** below).

*Figure 1: An overview of the transition of RAGs from Quarter 3 to Quarter 4 for 2018/19:*


The non-achievement of 14 objectives shown as red needs to be taken into the context of a challenging operational environment.

## 2.2 Quarter 4 Successes

A total of 33 Business Objectives were completed in 2018/19, 27 of which were completed in Quarter 4. The following objectives are key highlights from 2018/19:

**Adults Portsmouth –** The team aimed to support the Portsmouth Primary Care Alliance (PPCA) in the delivery of a 24/7 Integrated Primary Care Service following the successful award of a 2 year contract. Solent has successfully provided the required support to the PPCA over the past year by developing clear pathways and processes for directing appropriate care to integrate our services. The new service encompasses Acute Visiting, Enhanced Access and Out of Hours services and aims to reduce avoidable hospital admissions and inappropriate attendances whilst improving patient experience in Primary Care. The improved infrastructure with PPCA and Multispeciality Community Provider (MCP) Programme provides the platform for development of the Portsmouth Intermediate Care Service (PICS); a medium-term multifaceted strategy identified in 2019/20 Business Objectives.

**Adults Southampton –** A key objective for Adults Southampton was to reduce admissions and Delayed Transfers of Care (DTOCs). Throughout the year the service have worked closely with local partners to support system integration by aligning discharge processes and adopting new models of care to support patient pathways and release system pressures. Success of this has been widely received and also resulted in Adults Southampton achieving positive feedback in the Partner Organisation report for University Hospital Southampton Complex Patient Discharges.

**Child and Family Services** – As a way of improving patient experience where services are delivered by more than one provider at the same, the Child and Family service line 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. The service has also made progress through engaging external researchers to support evaluation and research into the success of this programme.

**Sexual Health Services –** To help manage the increasing demand for Sexual Health Services, a Webchat facility was created, providing 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 about 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. Analysis has shown that the majority of people have had all questions answered fully when using the help query button. The team have developed sophisticated answers to ensure they can capture as much support for clients as possible. This therefore means that clients have not needed to speak to anyone in service further and the feedback has been very positive.

**Specialist Dental Services –** Due to a number of forthcoming retirements, the service had planned to deliver a fit for purpose workforce model by the end of March 2019. This Business Objective was successfully completed ahead of schedule.

A recent successful rolling recruitment programme has ensured that the service have enough dentists to deliver the contracted activity and has enabled the service to develop existing staff to step in to future retirement posts. Staff have also been between sites to ensure relevant and safe skill mix in all areas. The rolling recruitment programme will continue going forwards in 2019/20.

**Estates and Facilities** - Relationships with corporate and service colleagues further improved in the period with Estates becoming more embedded across all areas through increased engagement. This was evidenced through the business planning process for 2019/20 where the Estates and Facilities objectives were seen to clearly align with those of our corporate and service colleagues with no surprises to the Estates teams from their business planning presentations, demonstrating the benefit of the peer-to-peer engagement that has been put in place across the Estates teams.

**Finance and Performance –** To ensure that reporting across our quality, financial, workforce and clinical record systems is consistent, aligned and enables triangulation; a significant trust-wide project to re-map our infrastructure's hierarchies was undertaken. Now this has been completed, there is a robust change control process in place to ensure that we can keep all our Trust systems up to date and aligned to the Trust's structures. As a consequential benefit, this will set the foundations for the Data Integration Project 2019/20, to combine and report against multiple data sources through our developing business intelligence system.

**ICT –** To ensure the Trust was compliant with the introduction of the General Data Protection Regulation (GDPR) by May 2018, the Information Governance team successfully implemented a GDPR Privacy by Design Culture, which included implementation of the new legislation within policy and practice. Over 95% of staff have been trained in this new legislation, with continuous awareness being raised across the Trust and plans for continuous reviews in place. As a result GDPR is a now a normal part of organisational culture at Solent.

**People and Organisational Development –** A key aim for 2018/19 was to increase staffing capacity through effective workforce planning, talent attraction, development and retention. The identified actions for this year were successfully implemented and there are signs of positive improvement and outcomes. Examples of these are a reduction in nursing turnover from 18% in M1 to 14.4% at the end of M12, consistent management of sickness absence under the 5% target; ending the year on 4.3%, and our vacancy rate has reduced from 5.6% to 4.3%. The 2018 NHS Staff Survey results improved from 2017, participation in the survey increased by 3%, and the engagement score increased from 7.1 in 2017 to 7.3 in 2018. Staffing capacity will continue to be an on-going challenge in relation to hard to recruit posts and general supply of the community and mental health workforce, the competitive labour market and the potential impact of Brexit, so this will feature as a new objective for 2019/20.

**Research and Improvement –** In order to increase access to research, the Care Home Research Partnership model was expanded into the Community Research Partnership model. This gives a collaborative framework for research across care homes, dental practices, schools, colleges and a number of community organisations. This has enabled access to research and quality improvement training for different professional groups and service users, whilst extending a reach to seldom heard groups. The success of this model has also enabled work across boundaries and ultimately formed the basis of Solent's winning entry at the Nursing Times Awards in October 2018.

## 2.3 Quarter 4 Challenges

At the end of Quarter 4, there were 14 Business Objectives rated as amber:


**1. Adults Southampton –** Create a workforce that is fit for the future with initiatives including skill mix, estates rationalisation and career development opportunities:

There are two milestones outstanding which were part of a two year plan, both of which should be addressed in 2019/20 objectives.

Neuro is currently undergoing a comprehensive service review with commissioners and have employed a senior matron to oversee the work to ensure this objective is successfully completed in 2019/20.

**2. Commercial –** Improve commercial and transformational, capabilities, capacities and processes within the Commercial Team and across the Trust:

The Commercial Team completed a significant review of key processes to ensure improved commercial capabilities, capacities and processes however a small number of milestones are yet to be completed with this objective.

Documentation to support functional toolkits for Business cases, contracts management, tender process and project management have been developed and are ready to be uploaded to SolNet for access for all Trust staff. Final training sessions for these toolkits have been booked for early June 2019 which will finalise the documentation and complete these milestone tasks.

**3. Estates and Facilities –** Align and deliver our Estate rationalisation plan with the Solent Estates strategy, the CCG Estate plans and the STP Estate requirements to deliver savings and improve asset utilisation:

Due to delays with the landlord for Adelaide Health Centre providing Heads of Terms for properties that Solent were not able to agree to, Community Health Partnerships were unable to move forward with the reconfiguration scheme for Adelaide Health Centre in accordance with the proposed programme.

Following discussions, the landlord is preparing revised Heads of Terms for Solent to agree. It is anticipated that the updated programme will be finalised by the end of May 2019 to enable this project to move forward in 2019/20.

**4. Estates and Facilities –** Deliver a robust, effective and value for money Facilities Management (FM) Service through the continuance of our FM transformation project ensuring we deliver on quality:

Due to delays with reaching final agreement to the proposed transformation changes the final plan has only recently been agreed which has had an impact on areas of FM review. Following uncertainty within the outsourced provider market, a decision was taken by the Trust Board to withdraw from the procurement exercise to outsource the catering service.

The patient and retail catering and hostess services will remain within Solent but will undergo a service transformation in line with Plan 'B'. The patient and hostess changes are expected to be in place by 1 July 2019.

**5. Finance and Performance –** Provide robust detailed financial information, linked to activity and workforce in collaboration with Services, in order to support our contractual and clinical requirements:

This objective has progressed well in parts with a fully costed workforce plan being produced. Although some service lines have workforce plans linked to activity, others are still in progress.

The Data Improvement and Electronic Staff Record Position Control projects that are now running will help enable all service lines to progress this during the 2019/20 financial year.

**6. ICT –** Introduce technology to enable service integration and innovation across the Trust and to improve mobile working:

Two milestones were outstanding with this objective. There was a delay with achieving enabled access for the Health and Social Care Wide Area (HSCN) Network Infrastructure due to changes with BT lead times and the managed print solution project was also delayed.

Both milestones have been reviewed and will be picked up as part of 2019/20 Business Objectives.

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

Two elements of this objective remain outstanding. There is a major issue concerning the increased acuity and there is no current agreement with commissioners around how to fund this.

Some principles for agreeing this have been outlined in the 2019/20 contract negotiations but this remains a risk. Principles have been agreed for the Crisis pathway workforce development but governance arrangements need to be agreed.

**8. People and Organisational Development –** Increase our brand presence and strengthen our reputation as a provider and employer of choice using creative and digital marketing solutions aligned to the Trust's vision and values:

The revised Solent NHS Trust corporate website went live in May 2019. The final task remaining against this objective is to integrate service microsites into the new Solent website which was delayed.

During the year we increased our brand presence through more external communications, including more public relations and social media activity, linked to the Solent Story, keeping more people safe and well at home and making difference. The team will build upon this work during 2019/20, developing our relationships and exploring more opportunities to increase reach.

**9. Primary Care Services –** Review our service model delivery to ensure that our pathways deliver safe, effective care and provide good value for money:

The objective has not yet completed as following changes in approaches, timelines have extended and there has been complexity around financials which has meant that resolution wasn't possible during the 2018/19 financial year.

Good progress against the majority of milestones was made in 2018/19; the outstanding issues will be picked up as part of the 2019/20 Business Objectives.

**10. Primary Care Services –** Put our people first, investigating and implementing an innovative approach to retaining and developing our people/our workforce:

There are two milestones outstanding against this objective. Due to gaps in the management structure this project did not progress as originally anticipated.

The outstanding milestones will be carried forward under the 2019/20 Business Plan for Primary Care Services and forms part of the workforce plan.

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

Part of this objective will be carried over into next financial year under the improving technology to reduce demand objective for Primary Care Services.

The Musculoskeletal (MSK), Pain and Podiatry website development is in progress as part of the Trust development work. Regarding connectivity, most key sites have experienced improved IT coverage, although issues remain in smaller sites, this represents a smaller proportion of activity.

**12. Sexual Health Services –** Focus on the implementation of an effective Chlamydia Pathway and partner notification system in line with the commissioning intentions paper and develop a click and collect service:

The Chlamydia Pathway pilot will not be carried out as originally intended as the scope of the project has now evolved into a more advanced offering. The programme will be rolled out once IT issues have been finalised.

The service identified when developing the 'Treatment by Post' offer that it would be better to work on the whole patient health record offer to provide an even better service for our clients, including partner notification, cancellation of appointments, Treatment by Post and access to their own health record including results.

**13. Specialist Dental Services –** Ensure that the service provides 'Accessible Information' communication tools to meet the accessible information standard 2016 for patients, carers and parents:

Providing Accessible Information where English is not the first language, remains outstanding. Due to complexity, this milestone is still underway and expected to be completed by August 2019.

The service has ensured that the necessary accessible information tools are available in each of our clinics with accessible information champions embedded in each locality to provide support to patients and staff.

**14. Specialist Dental Services –** Review finances for our current NHSE contract in line with the Commissioning Intentions paper to ensure appropriate contracts for aspects of the service are in place, whilst ensuring that changing service demographics are considered:

Issues with piloting a training package for General Dental Practitioners has meant that this objective will not deliver the additional income generation to planned timelines.

Following a successful revised pilot, a training manual has now been produced and is awaiting print. This objective should now be completed during Quarter 1 for 2019/20.

## 2.4 Quarter 4 Issues

The following 14 objectives have been escalated to red as they did not achieve the intended outcome by March 2019 as planned and experienced significant issues:


**1. Adults Portsmouth** – Define and agree an 'out of hospital' community care model with system partners:

The process of integration is proceeding and alongside the development of IT solutions. As a result of social care only recently transferred to SystmOne, further time is needed (possibly 12 months) before a Single Point of Access (SPA) or similar solution could be implemented.

**2. Adults Portsmouth** – Develop and roll out the Enhanced Care Home Project at scale to include all city wide care homes in partnership with GP's and Commissioners:

The enhanced care home project has had very a significant impact on the in-scope care homes. Further roll out was put on hold pending verification of the impact. This has now been fully analysed and the MCP programme has now approved roll out during 2019/20.

**3. Adults Portsmouth** – Review, develop and implement a Long Term Conditions Hubs model to include Diabetes and Chronic Obstructive Pulmonary Disease:

This is an important new partnership between the Primary Care Alliance and Solent NHS Trust and it has been important to ensure this innovation has a strong business case and governance which has taken longer than expected. It was identified during business case development that the original location proposed for the Hub did not have capacity and another venue was required. Work has been continuing to implement the service and four interlinked workstreams are now critical for achieving this objective (Estates, IT, Governance and Human Resources). It is now anticipated that the service should be able to go live in early summer of 2019.

**4. Child and Family** – Service Line infrastructure developments will support the delivery of our key Business Objectives by March 2019:

The Child and Family team were unable to complete this objective due to the difficulties in developing a usable business intelligence tool for our service managers to use. A number of interconnected strategies are in play to provide this outcome, which is required by all service lines, and therefore should come to fruition within the next year.

**5. Child and Family** – There will be an improved staff and patient experience of the delivery of children's services healthcare by March 2019:

Despite very significant service pressures the Child and Family team achieved the maintenance of very high patient satisfaction metrics and a continued gradual improvement in staff satisfaction metrics. However, the high target set for staff satisfaction was not met. Levels of staff satisfaction in Solent's own services, in common with services around the country, are very difficult to preserve in the

face of sustained high service pressure. Despite not being a specific target for next year, staff satisfaction and staff well-being remain in the top three areas of focus for the Child and Family team going forward.

**6. Estates and Facilities** – Implement monthly service line reporting of all Service Lines providing up to date Management Information on Solent Assets for those areas by March 2019:

Due to the challenges with finalising data, a service line reporting project has been included as a milestone within 2019/20 Business Objectives. A pilot project will be undertaken with the Adults Southampton team for completion by September 2019, with an expectation to roll out to other services by the end of March 2020.

**7. Finance and Performance** – Collaborate within the STP and wider Mental Health and Community partners to ensure we are getting Value for Money in line with the Carter recommendations and the Department of Health Future Operating Model:

This objective experienced significant challenges due to resource and data issues. As a result, the team have been working with individual directorates on tendering and savings opportunities including Estates and Facilities, Sexual Health Services and Adults Southampton, whilst actively working collaboratively with the STP and Southern Health Foundation Trust (SHFT). The team is working towards having a robust data source to enable better viability of the trust spend and the opportunities to save money. Data Analytics are key to this and we have been working internally to upskill the team, however the lack of good data and resource has been a challenge.

**8. Mental Health Services** – Work with Southern Health to adopt a standard approach to beds and bed management including admission criteria, treatment standards, multi-disciplinary team provision and discharge facilitation:

Positive progress has been made with this objective and all of the preparatory processes have been completed. However, in order to fully complete this now requires executive support for proceeding.

**9. People and Organisational Development** – Improve employee engagement and wellbeing through continuous involvement and collaboration in the delivery of organisational development and workforce change programmes:

NHS Employee Engagement staff survey 2018 results are noteworthy, participation increased from 56% to 59% and the Trust was identified as best in class by Listening into Action for employee results nationally. However, two milestones will roll forward into 2019/20 business plans due to resourcing and operational pressures. The Equality Delivery System 2 (EDS2) action plan will be reviewed by the Board after the new Equality, Diversity and Inclusion strategy has been developed.

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

Phase 1 has been completed; however 2 milestones are outstanding on the objective as these were delayed due to preparations for the CQC inspection. The oustanding milestones were obtaining the figures for reduction of temporary staff in Quarter 4 and agreeing an approach to workforce development across Mental Health services and Partners. This will form part of 2019/20 plans.

**11. Primary Care Services** – Participate and where appropriate lead system development within the two cities:

Following an executive to executive discussion around the MSK and MSK triage, there remains no clarity on the way forward. CCGs have extended the Specialist MSK provision in South East Hampshire for a further 2 years whilst they determine their preferred delivery model.

**12. Primary Care Services** – With support from the Solent Commercial Team, we will resolve the organisations Diagnostic Contracting Issues:

Solent NHS Trust has identified a solution for the Salisbury, Wight and South Hampshire Domain NHS Trust (SWASH) consortia which is being evaluated internally. Discussions regarding the preferred solution are ongoing with the SWASH consortia which are causing delays in the anticipated timeline for resolution and have been exacerbated by staffing constraints. It is likely that the procurement of Solent NHS Trust's diagnostic provision may be delayed beyond August 2019 to allow the resolution of the Picture Archiving and Communication System (PACS) prior to tender. As a result this objective will transfer to Commercial for resolution in 2019/20.

**13. Quality** – To facilitate, promote and support a blended approach to the delivery of effective models of patient, carer, and user engagement/ involvement through the embeddedness of our community engagement strategy:

Whilst some progress was made in relation to both promoting and supporting a blended approach to patient engagement, particularly in the use of Always Events, through our Quality Improvement projects and the work of the Young Shapers, this objective has not been fully completed. This is because it links with the Community Engagement Strategy which has been approved at Board and will be taken forward for implementation during 2019/20. Therefore the main elements of this objective will be incorporated into this work.

**14. Specialist Dental Services** – Provide accessible dental treatment for bariatric patients by working with NHS England in conjunction with the Managed Clinical Network:

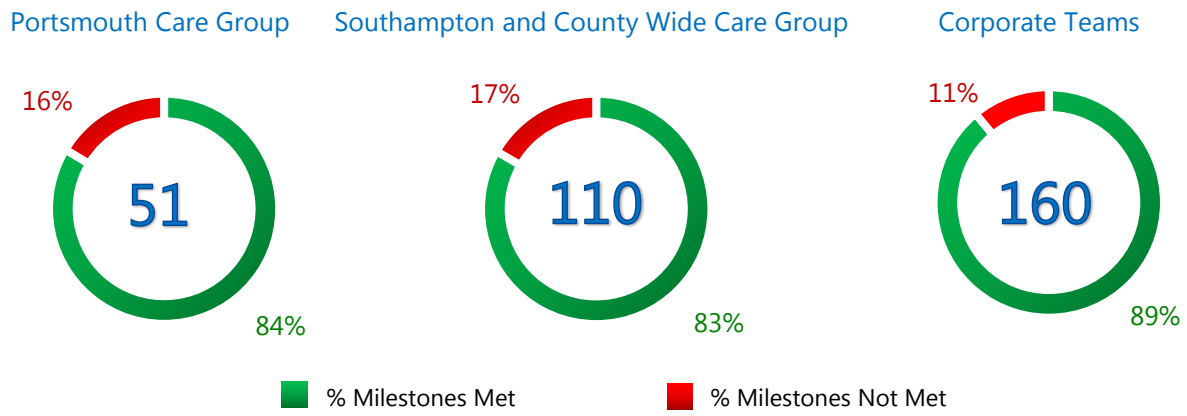
Good progress has been made with this objective and and facilities are in place in the dental clinics, however further bariatric facilities are dependant on Estates. Wheelchair recliners with bariatric benches have been installed in each locality to enable the service to treat patients locally to where they live. The team are currently working with Estates, commissioners and the managed clinical network to improve building facilities and access.

## 2.5 Milestone Progress

Since April 2018, a total of 323 (86%) Business Objective milestones have been met, this is a 16% improvement from 2017/18 where 70% of the total milestones were completed. Although comparatively, the total number of milestones being monitored has decreased this year, this reduction has enabled higher productivity, which is demonstrated by only 52 (14%) milestones being not met at year end across the whole Trust. Out of the 52 milestones not met, only 23 are at risk of not delivering, as it is expected that the remaining 29 should complete by the end of Quarter 1 for 2019/20. This indicates that in 2018/19, where milestones have not met their original target dates, there has generally been improved project management activities to ensure the milestones do not significantly impact delivery of the objectives.

The charts below (figure 2) illustrate the number of milestones that have been met at the end of Quarter 4 across our 3 Care Groups and Corporate Teams with a percentage breakdown of milestones met and not met:

*Figure 2: An overview of the current milestone status with total milestones met in centre:*




*N.B. 11 Child and Family milestones met cover both Southampton and Portsmouth Care Groups.*

# 3. Additional 2018/19 Projects

## 3.1 Integrated Care Partnership

Solent NHS Trust is fully engaged in the Portsmouth and South East Hampshire Health Integrated Care Partnership (ICP), and alongside other partner organisations we have contributed to the system operating plan.

Programme Boards for each work stream within the ICP (Urgent Care, Elective Care, Mental Health, Community Health and Care, and Children's Services) are working to deliver their relevant projects.

## 3.2 Verto

The 2018/19 planning year has also seen the first full year of use of the Trust's Project Management tool – Verto. The ability for all objectives to be viewable and reportable for all parties involved has proven to be a valuable tool in the Trust systems portfolio, providing an accessible and transparent platform for senior management to review at any time.

Further developments requested by Solent for Verto mean that 2019/20 Business Objectives will see the CPMO able to provide slippage reports detecting and highlighting which milestones have been moved from their original date by: the number of days and the number of times that it has moved. This will provide greater visibility of objectives that are experiencing difficulty allowing them to be identified and rectified at an earlier stage. The slippage report will also form part of monthly performance review meetings held with each service line, again creating greater transparency and oversight for senior management.

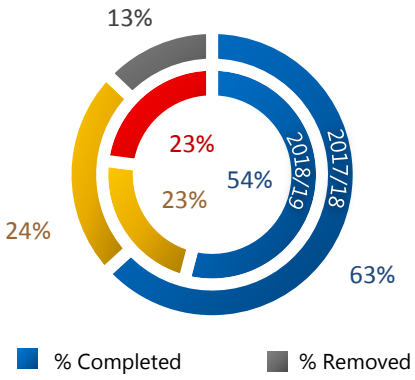
# 4. Final Year-End Review

## 4.1 Business Objective Progress

Following a 6 month review of all Business Objectives in August 2018, Solent gained a more realistic vision for the final two quarters of 2018/19, which lead to higher productivity and increased benefits realisation at year end, demonstrated by an 81% rise in completed projects since Quarter 3. This was a crucial checkpoint to not only check progress and refocus for the rest of the year, but also helped ensure that all objectives were still Specific, Measurable, Achievable, Realistic and Timely (SMART).

A total of 33 (54%) Business Objectives completed on time in 2018/19 (see inner ring on figure 3). There are 14 amber (23%) and 14 red (23%) Business Objectives which are still being monitored and have milestones yet to be completed. The amber items have mitigation in place to complete them or are due to be completed in the coming months. In contrast the red objectives are experiencing more significant issues, 4 were unable to complete by the original target due to external factors, such as contractual issues with system partners.

*Figure 3: 2018/19 (inner ring) v 2017/18 (outer ring) Year-end position*



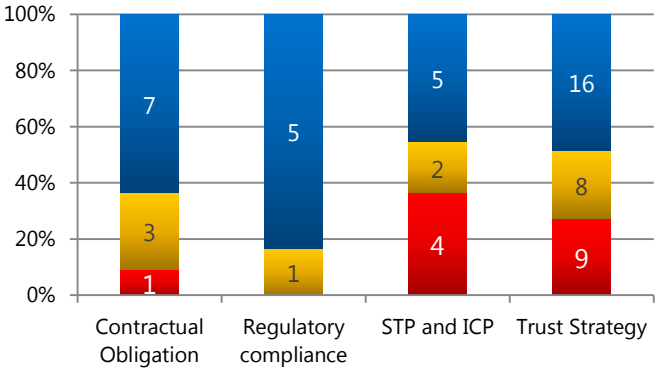

Although comparatively, the percentage of objectives completed at year end has decreased since 2017/18, where 63% of objectives were completed (see outer ring on figure 3), there were no objectives considered unachievable and removed from plans in 2018/19, in contrast this amounted to 13% in 2017/18. It is projected that if all 14 amber objectives complete over the next quarter, Solent would have met over 77% of all Business Objectives for 2018/19 and this in turn would be a 13% improvement compared to 2017/18.

## 4.2 Major Organisational Programmes (MOPs) Vs Major Organisational Drivers (MODs)

Each Year every Business Objective is aligned to MODs - Why we are doing these projects and MOPs – The main theme or work stream.

**MODs** - Contractual Obligation, Regulatory Compliance, STP and ICP and Trust Strategy.

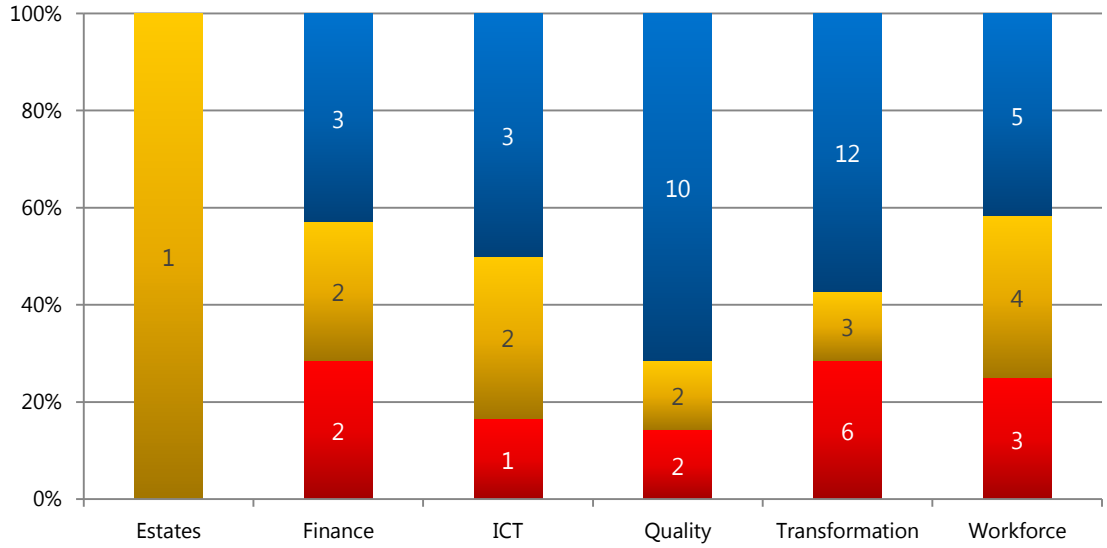
*Figure 4: Breakdown of MODs by objective status*




Although the majority of Business Objectives were aligned to the Trust Strategy driver (54%), proportionally the most successful driver was Regulatory Compliance with 83% objectives completing as shown in figure 4. This is consistent with other measures such as the Trust's CQC rating.

**MOPs** – Estates, Finance, ICT, Quality, Transformation and Workforce.

*Figure 5: Breakdown of MOPs by objective status*




The completion rates of the MOPs appear to more evenly distributed, with the exceptions being Estates and Quality. Only 1 objective was aligned to the Estates MOP which was from the Estates and Facilities Corporate Team, however, it is expected that this objective should be completed by the end of May 2019.

The greatest volumes of objectives completed were aligned to the Quality and Transformation MOPs, together equating to 66% of completed objectives and 36% of the total Business Objectives Trust-wide. This highlights one of the key elements of the Trust's vision of providing great care and how it has been a core value across the majority of Business Objectives for 2018/19.

# 5. Looking Ahead

## 5.1 2019-22 Business Planning

The Solent NHS Trust 2019-2022 Business Plan is now under way with the first of the milestones for the year being analysed and collated.

The planning cycle has been extended beyond a single year in recognition that thorough planning with meaningful objectives cannot always be completed in a 12 month period. This is evidenced by 54% of 2018/19 objectives completing as planned, with 23% requiring some additional months to complete. This can be equally attributed to both natural and unavoidable slippage as well as some ambitious timescales for a number of objectives.

The extension of the planning period is also in recognition of the increasing partnership working that Solent NHS Trust is involved in and the longer forecasting that results. The Trust's commitment to working with partner organisations in the local health economy has required that initiatives are approached in a more methodical way and one that considers what an entire care group's goals may be rather than purely at Service Line or individual Trust level.

## 2.1 Solent NHS Trust Performance Report - Operations April 2019/20

### Activity

| | | | Same Period 2018/19 | |
|---|---|---|---|---|
| 15,984 | New Referrals in month* | | 14773 | |
| 73,563 | Attended Contacts in month* | | 70610 | 4% ↑ |
| 2,890 | DNA'd Appointments in month* | 3.7% | 3353 | |
| 23 | Delayed Patients in month (DTOCs) | | 18 | |
| 348 | Delayed Days in month | | 112 | |
| 14,523 | Discharges in month* | | 14338 | |

### Key Performance Indicators

| | |
|---|---|
| 202 | KPIs due in month |
| 163 | KPIs achieved in month |

### CQUIN Schemes

| | |
|---|---|
| 10 | CQUIN Schemes |
| n/a | Milestones due YTD |
| n/a | Milestones Achieved YTD |

| | |
|---|---|
| 0 | Contract Performance Notices (CPN) Open |

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

### Hotspots

- Wheelchair provision delays
- CAMHS Portsmouth Waiting List
- COAST / CCN Service Provision Portsmouth
- Adult Speech and Language Therapy Waiting Times Portsmouth
- Secondary Care Psychological Therapies Waiting Times
- OPMH Waiting Times
- IAPT Information Governance Breaches
- MSK 0-12 Portsmouth Waiting Times
- CAMHS Southampton Waiting List and Vacancy Pressures
- Domiciliary Phlebotomy Contract Performance Notice (CPN)
- VTE Assessments

# 2.2 Performance Subcommittee and Regulatory Exceptions

## Portsmouth Care Group

The Improving Access to Psychological Therapies (IAPT) service has had a higher rate of Information Governance (IG) breaches over the past 18 months. A review of themes has been undertaken and as a result improvements to administration processes and work place environment have been implemented to reduce the risk of further IG breaches occurring.

The average waiting time for the Secondary Care Psychological Therapies service over recent months has been 29 weeks, with some patients waiting up to 44 weeks for trauma services. Service users have access to interim general support whilst on the waiting list and individual patient cases are reviewed for risk on a weekly basis. As this position has been ongoing for some time, it has been requested that a further review takes place between Solent and Portsmouth CCG to consider the available options to reduce the waiting times or find an alternative long term solution to resolve the risk.

The demand for the CAMHS service has continued to increase whilst we have seen a reduction in the trained workforce. Specific work is underway within the city to remodel the service pathway to mitigate this. The specific area of concern with the service is within the Neurodevelopmental, where continued high referral rates have caused an ongoing challenge in meeting the demand for specialist assessments. The service have now allocated specific resource as part of a Waiting List Initiative and modified their access pathway to clear the backlog and attempt to create a more sustainable service over the next few months.

There have been an increased number of non-urgent referrals to our Speech and Language Therapy (SLT) service from care homes, which has resulted in an imbalance of demand and capacity. To address this, the Service are currently piloting a care home project to improve competency within care home staff, aiming to reduce referral rates to the service and therefore free up clinical capacity for other patients requiring access to the service.

Referrals to the Older Persons Mental Health (OPMH) service peaked in March which has caused 33% of patients to breach the 6 week waiting time target during this period. Operational changes are due to be implemented during May which should reduce the waiting time, although this is being closely monitored within the organisation.

Plans had been made to reduce the operating hours of the COAST/Children's Community Nursing (CCN) service to address the recent concerns around capacity. This has been superseded by a need to take urgent action to protect staff wellbeing and patient safety, which has resulted in the service being closed for a period of time. Referral partners have been informed and the impact of this closure will be closely monitored as part of a planned service redesign looking at population need and workforce sustainability.

There has been a recent increase in demand for the Musculoskeletal (MSK) 0-12 service in the Fareham and Gosport / South Eastern Hampshire areas. The service is currently unable to see all children on the urgent waiting list and those which are breaching the routine waiting list. A demand and capacity analysis has indicated that demand far exceeds capacity, so the service is working with commissioners to propose a solution.

The Community Paediatric Medical Service (CPMS) continues to struggle with waiting time pressures as the demand is now outstripping the budgeted establishment. A skill mix review of clinical staff is underway, alongside plans to improve processes within the service.

## Southampton & County Wide Care Groups

The interim additional funding from Southampton CCG for our CAMHS service is coming to an end. This additional resource has provided extra capacity for the service and waiting times have improved significantly as a consequence. It is expected that during quarter 3, post-funding, demand will again begin to exceed capacity.

After the successful implementation of the remedial action plan for Domiciliary Phlebotomy we have closed the contract performance notice (CPN) with Southampton CCG. This means that the trust has no existing CPN's which is a good position for the trust.

Solent is now sharing robust and validated data with Millbrook and is working collaboratively to help improve the provision of Wheelchairs. However, we have seen no tangible improvements in service delivery to our patients from Millbrook.

## Regulatory Performance

**NHS Improvement Single Oversight Framework**

The Trust has achieved a level 2 on the NHS Improvement scale, where level 1 is the best and level 4 the most challenged. This is a good result for the trust.

The Organisational Health Domain has continued to see high levels of sickness, with staff sickness being over the threshold for the seventh consecutive month. The Trust staff turnover remains above the 12% threshold, but is still significantly improved compared to the prior year. Usage of temporary staffing has remained within the 6% threshold for the fourth consecutive month. Further information on workforce performance is in section 5.2.

The Safe Domain has seen an improvement in VTE assessments in month due to significant work in our Mental Health services to improve their data capture processes, but reports a single case of Clostridium Difficile in Jubilee. Further detail on this can be found in the quality performance in section 3.2.

In the Operational Performance Indicators, improvement has been seen on the 6 week diagnostic wait, with the 99% target being achieved consistently for the past two months. The data reported against the Data Quality Maturity Index (DQMI) - MHSDS dataset score is now being reported monthly. The data demonstrates a significant change in performance from October 2018 onwards, which is reflective of a national change in the specification of what is included against this dataset. For 2019/20, Solent have signed up to the national CQUIN to improve the DQMI score.

Within the Caring Domain, performance against the Mental Health Friends and Family Test for patients has been one of the more challenging metrics to achieve all year, with the target being met only once. The 12 month average for the service is approximately 88%, compared to the NHS Benchmarking Network median of 90%.

The Use of Resources score has achieved a level 3 in month. This is reflective of a planned financial deficit in month 1.

The overall performance against the Single Oversight Framework remains positive, and can be seen in detail in section 6.1.

# 3.1 - Quality Performance

April 2019/20

## Serious Incidents

| | |
|---|---|
| 5 | Serious incidents occurred in month |
| 4 | Less year to date than 17/18 |
| 1 | YTD Healthcare Infections / Cdiff / MRSA |
| 0 | YTD Safety compliance breaches |

## Friends and Family Test

| | |
|---|---|
| 1347 | Responses received |
| 764 | More than same month 17/18 |
| 96% | Positive ratings % |
| 1% | Negative ratings % |

## Formal Complaints

| | |
|---|---|
| 19 | Complaints received in month |
| 18 | Required response in month |
| 2 | Breaches in month |

## Plaudits

| | |
|---|---|
| 98 | Plaudits received in month |
| 10 | More than year to date 18/19 |

"I would just like to thank you all for your hard work, patience and care you have given me while I've been here... I will be forever grateful"

"without your help I wouldn't be where I am now. There were times along the way when I wanted to give up but you never let me – Thank You".

"you have shown a level of care and patience I did not think possible. You are a credit to the NHS and your profession"

"I genuinely felt supported"

"Thank you so much I am delighted to have come here"

"You've been of enormous help and definitely gone beyond the call of duty"

# 3.2 Chief Nurse Commentary –April 2019

In addition to providing the month one performance this report will provide a summary of the year end position.

## Events to Note

- The Trust celebrated International Nurses Day 2019 by holding its second Nursing Conference on Friday 10 May 2019 with the theme: *'Partnering with patients: Shaping the nursing workforce in response to the changing nature of healthcare'*. We were delighted to welcome Andrea Sutcliffe, Chief Executive Officer, Nursing and Midwifery Council, as one of our keynote speakers and also service users who shared their stories about how Solent staff made a difference. We held our inaugural 'Nurse of the Year Awards' where we received 47 nominations from colleagues, patients and carers - which were shortlisted to 11. The winners were:
  - Runner up: Emma Ives – Diabetes Specialist Nurse, Adults Southampton
  - Runner up: Claire Campbell – Child and Adolescent Mental Health Service Nurse, Portsmouth
  - Winner: Vanessa Bull – Learning Disability Nurse, Integrated Jigsaw team, Southampton
- We have commenced the planning of the Allied Health Professionals Conference which will be held on 10 October 2019 ahead of #AHP Day which falls on 14 October.
- On 15 May, four of our nurses attended a service at Westminster Abbey to commemorate the life of Florence Nightingale and the centenary of the funeral of Edith Cavell.
- Following an invitation for expressions of interest from Ruth May, Chief Nursing Officer, England to join an 'Improving Transition Collaborative' programme with NHS Improvement, we are delighted to have been accepted onto Cohort 2, which will commence in September 2019. This work will be led by Stephanie Clark, Head of Quality & Professions, Children's services.
- The Trust's Learning Disability team lead and a service user, Lee, shared the Learning Disability Strategy which has been developed in response to the 'Learning Disability Improvement Standards', published by NHS Improvement (NHSI) in June 2018. The final strategy will be formally launched following Board approval later in the year.
- The 'Learning from excellence' module on Ulysses has been launched. This has been designed to encourage all employees to highlight good practice which will enable us to celebrate this and to share learning across the Trust. The reporting is simple and staff log onto the reporting page on SolNet to complete the form.

## Complaints Update

In March 2019, the Trust received 15 formal complaints and 19 in April. The complaints are broken down by service line in the table below:

| Service Line | March 2019 | April 2019 |
|---|---|---|
| Adults Portsmouth | 1 | 1 |
| Adults Southampton | 0 | 2 |
| Childrens Services | 3 | 4 |
| Primary care | 4 | 4 |
| Sexual Health | 1 | 4 |
| Adult Mental Health | 4 | 2 |
| SPA | 0 | 0 |
| Special Care Dentistry | 1 | 2 |
| Corporate | 1 | 0 |
| Total | **15** | **19** |

Similarly to previous months, the themes related to concerns about quality of clinical care received, concerns regarding communication, concerns regarding staff attitude, access to appointments and arrangements to support safe discharge.

There were three breaches recorded in March, two of which were due to service delay in providing the final response and the third was due to an administration error by the PALS and complaints team which meant there was a delay is sending the response out to the complainant.

In April there were two breaches, both of which were delayed at service level, one of these was subsequently downgraded to a service concern with agreement of the complainant and remains open. The second breach has now been closed.

We were informed in April 2019 that the Parliamentary Health Service Ombudsman (PHSO) had upheld a complaint for a patient of Sexual Health services. They have shared their recommendations and the subsequent action has been completed.

The team are trialling the inclusion of plaudit information on the Chief Nurse Infographic. The month 1 position shows a slight increase in the number of plaudits received. Receiving plaudits continues to provide our staff and teams with positive reflections related to the care and services provided.

## Incident Updates

One case of C Difficile infection (CDI) was identified in Jubilee House on 26 April 2019. The patient had been on the unit for 11 days prior to this infection and had multiple courses of antibiotics, appropriately prescribed, during their inpatient episode at PHT, prior to this transfer which was most likely the causative factor. On review of the case, all care provided in Jubilee was appropriate and responses were timely and in line with policy. There was no learning identified on this occasion. It is noted that in December 2018, following a reported case of CDI in Jubilee, learning was identified and this case would indicate that this learning was effectively implemented.

The year-end data shows an increase in the number of incidents reported with (8,501) in comparison to the previous year of (7,686), with approximately 72% reported as 'Patient incidents' which is similar to the previous year. Of the total number reported, 97% were recorded as 'No Harm' and no specific trends have been identified. Overall this performance would suggest a positive reporting culture across the Trust. This is a continuing trend in month 1.

Compliance with hand hygiene and MRSA screening has remained consistent across the year and at year end, performance achieved above Trust target for both with a rate of 96% and 98% respectively against a target of 90%.

The number of Information Governance (IG) breaches being reported was identified as a concern in the February 2019 report and March saw a further small rise in the number of reported IG incidents. The year-end position shows that there was approximately a 24% increase compared to 2017/18. The analysis carried out by the IG lead has confirmed that whilst the number has increased, the severity/impact has reduced with fewer breaches meeting criteria for serious incidents, high risk incidents or for referral to the Information Commissioner's Office. There has been a slight drop in the number of breaches reported during April.

April has seen a spike in reported restraints and seclusions across Adult Mental Health and Older Person's Mental Health services. All episodes of restraint and seclusion have been reviewed in detail and it is confirmed that the actions taken were appropriate, lawful and managed in a safe and competent way.

Venous Thrombo-Embolism (VTE) Assessment continues to be a concern with the Trust achieving a year end position of 94% against a target of 95%. However 100% of patients who required prophylactic treatment had this prescribed thereby achieving a year end performance of 100%. The area where performance has remained inconsistent across the year is Adult Mental Health and the Clinical Director has taken steps to ensure improvement is achieved. It is noted that the month one position shows a significant improvement with a performance of 99% achieved across the Trust and a performance level of 97% and 100% AMH and OPMH

respectively. This will continue to be monitored through the Quality Improvement and Risk group and further actions taken if required in order to ensure sustained improvement is realised.

## Pressure Ulcer (PU)Monitoring

As reported previously, the Trust has implemented the changes to reporting pressure ulcers in line with national and regional guidance. The reporting now includes two new categories which are 'unstageable' and 'deep tissue injury'. As a result the Trust is beginning to see the anticipated changes to the number and breakdown of pressure ulcer incidents. The year-end position is as follows:

- There has been a 22% increase in reported pressure ulcers compared to 2017/18.
- The increase has been seen in the reporting of grade 2 and 3 pressure ulcers and a reduction in the number of grade 4's.
- Since the introduction of the two new categories, we have seen a month on month increase in the number of incidents reported under these categories, which indicates that the training and guidance provided has had a positive impact on staff understanding.
- There has been a reduction in the number of reported Grade 4 pressure ulcers month on month from January as expected with the introduction of the new categorisation.

## Wheelchairs Update

- The Trust continues to keep a focus on the issues for patients in relation to the provision of wheelchairs with services monitoring and escalating via Service Lines any issues associated with the provision of wheelchair services.
- A validation of activity data in children's services has been completed by the Trust and based on this and the information provided by Hampshire Wheelchair Services (HWS), (provided by Millbrook), there is a discrepancy between the numbers identified as being on the waiting list. The difference in the reported backlog alongside concerns for the large volume of patients waiting (post validation) has been escalated to West Hampshire CCG for further review and action and discussions remain ongoing. A similar validation exercise is planned for the adult cases in May 2019.
- All areas of concern have been escalated to the commissioners, West Hampshire CCG and directly to HWS as the provider.
- As a Trust we continue to engage with HWS to develop a collaborative relationship in order to achieve positive progress.

## Serious Incident (SI) Update

We are seeing sustained improvement in the management of SI's within timescale with no reported breaches in March or April.

During March, six serious incident investigations were registered and three in April. The categories are detailed below:

| Category | March numbers | April Numbers |
|---|---|---|
| **Unexpected Death** | 1 | 0 |
| **Pressure Ulcer** | 3 | 0 |
| **Medication Error** | 1 | 1 |
| **Safeguarding Vulnerable Adults** | 1 | 1 |
| **Sub- Optimal Care of the Deteriorating Patient** | 0 | 1 |

These investigations identified the following themes/learning:

- Documentation – the importance of the completion of patient records
- Communication – escalation to a senior clinician to discuss unexpected events
- Lack of awareness to report incidents and of the complaints process
- Visibility and supervision from senior clinical staff is essential in supporting safe high quality care
- At assessment, practitioners must ensure that they obtain full details of family/ significant others, especially those living with the patient, including gender, name and age
- If an objective MUST assessment is not achievable then subjective criteria should be used to document an overall clinical picture of risk status as outlined in the MUST guidance booklet
- Nutritional requirements should have been re-assessed on admission and appropriate care planned in line with assessment findings, rather than be dependent on previous assessments by other hospitals.

## Friends and Family Test (FFT)

- The number of responses received in 2018/19 has increased by approximately 25% compared to 2017/18
- The percentage of patients extremely likely or likely to recommend Solent services have been consistently high with a year-end position of 96% achieved and this remains the position in April
- The inpatient wards have seen an overall increase in the feedback received ending the year on 38% compared to 29% at the end of 2017/18 and a further increase is noted in April with 58%. This will continue to be monitored and services supported to further improve their position during 2019/20
- The Sexual Health Services and Adults Southampton end of year figures show a significantly higher rate of responses received in comparison to other service lines. Work will continue during the coming year to support all service lines to continue to improve and it is noted that Primary Care has had an increase in responses in month one
- Below is a word cloud of the most frequently used words used by patients, carers and families to describe Solent services and some examples of the comments made regarding the care received and the difference our staff make to patients.


"I was so impressed with the kindness and friendliness of the staff I saw today. The Dr was lovely and the lady who took my bloods very professional and caring. I was really nervous coming to my appointment they put me at ease straight away and I felt comfortable throughout the procedure." - **Sexual Health Services**

"Very nice place and lovely staff who made sure myself and my daughter feel at ease very good service thank you." - **Dental Services**

"Very professional physio team, focused on what participants can achieve whilst keeping a careful eye on levels of fitness and capacity. Encouraging and motivating. Many thanks**." - Adults Portsmouth Services**

# 4.1 - Financial Performance

April 2019/20

## Performance

£580k Deficit in Month

£37k Adverse to plan

£580k Deficit YTD

£37k Adverse to plan

£0k Breakeven Year End Forecast (adj)

£0k Achieving control target

## Purchase Orders and Debts

Eligible invoices raised in month 618

606 Purchase orders raised in month

Purchase orders raised in month against eligible invoices 98%

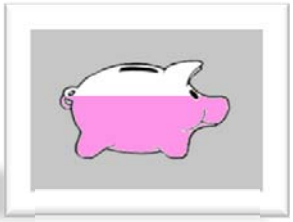
£5,190,970 Total debt month end

£885,076 Total debt over 90 days month end 17%

## Savings

£586,000 Savings Target YTD

£367,000 Savings Delivered YTD



63% Savings Achieved

£75,000 QIA Savings Delivered YTD

## Capital Finance Summary

£110,000 YTD Spend

£6,649,000 Year end plan


1.7% Spend against year end plan

# 4.2 Finance Commentary

## Month 1 Results

The Trust is reporting an in month adjusted deficit of £580k for month 1, £37k adverse plan. Month 1 actuals and plan includes a one off pay award for employees at the top of a band totalling £434k. The month 1 plan included £200k income for prior years over performance from local authorities; this income is expected in a future period. The Trust is expecting to achieve the quarter 1 control total of £1,069k deficit in line and has recognised £122k Provider Support Funding (PSF) and Financial Recovery Funding (FRF) income in month.

Discussions are ongoing with particular services regarding the ability to deliver their plan; particular pressures lie in Southampton, Sexual Health, Estates and some Corporate areas.

## CIPs

CIP delivery in month 1 was £367k, £219k adverse to plan, mainly due to under delivery in pay and non-pay schemes. It is recognised that delivery of CIPs is difficult in the current climate; extra effort is being applied to put all CIP schemes through the QIA process.

## Capital and Cash

Year to date capital expenditure at month 1 is £110k. Projects totalling £3,804k have been approved and in most cases are in progress.

The Trust is budgeted to receive £4,768k PDC funding for Phase 2 project at St Marys and St James hospitals in 2019-20, £1,118k of which has been spent YTD.

The cash balance at 30 April 2019 was £14m.

## Aged debt

Debt over 90 days overdue has increased by £93k since March. The Trust are working closely with SBS, setting priorities of debt to chase (generally highest value and oldest debt) and finance are working with services to clear queries/provide further backup where required.

## 5.1 - Workforce Performance April 2019/20

There were **2,910.1** FTE in post this month, which equates to 3,608 staff in post.

A decrease of **29.6** since last month

**88%** YTD mandatory training compliance

**31%** YTD information governance training completed

**10%** YTD appraisals completed

### Bank and Agency

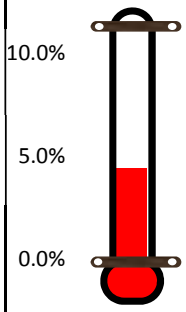
**28,679** Hours requested in month

**19,552** Hours filled by bank in month **£488,265**

**7,870** Hours filled by agency in month **£353,591**

**1,256** Hours requested not filled

In month, Solent are above agency ceiling by **£74,591**




**4.4%**

**Sickness & absence in month**

**93.4%** *budgeted establishment (FTE) worked in month*

**6.6%** *vacancy factor*

*FTE Posts* **204.9**

12 month rolling turnover is **14.8%**

**42** (32.8FTE) new starters in month

**44** (33.1 FTE) leavers in month

## 5.2 – People & OD Commentary

### Sustainable Workforce

The number of full time equivalent (FTE) in post for April (M1) was 2,910, a decrease of 29 FTE since March (M12), including 9.8 WTE staff from the Hampshire Liaison and Diversion Service who transferred under TUPE to the new provider.

Our vacancy factor in April was 6.6%, this is over our 5% target. This is partly due to the reduction in FTE and changes to workforce plans for the new year. We continue to focus on the hard to fill posts.

Average annual staff turnover at M1 is 14.8%. Our in-month turnover has been hovering around 14% over the last 12 months, reported as 13.7% at its lowest to 14.4% at its highest. Our Retention programme has had specific success in Nursing turnover where we achieved a significant improvement, 21% at its peak 2018, reducing to 14.8% at the end of M1 19/20.

Our year end (YE) agency expenditure was £4,240,000 against a YE target of £3,300,000. In month agency spend for M1 was £353,591, a £9k decrease from M12, and £75k over the national monthly agency ceiling of £279,000. Significant efforts have been deployed in service to reduce off framework agency use; this has resulted in this month's reduced spend. Sustained agency reduction continues to be a challenge and programmes such as the Hampshire and Isle of Wight (IOW) Collaborative Bank will support this work.

The Collaborative Bank will operate with a three tier approach –the aim of the Collaborative Bank is to eliminate agency by providing a wider pool of bank staff across HIOW. Solent Bank Staffing will continue to be the first tier of bank staffing, if shifts remain unfilled by our internal bank, the Collaborative Bank acts as a tier 2 provision, and tier 3 remains as the agency option.

The E-Rostering improvement plan continues. The Adult Mental Health programme has commenced and a significant work plan is under development to ensure sustained changes to rostering in service. This work is being led directly by the Operational and Clinical Director with People and OD support.

Our 2019/20 workforce planning activity has concluded, covering sustainable staffing, education & development, bank and agency forecasts and costing. Each service line presented a refreshed workforce plan, aligned to the delivery of business objectives at the Workforce Planning sub-committee on 18 April 2019. Monitoring of workforce plans will continue through service line governance and via the Workforce Planning Sub Committee, up through to People and OD Committee.

A review of workforce data and reporting has taken place in Q4 2018/19 with a view to improving data quality, and subsequently a refreshed workforce report has been released in M1. This review is also part of the ESR Improvement Programme which has commenced in M1, with the Establishment Control and Manager Self Service implementation being two key elements of this programme.

### Learning & Development

The statutory and mandatory training rate at the end of M12 18/19 was 89.1% against a target of 90%. At the end of M1 2019/20, compliance was 87.5% against a target of 90%. Momentum needs

to be maintained to consistently meet the 90% target via communications and leadership reinforcement and enablement.

We exceeded the 2018/19 IG training target of 95%, achieving a final year end compliance of 96.6%.

Our 2018/19 appraisal completion was 90.1% against a target of 90%. During February, March and April there has been regular engagement with staff with the aim of improving the performance appraisal discussion, to include a focus on values based objectives, career conversations and development opportunities. A refreshed appraisal form, tools and resources have been made available on SolNet. All appraisals must be completed by 30 September 2019.

Both Information Governance (IG) and Performance Appraisal (PA) are reset to 0% on 1 April at the start of each financial year.

2018/19 saw the expansion of our Apprenticeship programmes, most notably the first Registered Degree Nurse Apprentice cohort, the third cohort of Nursing Associate Apprentices, and the first senior leadership MBA apprentices. There has also been representation from Solent at the Occupational Therapy and Physio national trailblazer group to develop the new national apprenticeship programmes. The Apprenticeship Awards 2019 took place in March and celebrated the achievements of Solent clinical and business apprentices.

## Leadership, Culture & Values

We were pleased that our 2018 NHS Staff Survey results improved for the third year in a row. 59% of staff responded to the survey, which is the highest rate in five years. Services are responding to their Staff Survey results locally and this will feed through to service line operational and governance meetings and to the Engagement Sub Group and People and OD Committee.

Our Freedom to Speak up Guardian, Pamela Permalloo-Bass has been appointed for 10 hrs per week to lead on the strategic implementation of Diversity and Inclusion. The process of recruiting the Head of Diversity and Inclusion is underway; the post holder will lead on the Equality Delivery System version 2 and implementation of the associated work plan.

The third cohort of “Leading with Heart” commenced in March. 40 leaders are participating from across clinical and corporate services. As part of the June workshop, leaders from across the organisation have been invited to attend a Diversity and Inclusion workshop which will support us to embed diversity and inclusion throughout our organisation. The training will specifically help leaders to understand how to undertake an effective equality analysis.

## Health and Wellbeing

73.5% of our frontline people received the flu vaccine during the 2018/19 flu campaign, higher than in any previous year, and with a small shortfall against the target of 75%. The target for 2019/20 has been increased to 80%, which is a significant challenge. Planning has already commenced to achieve this target.

During March, the Occupational Health service successfully achieved the Safe, Effective, Quality Occupational Health Service (SEQOHS) reaccreditation. SEQOHS is a set of standards and a voluntary

accreditation scheme for occupational health services in the UK. This reaccreditation confirms the high standards provided by our Occupational Health Service and will be valid until 2024.

Our Occupational Health Service has successfully redeployed three members of the Behavioural Change team to support delivery of Health Promotion services as part of the OH service offer.

## Communication & Engagement

We continue to raise our profile externally with stakeholders and the media. During 2018/19 we took specific action to develop our media profile, generating over £700,000 worth of advertising value equivalent (AVE) space in print coverage alone (we are unable to measure AVE for broadcast media). Media campaigns included: NHS70, Care at Christmas and mental health nursing. Specifically, in March we saw coverage around our very positive staff survey results within the Health Service Journal and received further coverage regarding the Trust's CQC rating. PR activity during 2019/20 will focus on more thought leadership, national PR, award entries, as well as continued story finding. This has already begun and is evident with recent PR coverage around Internal Nurses Day and Mental Health Awareness Week.

Raising our profile develops our employer brand both internally and externally, helping to attract people to work for us and to retain talent. During March we successfully won an ONREC Award for our innovative mental health nurse digital recruitment campaign. Our focus on recruitment activities will continue into 2019/20.

Internal communication plays a key role in employee engagement. The NHS Staff Survey results are an indication that internal communications, both channels and messaging, are making a difference and contributing to a positive culture. In addition, in December the People and OD Committee were asked to rate Key Line of Enquiries (KLOEs) in relation to workforce, strategy, culture and leadership. Internal communications was rated as one of the top 3 KLOEs. The Committee said they are effective and engaging. During 2019/20, messages will be focussed on pride and passion and linked to our strategic purpose.

## 6.1 NHS Improvement Single Oversight Framework

The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework was introduced on 1 October 2016, at which point the Monitor 'Risk Assessment Framework ' and the TDA's 'Accountability Framework ' no longer apply. The Framework uses five themes: 'Quality of care'; 'Finance and use of resources'; 'Operational performance'; 'Strategic change'; and 'Leadership and improvement capability'. The 'Quality of care', 'Finance and use of resources' and 'Operational performance' themes contain a list of metrics, however not all of these have nationally measured thresholds. Where internal, aspirational thresholds exist, these have been included below, highlighted in grey. The 'Operational performance' metrics do not provide a performance assessment, however NHS Improvement state that they will consider whether support is required to providers where performance against the 'Operational Performance' metrics:

- for a provider with one or more agreed Sustainability and Transformation Fund trajectories against any of the metrics: it fails to meet any trajectory for at least two consecutive months
- for a provider with no agreed Sustainability and Transformation Fund trajectory against any metrics: it fails to meet a relevant target or standard for at least two consecutive months
- where other factors (e.g.. a significant deterioration in a single month, or multiple support needs across other standards) indicate we need to get involved before two months have elapsed.

Providers will be placed in a segment based on NHS Improvement's assessment of the seriousness and complexity of any issues identified as per the table below:

| Segment | Description |
|---|---|
| 1 | Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance. |
| 2 | Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support. |
| 3 | Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements. |
| 4 | Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures. |

Please note that Solent does not have any Sustainability and Transformation Fund trajectory metrics.
For some indicators, no definition has been confirmed by NHS Improvement. Our interpretation has been applied in the below.

# Quality of Care Indicators

## Organisational Health

Internal aspirational thresholds are highlighted in grey

| 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 | Apr-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% | 4.4% |
| 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% | 14.8% |
| 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% | 5.8% |

## 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 | Apr-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Written Complaints | | 19 | 27 | 17 | 20 | 17 | 12 | 23 | 17 | 14 | 17 | 15 | 18 | 19 |
| 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 | 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% | 96.6% |
| 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% | 84.9% |

## 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 | Apr-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% | 100% |
| % clients in settled accommodation | | 74% | 75% | 80% | 79% | 79% | 82% | 83% | 84% | 85% | 84% | 84% | 84% | 82% |
| % 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% | 5.9% |

## Safe

| 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 | Apr-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Occurrence of any Never Event | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NHS England/ NHS Improvement Patient Safety Alerts outstanding | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| VTE Risk Assessment | 95% | 91.0% | 99.0% | | 91.0% | 98.0% | 96.0% | 93.0% | 94.0% | 92.0% | 91.0% | 93.0% | 90.0% | 99.0% |
| Clostridium Difficile - variance from plan | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 |
| Clostridium Difficile - infection rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 |
| Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias | 0 | 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 | 0 |
| MRSA bacteraemias | 0 | 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 | 0 |

## Operational Performance Indicators

| 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 | Apr-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% | 97.3% |
| Maximum 6-week wait for diagnostic procedures | 99% | 99% | 99% | 100% | 100% | 100% | 97% | 99% | 96% | 98% | 97% | 99% | 99% | 99% |
| 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 | 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% | 100.0% |
| Data Quality Maturity Index (DQMI) - MHSDS dataset score | 95% | | | 97.2% | | | 97.2% | 83.9% | 83.8% | 84.0% | 84.0% | TBC | 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% | 58.3% |
| - 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% | 100.0% |
| - Waiting time to begin treatment - within 18 weeks | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

## Use of Resources Score

A few financial metrics will be used to assess financial performance, with a score from 1 (best) to 4 (worst) being assigned to each metric. These scores will be averaged across all metrics to derive a 'Finance Score' score for the organisation. An overall score of 3 or 4 in this theme will identify a potential support need, as will providers scoring a 4 against any individual metric.

| Indicator Description | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Capital service capacity | Financial Sustainability | 2 | 1 | 0 | 1.2 | 1.4 | 1.5 | 1.5 | 1.8 | 1.9 | 2 | 2 | 3 | 0 |
| *Score* | | *2* | *4* | *4* | *4* | *3* | *3* | *3* | *2* | *2* | *2* | *2* | *2* | *4* |
| Liquidity (days) | Financial Sustainability | -6.2 | -6.7 | -6.8 | -6.5 | -5.9 | -5.4 | -5.7 | -2.7 | -3.4 | -4.8 | -5.2 | -6.8 | -9.3 |
| *Score* | | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *2* | *3* |
| I&E Margin | Financial Efficiency | -0.9% | -1.3% | -1.4% | -1.2% | -1.0% | -1.0% | 0.9% | -0.5% | -0.3% | -0.3% | -0.2% | 0.6% | -3.7% |
| *Score* | | *3* | *4* | *4* | *4* | *4* | *4* | *2* | *3* | *3* | *3* | *3* | *2* | *4* |
| Distance from financial plan | Financial Efficiency | 0.3% | 0.2% | 0.1% | 0.1% | 0.1% | 0.1% | -0.2% | 0.0% | 0.1% | 0.0% | 0.0% | 0.8% | -0.3% |
| *Score* | | *1* | *1* | *1* | *1* | *1* | *1* | *2* | *1* | *1* | *1* | *1* | *1* | *2* |
| Agency spend | Financial Controls | 24% | 37% | 34% | 35% | 38% | 39% | 43% | 42% | 37% | 30% | 25% | 26% | 26% |
| *Score* | | *2* | *3* | *3* | *3* | *3* | *3* | *3* | *3* | *3* | *3* | *2* | *3* | *3* |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Use of Resources Score | 2 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 3 |
| | RAG | G | R | R | R | R | R | G | G | G | G | G | G | R |

## 7.1 Research & Improvement Commentary –April 2019

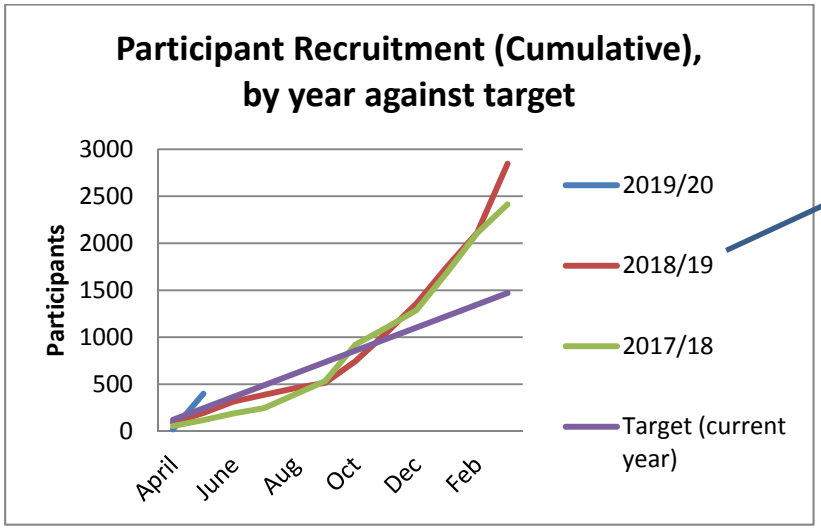
For 2019/20, we are introducing a performance summary for our Research and Improvement work programmes for oversight and assurance to the Trust Board for the first time.

Solent is a research active organisation, which means that we support patients and colleagues to participate in studies that may be of value to them. Being research active ensures that patients get access to novel treatments, and that staff are involved in the generation of new understanding of treatment and care options. We are involved in research in a number of ways – one way is by acting as 'host' for national and international trials, supporting patients to be take part if they would like to. We also act as partners in research programmes with local Universities or other organisations, to investigate areas of particular interest to us. We do this either as the lead or a collaborator.

The research team are part of the Solent Academy of Research & Improvement. The Academy has an integrated team covering Research, Innovation, Quality Improvement, Clinical Effectiveness and Patient Participation/ Involvement. The aim of the service is to support those that work with us and those we look after to have the skills and confidence to review their service, try new things, and make improvements where necessary. A full review of the year's activity for 2018/19 is given later in the papers – The Academy of Research & Improvement Annual Report 2018/19.

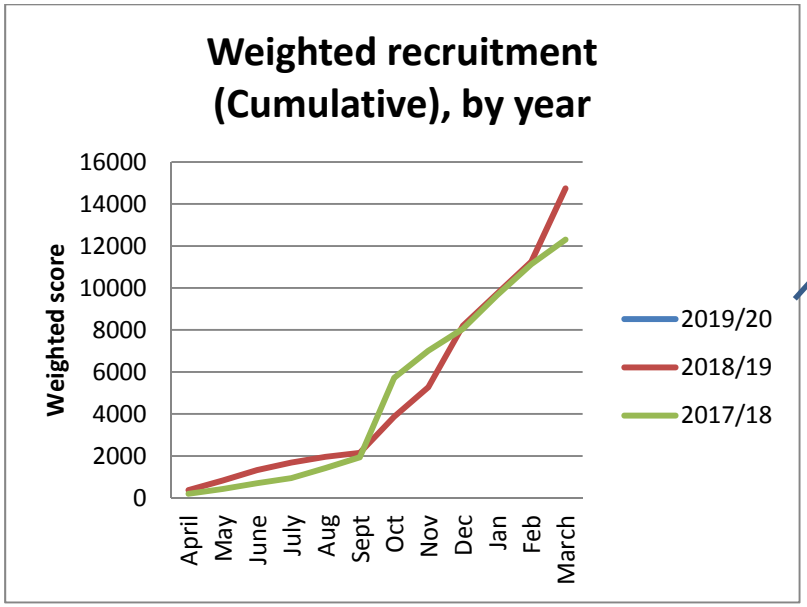
Research performance is monitored via national metrics and targets. The key metrics described in this report are:

1. Number of participants (patients, staff or others) recruited into studies (we are set an annual target).




We recruited 2850 participants into 50 studies in 2018/19, which is an 18% increase on the previous year, and more than double our target. To date this year we have recruited just over 400 participants against a target of 120

2. Weighted recruitment score (a weighted version of the number of participants recruited. They are weighted as different studies attract a different complexity score). It is this complexity weighted recruitment that influences funding.




Our complexity weighted score has also increased. This is the highest score for Care Trusts

**Item 12.1**

Solent NHS Trust

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Presentation to** | x | In Public Board Meeting | | Confidential Board Meeting | | | | | | |
| **Title of Paper** | Academy of Research & Improvement Annual Report | | | | | | | | | |
| **Author(s)** | Sarah Williams | | | **Executive Sponsor** | Dan Meron | | | | | |
| **Date of Paper** | 23/05/2019 | | | **Committees presented** | Assurance | | | | | |
| **Link to CQC Key Lines of Enquiry (KLoE)** | x | Safe | x | Effective | x | Caring | x | Responsive | x | Well Led |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | x | **W2** Vision & Strategy | x | **W3** Culture | x | **W4** Roles & Responsibilities | | | |
| | **W5** Risks and Performance | | **W6** Information | | **W7** Engagement | x | **W8** Learning, Improvt & innovation | x | | |
| **Action requested of the Board** | x | **To receive** | | **For decision** | | | | | | |
| **Link to BAF risk** | BAF # ---------- Concerning ---------- ---------- or | | x | N/A | | | | | | |
| **Level of assurance** *(tick one)* | Sigificant | | Sufficient | x | Limited | | None | | | |

The purpose of this paper is to summarise the activity supported by the Academy of Research & Improvement in the financial year 2018/19. This relates to activity and performance in:

- Research
- Quality Improvement
- Clinical Effectiveness
- Patient Participation
- Learning.

There is an overarching summary with selected projects in the main Annual Report, and an appendix listing every project by Service Line.

**Board Recommendation**

The Board is asked to approve the report.

Assurance Level

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)

Item 12.2

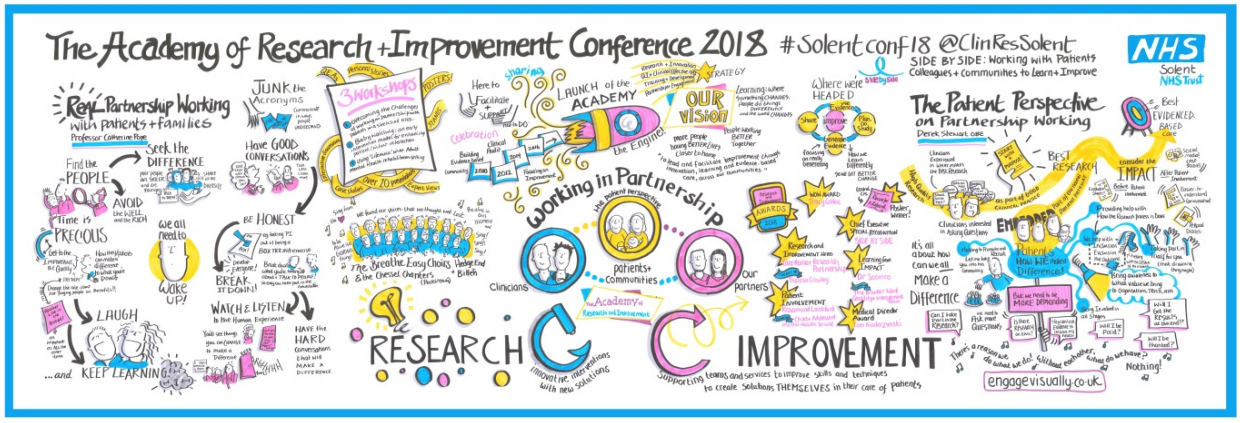
# Academy of Research & Improvement: Annual report 2018-19

## Trust overview

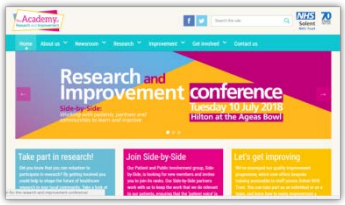
### Activity in numbers

| Research | Quality Improvement | Dragon's Den | Audits and Evaluations | |
|---|---|---|---|---|
| 50 studies<br>2855 participants | 350 staff trained<br>11 foundation days<br>2 practitioner cohorts<br>20 projects underway | 10 projects in progress | 14 national audits<br>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 physically 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; and patient views on the 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 light-weight 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.

## 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.

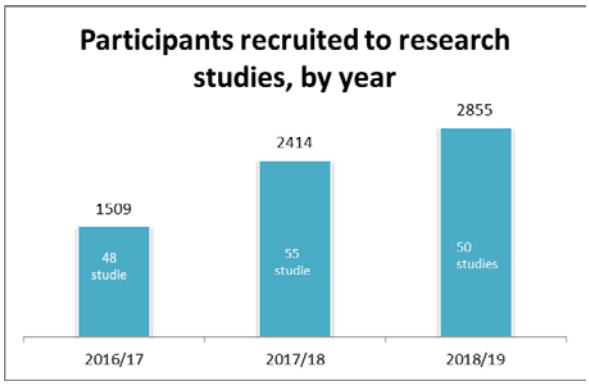

We also carried out an audit on diversity in research, which demonstrated that although we know anecdotally that research is typically less accessible to some groups (older adults, those who don't have home internet access, those who don't have English as a first language etc), we have limited evidence to demonstrate this. We are now collecting demographic data on all research participants and working with the local Research Design Service and 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, and it means that Solent retains its position as 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 as Solent won 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.

## 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 the Orthopaedic surgery team at Portsmouth Hospitals Trust. We 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 are physically active, when the majority are 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 on-going 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.

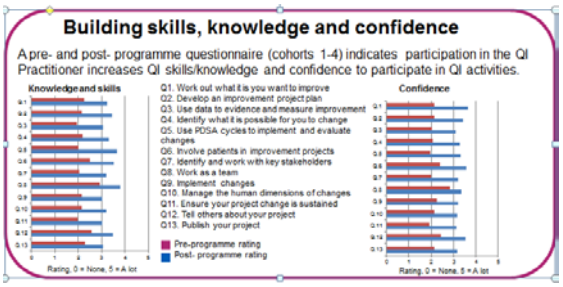
It is hoped that by understanding the complexity of assessment and costs, this will inform appropriate resourcing of assessment services and improve patients' experience.

## Quality Improvement (QI)

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 programme has extended into a stepped progressive model comprising 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.




| Foundation | Practitioner | Other |
|---|---|---|
| 11 training days | 2 courses, 12 teams | 8 QI leaders |
| 22 projects completed, 15 underway | 8 projects completed, 12 underway | 10 patient co-designers |


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 also planned for 2019. This will be supported by a specific QI training programme for patients and the public which is currently being co-designed.

## 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 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. 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 were 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

A patient questionnaire was developed to gain 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 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%.

### "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. 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. 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 a 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.

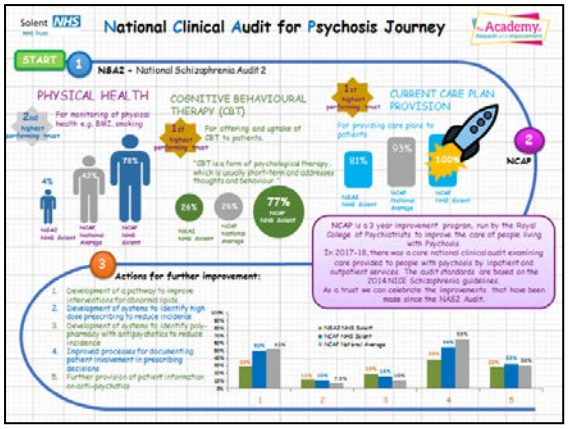
Examples of projects to design and implement outcome measures into clinical service are:

- 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% |

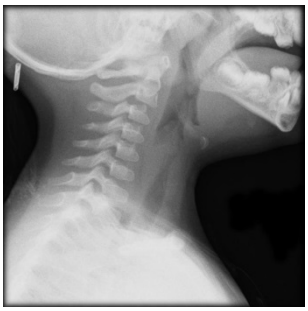
### Wound assessment in adult services (re-audit).

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).

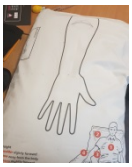
246 service users completed a paper based survey. 70% of patients preferred face-to-face consultations at the clinic as the first point of contact; 73% were willing to use live web chat services and 58% video-consultations. Only 40% reported that artificial intelligence chatbots would be acceptable. 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.

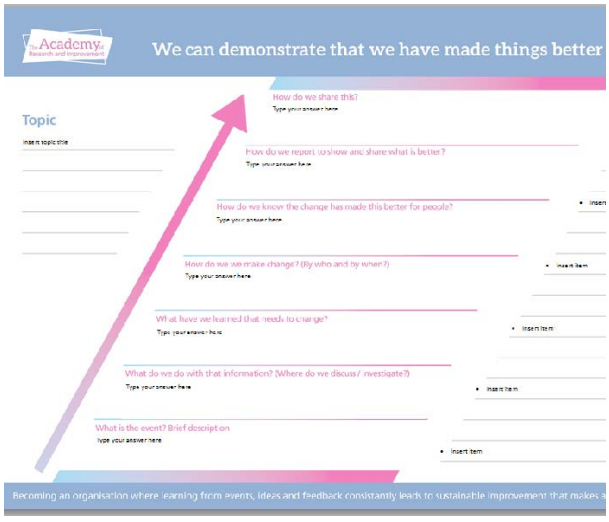
Often, people with mental health illness also have physical health challenges. In one service in Portsmouth, they are trialling

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 hopes to help change the focus to what 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 ongoing updates, please see www.academy.solent.uk or follow us on social media (@solentacademy).

**Item 13**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Title of Paper*** | Delivery of the Learning Disability Strategy – June 2019 | | | | | | | |
| ***Author(s)*** | Jackie Ardley, Chief Nurse | | | | | | | |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | X | **W2** Vision & Strategy | X | **W3** Culture | X | **W4** Roles & Responsibilities | x |
| | **W5** Risks and Performance | | **W6** Information | | **W7** Engagement | X | **W8** Learning, Improve & innovation | X |
| ***Date of Paper*** | 16 May 2019 | | **Committees presented** | | N/A | | | |
| ***Action requested of the Board*** | ☐ To receive | | x For decision | | | | | |
| ***Link to BAF risk*** | BAF # ---------- Concerning -- ---------- or N/A | | | | | | X | |
| **Level of assurance** *(tick one)* | Sigificant | | Sufficient | X | Limited | | None | |

**Board Recommendation**

The Board is asked to:

- Agree that a Learning Disability Strategy Implementation Group(LDSIG) be established.
- To agree that the LDSIG will report directly into Assurance Committee under the designated Non-Executive Director. The Committee will monitor and provide assurance of the Learning Disability Improvement Standards and delivery of the Learning Disability Strategy to the Trust Board.
- Request the Chief Executive to nominate an Executive Director to be accountable for delivery of the Strategy and LD Improvement Standards.
- Note that Executive Directors and Clinical Directors will identify suitable representatives from within their teams/services to be Implementation Leads and members of the Implementation Group for Year 1.

**Background**

NHS Improvement launched the national Learning Disability Improvement Standards in June 2018. The Trust assessment against the standards found a number of areas where improvements could be made. The new Learning Disability Strategy was subsequently developed and will:

- Act as an enabler to support compliance with the standards and
- Provide 'care equity' for people with disabilities by implementation of 'reasonable adjustments' to accommodate the specific needs of people with learning disabilities and to better involve them in their own care.

The Strategy will be approved by the Trust Board in June and launched at the Trust's Nursing Conference.

Arrangements need to be put in place to deliver the Strategy, embed it into operational activities and ensure there are continued and increasing levels of compliance with the Learning Disability Improvement Standards. An outline of the (draft) Strategy Delivery Plan is attached as **Appendix 1.**

Delivery of the year 1 objectives is a Quality Account quality improvement priority for the Trust in 2019/20.

It is recommended a fixed-life 3 year Implementation Group is established which would oversee delivery of the Strategy and monitor the Improvement Standards. Draft Terms of Reference are in **Appendix 2.**

The Learning Disability Improvement Standards require that the Trust has a board level lead responsible for monitoring and assuring the quality of service being provided to people with learning disabilities. This will be undertaken through the Assurance Committee which is led by a NED, and an Executive Director nominated by the Chief Executive to have operational accountability for delivery of the Strategy.

The other core member of the Implementation Group will be the Integrated Learning Disability Services Manager who will have overall programme management responsibility.

Additional members will be co-opted to the Group on an annual basis based on needs of the Delivery Plan:

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| Communications | Accessible Information | Community Engagement |
| Community Engagement | Clinical Audit | Company Secretary |
| Information Systems | Communication | |
| Learning & Development | Community Engagement | |
| Patient Safety | Human Resources | |
| Service Line Leads | Learning & Development | |
| | Patient Experience | |
| | Service Line Leads | |

Executive Directors and Clinical Directors will be asked to nominate suitable representatives from their teams to act as Implementation Leads and be members of the Group. The group will be asked to consider local partners through the three year implementation plan.

## Appendix 1: ** DRAFT ** "Care Equity" Delivering the Learning Disability Strategy - Plan Outline (v1 - 26 April 2019)

| What is needed? | How do we do this? | Implementation Lead/s | Yr1 (2019/20) | Yr2 (2020/21) | Yr3 (2021/22) |
|---|---|---|---|---|---|
| **Theme 1. Respecting and Protecting Rights**<br><br>*We need to ensure all Solent services are aware of the need to make "Reasonable Adjustments" in their care of people with a learning disability.*<br><br>*We need to ensure that all Solent clinicians are able to make "Reasonable Adjustments" in their care of patients with a learning disability.* | 1A. Strategy Awareness Events | Communications | ✓ | | |
| | 1B. Intranet resources | Communications<br>Learning Disability Services Manager | ✓ | | |
| | 1C. Develop service specific "Grab Guides" | Service Line Leads<br>Learning Disability Services Manager | ✓ | | |
| | 1D. Accessible information consideration | Accessible Information Lead | | ✓ | |
| | 1E. Patient flagging in Systm1 | Information Systems Team | ✓ | | |
| | 1F. Development of a vulnerable patient checklist | Information Systems Team | ✓ | | |
| | 1G. Generic Reasonable Adjustment care plans in Systm1 | Information Systems Team<br>Learning Disability Services Manager | ✓ | | |
| | 1H. Compliance audit based upon anticipated metrics | Clinical Audit<br>Learning Disability Services Manager | | ✓ | |
| | 1I. To ensure patient experience and outcome measures for patients with a learning disability are considered against feedback from non-disabled peers | Patient Experience Lead | | ✓ | |
| | 1J. To ensure Solent has a designated Executive Learning Disability Leader within its organisation which will feed into the Assurance Committee chaired by a NED | CEO to nominate lead Executive<br>Trust Board to agree reporting into Assurance Committee | ✓ | | |
| | 1K. To introduce a network of Learning Disability Strategy Implementation Leads across all service lines and relevant corporate teams | Executive Directors to identify suitable staff who will be members of the Implementation Group | ✓ | | |
| | 1L. To have a process wherein services proactively raise concerns about anticipated non-compliance around reasonable adjustments so that they can be supported to overcome these issues | Service Line Leads<br>(Follows 1H above) | | ✓ | |
| **Theme 2. Inclusion and Engagement**<br><br>*We need to engage with people with a learning* | 2A. Set up user engagement events across services and areas | Community Engagement Lead | | ✓ | |
| | 2B. Link with existing feedback forums (e.g. Learning Disability Partnership Boards) | Learning Disability Services Manager | ✓ | | |
| | 2C. Develop quality checking across Solent services | Learning Disability Services Manager | ✓<br>(Trial ) | ✓<br>(Launch) | |

| What is needed? | How do we do this? | Implementation Lead/s | Yr1 (2019/20) | Yr2 (2020/21) | Yr3 (2021/22) |
|---|---|---|---|---|---|
| *disability to learn from their experiences in order to co-produce further service improvements.*<br><br>*We need to include people with a learning disability in the Solent community as well as reaching out into learning disability communities.*<br><br>*We need to demonstrate our continued commitment to people with a learning disability by providing transparent quality data to Solent's Assurance Board* | 2D. Seek support from Healthwatch in gathering the views of people with a learning disability. | Community Engagement Lead | ✓ | | |
| | 2E. To learn from the feedback received and demonstrate clear resulting change | Community Engagement Lead<br>Patient Experience Lead | ✓ | | |
| | 2F To seek to support people with a learning disability to be included in the oversight of the Trust | Community Engagement Lead<br>Company Secretary | | | ✓ |
| | 2G. To develop a Solent wide feedback forum for people with a learning disability. | Community Engagement Lead (to include representatives from different geographical areas & clinical pathways) | | ✓ | |
| | 2H. To look at paid and non-paid work within Solent for people with a learning disability. | Human Resources | | ✓ | |
| | 2I. To explore apprenticeships within Solent for people with a learning disability | Human Resources | | ✓ | |
| | 2J. To proactively engage in local partnership boards and self-advocacy forums | Community Engagement Lead<br>Learning Disability Services Manager | ✓ | | |
| **Theme 3. Workforce Engagement**<br><br>*We need to ensure that staff understand the needs of patients with a learning disability and are able to make reasonable adjustments to the care they deliver* | 3A. Expert by experience training | Learning & Development<br>Learning Disability Services Manager<br>(Already in place; action to extend access and recognition) | ✓ | | |
| | 3B. On-line staff training (across SHIP) | Learning & Development<br>Learning Disability Services Manager | ✓<br>(Develop & Trial) | ✓<br>(Launch) | |
| | 3C. To undertake audit of compliance in making reasonable adjustments. | Clinical Audit<br>Learning Disability Services Manager<br>See 1H above | | ✓ | |
| | 3D. To develop Learning Disability Champions network across services | Service Line Leads | | ✓ | |
| | 3E. To provide signposting information on our website for staff who may need advice for a family member or friend who may have a learning disability | Communications<br>Learning Disability Services Manager | | ✓ | |
| **Theme 4. Specialist Learning Disability Services** | 4A. STOMP/STAMP – reducing over-prescribing of psychiatric medication for people with a learning disability | Adult Mental Health (for STOMP)<br>Children's Services (for STAMP) | ✓ | | |

| What is needed? | How do we do this? | Implementation Lead/s | Yr1 (2019/20) | Yr2 (2020/21) | Yr3 (2021/22) |
|---|---|---|---|---|---|
| *We need to ensure we are actively engaged in regional and national developments in addressing health inequalities for people with a learning disability.* | | Pharmacy (for Policy) | | | |
| | 4B. To ensure Solent's GP services are supported to become "GP Champions" | Primary Care<br>Learning Disability Services Manager | ✓ | | |
| | 4C. Hospital passports | Learning Disability Services Manager | ✓ | | |
| | 4D. Annual Health Checks – for Solent's GP services to be positively engaged with annual health checks | Learning Disability Services Manager | ✓ | | |
| | 4E. Health Action Planning - for Solent's GP services to be positively engaged with health action planning | Learning Disability Services Manager | ✓ | | |
| | 4F. LeDeR engagement | Head of Patient Safety<br>Learning Disability Services Manager | ✓ | | |
| | 4G. "Transforming Care" | Learning Disability Services Manager | ✓ | | |

Appendix 2:

**Learning Disability Strategy Implementation Group**
**TERMS OF REFERENCE**
**** DRAFT v1 ****

**1 Purpose**

1.1 The Learning Disability Strategy Implementation Group has been established to:

- Provide assurance to the Board the Trust has embedded a culture, systems and processes which supports "Care Equity" for people with disabilities and the implementation of reasonable adjustments including:
  - Protecting & Respecting Rights
  - Inclusion & Engagement
  - Workforce Engagement
- Monitor delivery of the Trust Learning Disability Strategy
- Monitor progress in maintaining and improving compliance with the national Learning Disability Improvement Standards *(NHS Improvement, June 2018)*

The Group will have a fixed life of 3 years from the date of the first meeting.

**2 Duties**

2.1 Approve the Learning Disability Strategy Delivery Plan; the plan will be reviewed and refreshed on an annual basis.

2.2 Receive reports from the Integrated Learning Disability Services Manager and Implementation Leads on progress with delivery of the Learning Disability Strategy Delivery Plan.

2.3 To oversee any supporting work programmes associated with delivery of the Learning Disability Strategy.

2.4 To oversee the monitoring of compliance with the national Learning Disability Improvement Standards and provide assurance to the Board that standards are being maintained and improved where appropriate

2.5 To provide direction on reporting requirements to the Assurance Committee for onward report to the Board, and to review any reports (even virtually, if the timings of the meeting do not permit) ahead of submission to the Board or external bodies.

**3 Membership**

3.1 Membership of the Group comprises of:

- Non-Executive Director (Chair)
- Lead Director (Deputy Chair)
- Integrated Learning Disability Services Manager
- Patient/Carers? (or member of representative body)

Additional members will be Implementation Leads based on the Delivery Plan:

| Year 1 | Year 2 | Year 3 |
|---|---|---|
| Communications | Accessible Information | Community Engagement |
| Community Engagement | Clinical Audit | Company Secretary |
| Information Systems | Communication | |
| Learning & Development | Community Engagement | |
| Patient Safety | Human Resources | |
| Service Line Leads | Learning & Development | |
| | Patient Experience | |
| | Service Line Leads | |

Membership will be reviewed annually following the refresh of the Delivery Plan.

3.2 Other attendees may be invited to attend the meeting for specific items at the invitation of the Chair.

**4 Chair**

4.1 A Non-Executive Director (TBC) shall be the Chair of the Group and the Board level lead responsible for monitoring and assuring the quality of service being provided to people with learning disabilities

The Deputy Chair will be (Executive Director TBC) who is nominated by the Chief Executive to have accountability for delivery of the Learning Disability Strategy and national Learning Disability Improvement Standards.

**5 Secretary**

5.1 Administration of the meeting shall be supported by TBC who will arrange to take minutes of meetings, maintain an accurate Action Log and provide appropriate support to the Chairman and members.

5.2 The agenda and any papers shall be circulated to members five working days before the date of the meeting.

**6 Quorum**

8.1 No business shall be transacted at the meeting unless the following are present;

- Chair or Deputy Chair
- Integrated Learning Disability Services Manager

**7 Frequency**

7.1 Meetings will be held every other month for 1½ hours

**8 Minutes of meetings**

8.1 Minutes of the meeting and Action Log will be shared with the members following agreement by the Chair and within five working days of the meeting.

**9 Authority**

9.1 The Learning Disability Strategy Implementation Group has no powers, other than those specifically delegated in these Terms of Reference.

9.2 The Learning Disability Strategy Implementation Group is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties
- to call any employee to be questioned at a meeting as and when required.

**10 Reporting**

10.1 The Group will report to the Assurance Committee and onward to Trust Board.

| | |
|---|---|
| Version | DRAFT 1 |
| Agreed | Date: TBC |
| Date of Next Review | Date: TBC |

**Item 14**

NHS Solent NHS Trust

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Review of the CQC Post-inspection Actions | CQC Follow-Up Report: June 2019 | | | | | | | |
| ***Author(s)*** | Jackie Ardley, Chief Nurse<br>Moira Black Head of Compliance and Organisational Effectiveness | | | | | | | |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | X | **W2** Vision & Strategy | X | **W3** Culture | X | **W4** Roles & Responsibilities | X |
| | **W5** Risks and Performance | | **W6** Information | | **W7** Engagement | X | **W8** Learning, Improve & innovation | X |
| *Date of Paper* | 20 May 2019 | | Committees presented | | N/A | | | |
| *Action requested of the Board* | X To receive | | ☐ For decision | | | | | |
| *Link to BAF risk* | BAF: #57 Concerning: Quality Governance or N/A ☐ | | | | | | | |
| **Level of assurance** *(tick one)* | Sigificant | | Sufficient | X | Limited | | None | |

The purpose of this paper is to provide the Board with an update on progress against the CQC single requirement notice 'Must do' and the 'Should do's. It also outlines the continuing work programme in place to support best practice.

**Background**

At the last formal Board meeting, we informed Board of the excellent and consistent achievement of every single one of our fifteen core services being rated 'Good' overall, as well as a Trust rating of 'Outstanding' for the 'caring' domain.

The full CQC final inspection report can be found here: https://www.cqc.org.uk/provider/R1C

**Oversight and Assurance Process:**

1.1 'Must Do' Single Requirement Notice

Since the report publication at the end of February, 2019, the Mental Health service line has worked to deliver the single Requirement Notice ('Must Do') for Medicines management in one discrete location. This is due for completion by August 27th 2019, and is currently on its' expected trajectory towards achieving that. Actions are reviewed at unit level governance meetings, forwarded to QIR by the Professional Lead and will undergo further regular and rigorous review at QIR and Assurance Committees. Once the components of the Requirement Notice are fully achieved, we will inform the CQC of this: we could then reasonably expect a local inspection to that service to check that regulatory compliance is embedded. We intend to roll out the learning from this Requirement Notice across all core services, and this will be regularly discussed within our Quality, Improvement and Risk meeting and upward to Assurance Committee.

1.2 'Should dos'

The 'Should do's' have been reviewed at Trust-wide and service line levels. After a training session to all Professional Leads, the actions have been uplifted to Verto for ongoing actions and tracking. Specific actions have been allocated to nominated individuals for follow up, and these are under

regular review at service level governance meetings, rag-rated and tracked though our usual governance routes. These will be reviewed at Performance Review Meetings by Service Line and care Group.

1.3 Preparation for Specialist Dental Services and Sexual Health Services

Further support to the Specialist Dental Service and Sexual Health service has been provided by a series of internal "quality visits", a half day study session to governance leads, and ongoing conversations to facilitate compliance in the run up to potential inspection periods. The Estates team have very helpfully supported this work by timely discussions and appropriate interventions.

1.4 Quality Reviews

A planned programme of quality reviews have commenced with the first two reviews completed on Spinnaker and Jubilee house in Portsmouth. We identified areas of both good practice and areas for improvement. During the review we saw people treated with compassion, kindness, dignity and respect.

For the area requiring regulatory and leadership oversight, the senior leadership team are leading an improvement programme including a package of support for frontline staff. This is being reviewed monthly by a report written by the service triumvirate and presented at a meeting chaired by the Chief Nurse. All regulatory requirements are reviewed by the Head of Compliance.

1.5 Unannounced Mental Health Act visit

At the end of April, we had an unannounced Mental Health Act visit to Brooker Ward (Older People's Mental Health). The feedback on the day was positive, with comments made that all Mental Health Act paperwork was in order, all Section132 Rights were complete, and staff have a very good understanding of the Mental Health Act, The Mental Capacity Act, and Best Interests Assessments. We look forward to receiving the formal report in the next few weeks.

1.6 Engagement with HOSP and HASC

In April, we presented our CQC report and its' findings at Southampton Hospital and Oversight Scrutiny Panel (HOSP), and Portsmouth Health and Adult Social Care Select Committee (HASC), where we were congratulated on our ratings and ambitions to become even better. We look forward to welcoming CQC colleagues back to the Trust to conduct their inspections of our Sexual Health Services and Specialist Dental Services at some time in the future.

**Board Recommendation**

The Board is asked to:

- Note the contents of the report.

Assurance Level

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)

**Item 15**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Title of Paper*** | Professional Leadership Report – May 2019 | | | | | | | |
| ***Author(s)*** | Angela Anderson, Associate Director Professional Standards | | | | | | | |
| **Executive Sponsor** | Jackie Ardley, Chief Nurse | | | | | | | |
| **Well Led KLoEs** | **W1** Leadership Capacity & Capability | X | **W2** Vision & Strategy | X | **W3** Culture | X | **W4** Roles & Responsibilities | X |
| | **W5** Risks and Performance | | **W6** Information | | **W7** Engagement | X | **W8** Learning, Improve & innovation | X |
| ***Date of Paper*** | 16 May 2019 | | **Committees presented** | | N/A | | | |
| ***Action requested of the Board*** | X To receive | | ☐ For decision | | | | | |
| ***Link to BAF risk*** | BAF #57 Concerning: Quality Governance or N/A ☐ | | | | | | | |
| **Level of assurance** *(tick one)* | Sigificant | | Sufficient | X | Limited | | None | |

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

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

**Background**

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

This paper provides an update on developments since the November 2018 report.

**Current Position**

**Professional Leadership:**

**Allied Health Professional and Nursing Strategy Review:**
During 2019, both the Allied Health Professional (AHP) and Nursing strategies are due for review and this has provided the opportunity to explore adopting a new and exciting approach to the development of a professional strategy. The aim is to develop a framework that encompasses all clinical staff, building an inclusive and collective clinical strategy.
The clinical strategy will focus on delivering high quality, safe and innovative care in the community, responding to patient and carer feedback and leading to improved patient experience. It will demonstrate interconnectivity and synergy with other Trust-wide strategies, frameworks and business planning e.g. Community Engagement Strategy, Career Framework and workforce planning.
The vision for this NEW multiprofessional clinical strategy is that it;

- Engages registered and non-registered clinical staff, in all professional groups across the Trust
- Acts as a 'living' document that guides best practice, shared learning and improved experience across professions and services
- Provides a strong foundation in health and care partnerships, utilising guiding principles of co-production and asset-based approaches

The strategy will be developed further during quarter 2 with a view to formally launching the strategy during quarter 3, 2019/20.

**AHP Forum:**
The AHP Forum continues to meet on a quarterly basis and has excellent attendance from senior AHPs across the Trust. One of the recent forum meetings had a special focus on continued professional development and explored ways our AHPs created development opportunities outside of the formal funding streams from Health Education England (HEE) and other bodies. The outcome of this work will feed into the AHP Conference which is planned for later this year.

**Matron Forum**
The Matron's continue to meet and in the last quarter have worked to develop a Matron's Charter which outlines the key attributes, expectations and role of the Matron. This was shared at the recent Nursing Conference and will be used to shape the development of a core role description for Matron's across the Trust which it is intended will provide consistency. The group are also connecting with a newly established national matron's network.

**Hampshire & Isle Of Wight (HIOW) AHP Council:**
In line with the Long term Plan and as part of the Sustainability and Transformation Partnership (STP), an AHPs Council has been established to ensure the expertise and potential of this diverse group of professions is fully maximised in transforming Health and Care at local, Place and STP level.
The council will drive delivery of the HIOW AHP place-based plan focusing on key themes of:

→ Workforce of the Future
→ Excellence through Leadership
→ Value and Innovation
→ Quality Evidence Based Care
→ Health and Well being

The council will operate by:

- Facilitating a framework for AHP engagement at local, PLACE and STP level

- Being active members of key STP related groups e.g. LWAB, Clinical Executive Board and Quality Board
- Sharing and facilitating excellence, innovation and use of technology in AHP practise across the STP
- Engaging with local and national stakeholders demonstrating where AHPs can make a positive impact
- Bridging the health, social care and wider care system to provide co-ordinated solutions
- Working closely with a range of Education providers to ensure development of a sustainable and skilled workforce
- Facilitating benchmarking of services on quality, efficiency, cost and outcomes
- Utilising a range of engagement and communication methods at STP and Place level.

Dr Clare Mander, AHP Professional Lead for the Trust has been elected by her peers as the Council Chair for the first 12 months.

**Revalidation & Reregistration:**

During this reporting period two staff members have failed to re-register which has resulted in a lapse in registration. Actions were taken in line with Trust policy and both staff members are now registered to practice.

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

**AHPs:**

- National Challenge Fund research underway investigating the role of OTs in Vocational Rehabilitation within Primary Care – only one of two Trusts nationally to be selected.
- Pilot of rotating advanced practice paramedics from SCAS within PRRT is underway in Portsmouth.
- The new Portsmouth model for Intermediary Care will include advanced and consultant practitioners which creates career development and progression opportunities for AHPs and Nurses.

**AHP apprenticeships:**

Many AHP apprenticeships are ready for delivery. However due to the small numbers from individual Trusts, Health Education England (HEE) is working with all Trusts in the Wessex region to jointly procure a training provider. It is expected that AHP apprenticeships will be available from January 2020.

Podiatry and Occupational Therapy have been identified as Solent's two priority areas for degree level apprenticeships. Our other AHPs have a strong supply via traditional educational routes or have not yet had the degree level competencies frameworks agreed.

**HIOW OT Apprenticeship Consortium**

Data from the undergraduate OT programmes across the South indicate a 35% decline which could potentially result in significant supply issues over the next few years; as well as viability of these programmes going forward. We currently have OTs across four of our service lines (Adults Portsmouth, Adults Southampton, Mental Health and Children and Families) with new and emerging OT roles in Primary Care. OT is our second largest AHP profession (last head count = 120 OTs).

Across HIOW, an OT Apprenticeship Consortium (NHS Trusts & LAs) has been developed with the aim of generating sufficient interest to make a local OT apprenticeship programme viable. The group will then look to jointly procure places when the new national procurement framework is released later this month, (May 2019). Southern Health Foundation Trust has agreed to be the lead provider.

**Podiatry**
Discussions have taken place to explore the practicalities of the degree level apprenticeships, but unfortunately there has not been any interest expressed within the local system to make a local programme viable. HEE is facilitating discussions about regional distant learning opportunities.

**Nursing Associate**
In January 2019 the NMC introduced regulation of the nursing associate role, and has published the standards of proficiency. As a result Solent NHS Trust have asked that staff working within nursing teams and applying for the foundation degree in health and social care are entered onto the nursing associate pathway.

April 2019 saw 9 Health Care Assistants (HCAs) commence the nursing associate programme at Solent University, Southampton. Mental Health (MH) services have undergone a workforce transformation consultation and have identified staff that will be able to use apprenticeship funding to progress into both the nursing associate and registered nurse degree apprenticeship programmes.

**Registered Nurse Degree Apprenticeship (RNDA)**
Solent University, Southampton, were successful in becoming NMC accredited and now offer both direct entry and an apprenticeship route to degree nursing. Solent NHS Trust has identified staff to commence the 4 year adult registered nurse degree apprenticeship. Solent University will offer the mental health nursing degree apprenticeship from 2020. Currently there are 2 Health Care Assistants from Adult Mental Health services who are completing the 4 year Mental Health Registered Nurse Degree Apprenticeship with the Open University.

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

**Newly Qualified Clinical Staff Induction Programme**
Based on the success of the newly qualified nurse induction programme in 2018/19 the Educators in Practice will be leading the delivery of a new multiprofessional induction programme for newly qualified staff across professions. This will provide equity and will also enhance the preceptorship offer.

**Recruitment and Retention**
The Trust continues to work with NHSI in relation the recruitment and retention programme and the leads for this work held a follow up summit with colleagues across the Trust to review progress on each of the work streams.

In April the Trust were invited to submit a bid for funding to the Chief Nursing Officer, England, which is to support reducing pre-registration attrition and increasing retention. Following discussions with Chief Nurses across the STP a combined expression of interest has been submitted and we await the outcome.

**Preceptorship**
Solent NHS Trust continues to run a one year preceptorship programme for both Newly Qualified Nurses and AHPs. There have been no significant changes to the programme.

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

**Non-Medical Prescribing (NMP) Conference**

In February 2019 the Trusts annual NMP conference was held and had attendance from 100 (approximately 50%) of the registered NMPs in the organisation. The conference was opened by the Chief Nurse and chaired by Sue Hill, Workforce Transformation Lead, HEE. The conference had presentations from national subject experts and also included workshop sessions for those attending. Overall the evaluation of the day was very positive.

**Nursing Conference**

To coincide with International Nurses Day the Trust held its Nursing Conference on 10 May 2019 with in the region of 200 nurses attending on the day. The conference was honoured to have Andrea Sutcliffe, Chief Executive of the Nursing & Midwifery Council as its keynote speaker. The theme for the conference was 'Partnering with Patients' and had a number of inspiring contributions from service users sharing their experiences of our care. The Learning Disability (LD) strategy was shared by the Trust LD lead and Lee, a service user. Tricia Reynolds one of our LD nurses also presented a reflection of the last 100 years of Learning Disability nursing in recognition of its centenary.

This year saw the introduction of the first Nurse of the Year awards with 47 of our nurses nominated by both colleagues and patients. The nominations were shortlisted to 11 people who were filmed prior to the conference and their stories shared prior to announcing the winner. The winner and runners up were selected by a panel led by one of our volunteers. The Nurse of the year is Vanessa Bull, a learning disability nurse with the Jigsaw team who are based in the Civic offices in Southampton.

**'Service to commemorate the life of Florence Nightingale and to mark the centenary of the funeral of Edith Cavell'**

Four of our nurses, three of whom were nominees in our Nurse of the Year awards, had the privilege of attending the ceremony held in Westminster Abbey held on 15th May 2019. The ceremony recognised the enormous contribution both Florence and Edith made to the nursing profession as well as to influencing social justice. The nurses, Jackie Osbourne, Claire Robinson, and Lisa Kirk said that it was an honour to be present and that it is a day that they will never forget.

**Solent AHPs Conference (Upcoming)**

Planning is underway for the AHP conference which it is planned will take place on 10 October 2019, ahead of #AHPsDay on the 14 October 2019.

**<u>Celebrations and Successes:</u>**

The Trust has nominated five people for this years Chief AHP Officers Awards 2019 across three categories including workforce, NICE guidance and Research and Quality Improvement. We await the results of shortlisting.

We are delighted that three of our nurses have been confirmed as Queen's Nurses by the Queens Nursing Institute. This is a great honour for community nurses and the application process is rigorous. The three nurses are Suzi Graves, Senior Matron, Adult Services Southampton; Julie Southcott, Clinical Matron, Adult Services Portsmouth; Tracey Tudball, District Nurse, Adult Services Southampton.

The Southampton Tissue Viability team won the best poster award at their recent National Conference and were also voted the winning poster at the recent Trust nursing conference.

The Portsmouth Health Visiting team won the best poster award at the 'Global Perspective Conference' in Liverpool in May 2019.

Dr Lynn Dangerfield, Clinical Services Manager - Adult community Speech and Language Therapy, Portsmouth has received confirmation that her poster presentation '*Managing dysphagia referrals in nursing and care home settings: the development and introduction of pre referral information packs*' has been accepted for the Royal College of Speech & Language Therapy conference to be held later this year.

**Recommendation**

The nursing and AHP professions across the organisation continues to be very active in raising their profile and contributing both internally and externally to the development of the nursing and AHP professional workforce in order to ensure that it is fit for purpose and ready to meet the challenges of the changing healthcare environment. This report has provided a summary of the key activities being undertaken since the last report.

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

Assurance Level

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)

Item 16

# Annual Report for Health and Safety
# For the year 1 April 2018 to 31 March 2019
# Board Version

## Section 1: Executive Summary

The purpose of this report is to provide evidence that arrangements are in place for health and safety management and that we are meeting our statutory requirements for health, safety and security. This report informs the Trust Board of the activities undertaken in relation to health and safety and the Health and Safety Group and sets out some objectives for 2019/2020. The report has been produced using the Health and Safety Executive (HSE) guidance "Managing for health and safety (HSG65)" and covers staff, patients, visitors and contractors for the period from 1 April 2018 to 31 March 2019.

The table below provides a summary of each of the key areas reported on and is RAG rated to enable a quick overview to be seen with further detail available within the body of the report:

| | |
|---|---|
| **Section 2: Governance and Management Arrangements** | |
| Solent have remained compliant with (section 2 (3) HASAWA) | |
| Solent have remained compliant with section 2(2)(7) HSAWA | |
| Health and Safety Executive legislative consultations/changes | |
| Assessment and Inspections | |
| **Section 3: Compliance and Assurance** | |
| External Agencies and reporting of Incidents | |
| RIDDOR | |
| DoH Central Alert System (CAS) | |
| **Section 4: Annual Security Management Report** | |
| Strategic Governance | |
| Lockdown Procedures – refer to Section 4 Page 7 | |
| Crime Reduction Surveys | |
| **Section 5: Annual Fire Management Report** | |
| Fire Risk Assessments | |
| Compliance with The Regulatory reform (Fire Safety) Order 2005 | |
| **Section 6: Annual Estates Management Report** | |
| Statutory and Mandatory Maintenance | |
| Backlog Maintenance | |
| Water Safety Management | |
| Asbestos Management | |
| Compliance | |
| **Section 7: Risks and Issues** | |
| Incident Reporting | |
| Manual handling | |

Key areas of focus for 1 April 2019 – 31 March 2020 have been identified and the detail can be seen in Section 8 of the annual report. These will be monitored and progress reported on at the quarterly Health and Safety Group meetings and will also be reported on in the 6 month update for the 2 December 2019 Board meeting.

## Section 2: Governance and management arrangements

Solent NHS Trust as an employer is required to appoint one or more competent persons with the necessary skills, knowledge, and experience to assist in helping them to meet their legal duties. Solent NHS Trust meets this obligation; the Trust has a full time Health and Safety Manager and other competent persons are in place in regards to Estates Management, with specialist advisors for fire safety, local security management, and environmental management.

**Solent have remained compliant with (section 2 (3) HSAWA)** with the Chief Executive Officer (CEO) reviewing and endorsing Solent's commitment to health and safety with the signing of the health and safety policy statement of intent.

*A copy of the signed Health and Safety Statement of Intent can be found in Appendix A.*

**Solent have remained compliant with (section 2(2)(7) HSAWA)** with the CEO delegating executive lead responsibility of health and safety to the Deputy Chief Executive, and the Chair (Associate Director of Estates and Facilities) of the Trust Health and Safety Group who has the authority to act upon the decisions reached by the Group. It is the view of the Health and Safety Manager and the Associate Director of Estates and Facilities that the Health and Safety Group is compliant in fulfilling its statutory requirements with the representation of both elected unionised representatives of employee safety and non-unionised employees in accordance with the Safety Representatives and Safety Group Regulations, and the Health and Safety (Consultation with Employees).

The Health and Safety Group met quarterly on 24 April 2018, 31 July 2018, 23 October 2018 and 22 January 2019; the following are some examples of notable areas of work which have been led by the Health and Safety Group over the last year;

- Review of the Health and Safety Group Terms of Reference
- Changes in Health and Safety legislation as a standing agenda item. Any impacts are reflected within organisational policies and/ or Standard Operating Procedures
- Fuller Representation at Health and Safety Sub-Group
- Evacuation mats and evacuation chairs
- Falls witnessed/not witnessed
- Poswillo dental ventilation system
- Central Alert System ( CAS) distribution list
- Water coolers
- Electric motorised scooters
- Storage resulting in drugs overheating.
- Lone working devices usage, lone working risk assessments
- Estates compliance report

The Associate Director of Estates and Facilities (Chair) confirmed that any outstanding action's recorded on the action tracker from this year's Health and Safety Group programme will be carried forward to next year.

The Group is working effectively with an open culture where attendees are playing an active role in talking through decisions about health and safety to identify joint solutions to issues being raised.

**Health and Safety Executive legislative consultations/changes** during 2018/19, review outcome and action

| Legislation | Review Outcome | Action taken |
|---|---|---|
| Courts review on jail sentence for workplace manslaughter | Employers or managers convicted of gross negligence manslaughter after a work place fatality will be facing a longer prison sentence under a new guideline published by the Sentencing Council | Cooperate manslaughter training power point created to be presented to senior management |
| New Safety Agency Proposed for the Construction sector planned to fill "competency" vacuum | The Construction Industry Council (CIC) have proposed augmenting the Joint Competency Authority set out in the Hackett review with a new Building Standards Agency to act as a guardian of professional competency in fire safety | No action taken awaiting final outcome |
| Amendment of the Health and Safety (Safety Signs and Signals) | The minimum general requirements concerning signboards: conditions of use and the minimum requirements for hand signals and coded signals to be used | No action required |
| Amendment of the Ionising Radiations Regulations | Amended as follows:<br>The definitions of "classified person", "controlled area" and "radiation passbook". | Shared with relevant service team |
| Fire Safety Regulations and Building Regulation | independent review of building regulations and fire safety to define clearer roles and responsibilities throughout the design and construction process, as well as during a building's occupation | No action taken awaiting final outcome |
| Workplace Exposure Limits EH40 | Revised Indicative Occupational Exposure Limit Values (IOELVs) for thirty-one chemical substances to help protect workers from the ill-health effects of exposure to hazardous substances in the workplace. | Applied directly onto the Sypol COSHH Assessments |
| Control of Asbestos Regulations | Increase in the interval by 1 year for licensed workers to attend medical examination | No action required due to no Solent NHS employee work with asbestos. Will be reflected in revised asbestos policy for accuracy and information |

**Policies and Procedures** developed or reviewed by the Health and Safety Manager and approved by relevant Groups/ Groups during 2018/2019 were:

- Safe Use of Display Screen Equipment and Mobile Devices Policy
- First Aid at Work Policy
- Health and Safety Policy
- Moving and Handling of People and Inanimate Load Policy
- Health and Safety Workplace Inspection Procedure

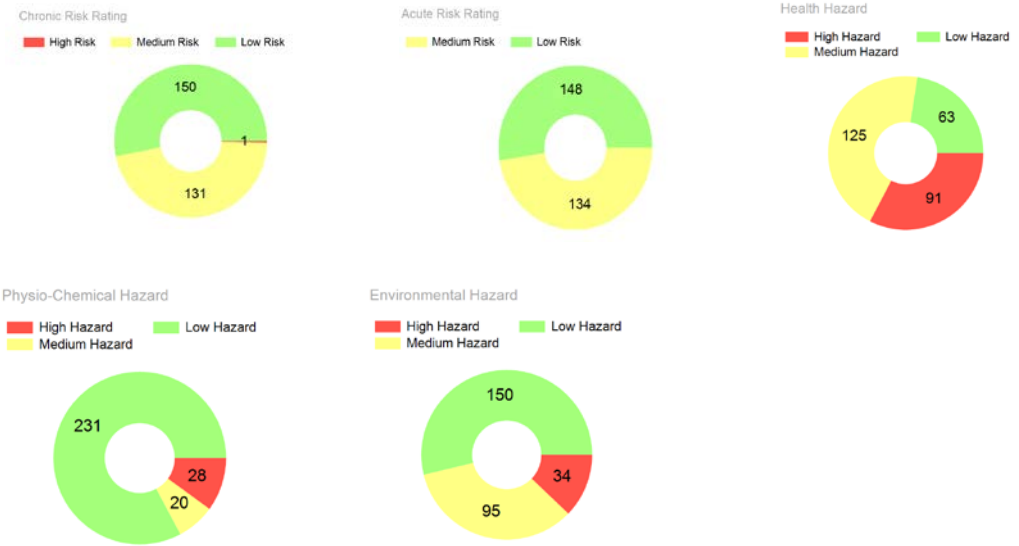
The following policies are for review during 2019/ 2020

- Control of Substances Hazardous to Health (COSHH) Policy
- Policy for the safe handling and disposal of healthcare waste
- Medical Devices Policy
- Central Alert System (CAS) Policy

## Assessments and Inspections

### Control of Substances Hazardous to Health (COSHH)

During 2018/2019 there were an additional 33 COSHH assessments undertaken, all of the 238 substances used are compliant under COSHH, with adequate control measures and safe to use.




### Going Forward

The health and safety manager will engage with service lines directly to establish a reduction of the number of substances used, standardise substances and evaluate safer alternatives.
The projection will be to reduce the current substances in use down by 10% over the coming year

### Workplace inspections

A schedule of workplace health, safety and security inspections and a series of workplace inspection checklists covering relevant health, safety, welfare and environmental legislation which supports aspects of compliance with the Management of Health and Safety at Work Regulations (MHSWR) and the Workplace (Health, Safety and Welfare) Regulations (WHSWR) have been created to meet the needs of Solent NHS staff working environments.

These assessments started to take place late during 2018/2019; each site and service within them was given a priority rating 1, 2 and 3. As of 31 March 2019 the Health and Safety Manager has completed circa 30% of the priority 1 buildings. All outstanding actions/ recommendations are tracked via the Health and Safety Workplace Inspections Action Plan

Tracker; all actions have been completed or are still within the stipulated completion date. A programme to complete the remaining inspections has been developed with completion by the end of March 2020.

**Going forward**

- Lessons learnt for the inspection to be raised through the Health and Safety Group and with appropriate Trustwide communications.
- Health and Safety Manager to prioritise areas not assessed during 2018/19
- Feed any appropriate actions to the Estates Backlog Maintenance tracker
- Continue to work closely with services to aid the completion of the inspections
- Support managers who will be expected to take local remedial action in response to the assessment findings

**Ligature assessments**

All ligature assessments were completed during 2018/ 2019 with the minimum attendance of at least an Estates representative, Health and Safety Manager, a senior person who works on the ward where the assessment relates to and another clinical person who does not work on the ward. All findings were fed back to the Project Group for Ligature Risk Assessment and Management, this group has now been replaced by the Ligature Board Meetings effective from March 2019. Continued works are taking place with the Estates team to reduce these ligatures and working with services in formalising appropriate mitigating controls

**Additional training undertaken** by the Health and Safety manager during 2018/2019 was:

- Ligature point and ligature cutters (3 different implements that are available to cut ligatures)
- Ligature audit for new staff joining the audit team to have practised a 'dummy' audit on the paperwork
- Occupation health and wellbeing team training (bi monthly) covering noise/monitoring, lighting, temperatures, display screen equipment, manual handling, biological agents under EH40
- Workplace inspection
- COSHH

## Section 3: Compliance and Assurance

### External Agencies and Reporting of incidents

The Health and Safety Manager can confirm that there were no investigative proceedings being undertaken in regards to breaches of health and safety legislative requirements or the Environmental Protection Act by either the Health and Safety Executive or the Environmental Protection Agency.

Solent NHS Trust has not received a visit from any external regulatory agency, either pre planned or as a result of a specific incident complaint during 1 April 2018 to 31 March 2019.

### Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR applies to a set of reporting requirements for work activities in Great Britain; the main purpose is to provide reports, where appropriate, to the Health and Safety Executive and to Local Authorities.

**Solent were 100% compliant with all reportable incidents under RIDDOR** being reported within the stipulated time frame to the Health and Safety Executive

**Tables below break down the incidents by subject/ affected personnel and % RIDDOR per total no of incidents reported in same year – 3 year comparison**

| Staff or member of Public | Location | Injuries | Incidents |
|---|---|---|---|
| Staff | Solent Property | Injury preventing the injured person from working for more than 7 days | 4 |
| Staff | Community | Injury preventing the injured person from working for more than 7 days | 1 |

| Year | No of reportable RIDDOR's | Direction of change | % RIDDOR per Total No of incidents reported in same year. |
|---|---|---|---|
| 2018/2019 | 5 | ↑ | 0.5% |
| 2017/2018 | 4 | ↓ | 0.4% |
| 2016/2017 | 13 | ↑ | 1.3% |

When a RIDDOR is identified the Health and Safety Manager continues to investigate all RIDDOR incidents providing support and will continue to work with department to further improve the quality of investigations undertaken and sharing of lessons.

RIDDOR awareness has improved with the provision of guidance of what is reportable under RIDDOR through the health and safety Group and the health and safety webpage.

## Department of Health Central Alert System (CAS)

Solent NHS Trust receives safety notices and alerts from a number of agencies that require consideration and in many cases action by managers and employees. Methods of receiving alerts and notices are through the MHRA Central Alert System (CAS). Internally these alerts are appropriately cascaded to Solent NHS Trust Services nominated points of contact to which the notices can be acted upon accordingly.

The table below shows the numbers and breakdown of the type of alerts received via the Department of Health through the Central Alerting System (CAS) for 2018/2019

| Year | Medical Devices Alerts | Estates Facilities Notices High Voltage | Estates Facilities Notices Low Voltage | Civil Emergency Messages | Patient Safety Alerts | Drug Alerts | Estates and Facilities Alerts | Dear Doctor Letter | *NHS Improvement* | Supply Disruption Alert |
|---|---|---|---|---|---|---|---|---|---|---|
| 2018/ 2019 | **48** | **9** | **3** | **5** | **8** | **19** | **8** | **3** | **3** | **3** |

**Solent NHS Trust is 100% compliant** as all 109 alerts received within 2018/2019 were acknowledged within the stipulated timescales, no alerts are outstanding and all alerts having been closed off within each alert timescales back to the Department of Health. Safety alerts will be continued to be monitored to ensure compliance within time-frames mandated

To ensure accuracy the CAS Administrator has been circulating every other month the CAS Alert contact distribution list to the Services nominated points of contact and the health and

safety Group attendees , requesting any names to be added or removed. Since March 2018 an additional 45 names have been added and 25 old contact details have been removed. This process will continue.

## Section 4: Annual Security Management Report 01 April 2018 – 31 March 2019

The New Accredited Security Management Specialist (ASMS) role was filled by a new employee who started with the Trust on the 1 October 2018. The role undertaken by the ASMS is a dual role with the ASMS also undertaking work relating to Emergency Planning Response and Resilience as a deputy to the lead role.

The ASMS continues to work towards the previous NHS Protect standards which were disbanded back in 2017, as there are no new standards provided by NHS England the agreement with all trusts was to continue to work with the previous 2017 standards until new standards are implemented. By adopting these principles through the ASMS role this ensures the trust puts the security of staff at the forefront of their commitment to maintaining a safe environment.

The standards work towards 4 key principles.

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account.

### Strategic Governance

The Solent NHS Trust ASMS continues to oversee the security of trust sites and the safety of staff; this is completed utilising crime reduction surveys. The ASMS continues to reach out to staff at meetings and training days pushing the message of security and encourages a pro security culture among staff. The aim is to ensure the safety of staff and the protection of trust's assets.

As a result of this the ASMS has continued to receive support from:

- The Director of Estates and Facilities
- The Health and Safety Manager
- Premises / Line Managers
- Service Lines

The ASMS Dual Role means collaborative work takes place with support from:

- The Chief Operating Officer Southampton and County Wide on matters relating to emergency planning and business continuity of the trust.
- The Emergency Planning Lead.

### Inform and involve

The following specific security policies have been reviewed by the ASMS during 2018/19

- RK06 Emergency Lockdown Policy
- The Management of Security , Violence and Aggression Policy
- Surveillance Camera System Policy
- RK09 Suspect Package and Bomb Threat Policy

Policies currently under review:

- Police Liaison Policy
- Nuisance Calls Policy

**Information and intelligence** has taken place with meetings, and close working relationships with Head of Counter Fraud and Security Management for Hampshire and Isle of Wight, Local counter Fraud specialist, Police, and local Trusts.

The ASMS has held several meetings to establish contacts with other ASMS's in the South East and Wessex areas and WASP (Wessex Area Security Professionals) meetings have been hosted by the ASMS to continue where NHS protect left off, addressing issues affecting the local trusts, alerts have been shared and general discussion on NHS related security issues.

As part of the ASMS role he has worked closely with the estate design and service teams to ensure that appropriate security measures are included at the design stage of planned property refurbishment and redevelopment projects to avoid the additional and more expensive retrofit option that often occurs.

The ASMS continues to support staff who have been subjected to physical assaults or abuse. During 2018/19 working in partnership with the services, have issued out warning letters to individuals

- Letter to a Vexatious patient at Nicholstown GP surgery x2
- Letter to a Vexatious patient at RSH Special Dental Surgery

**Prevent and Deter**

**Lockdown Procedures** were created for Solent owned and controlled properties in the event of any emergency to ensure staff safety. Each site was prioritised as a 1, 2 or 3 rating, dependent on the occupancy of the site. Each site is visited and then risk assessed to look at possible access and egress, the site is then photographed and a suitable refuge point is chosen. This information is added to a lockdown procedure and action card to be displayed at each location to aid the quick lockdown. The lockdowns are reviewed annually, biannually or tri-annually dependent on their given priority status.

During 2018/19 the following buildings have been completed:

**Priority 1:** Comprise 54 buildings with 227 services operating from them, (as of 31 March 2019 we have completed 31 buildings covering 156 services).

**Priority 2:** Comprises 10 buildings with 15 services operating from them (as of 31 March 2019 we have completed 1 building in total covering 6 services).

**Priority 3:** Comprises 15 buildings with23 services operating from them (as of 31 March 2019 we have completed 1 building covering 1 service).

**Crime Reduction Surveys (CRS)** concentrates on layers of security working from the outside in and is designed to address issues relating to security on site (Perimeter security, Access Control, Policy and Procedure), and up to date crime data sourced from a police website www.police.uk

CRS surveys completed so far:

(1) Western Community Hospital Site review.
(2) Western Community Hospital Security Unit review
(3) Battenburg Children's Centre
(4) Andover Health centre (Sexual Health)
(5) Falcon House CCTV and perimeter fence
(6) Rose road Neuro
(7) Portswood GP Surgery
(8) SARC centre (Treetops)

**Hold to account**

Where appropriate the (ASMS) continues to support staff members who have been subjected to assaults or verbal abuse resulting in consultation with staff members, prior to any sanctions being sought. This has resulted in working closely with Hampshire police to push for sanctions for the following incidents:

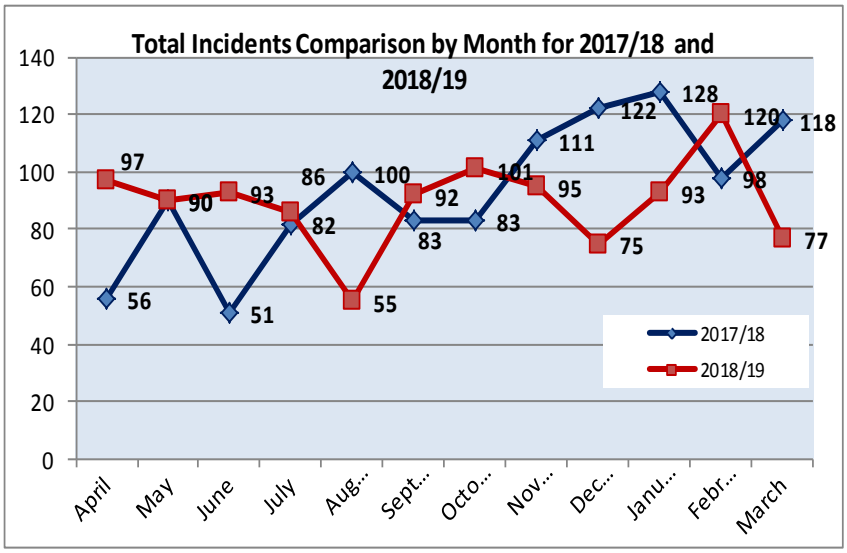
- Vexatious Patient (GP Surgery) x 2
- Nuisance caller (Highpoint)
- Threatening Family Member (JIGSAW)
- GBH Assault (Maples PICU)

**Conclusion**
In summary the Trust has over the last year, demonstrated that it has the ability to respond reactively to a security incident and if an event should occur the incident will be formally reviewed to identify lessons learnt and will proactively support designing buildings and creating processes/procedures to reduce security incidents occurring.

The ASMS continues to improve working relationships with Hampshire Police to ensure that where criminal activity takes place, including violence and aggression directed at our staff, that every action is taken to ensure the perpetrator is identified and action taken. So far the ASMS has been involved in the police investigation of 2 incidents involving vexatious patients who have targeted the trust.

The ASMS is now working in collaboration with the new Counter Fraud Specialist; on matters relating to fraudulent activity concerned with the trust. This partnership working is designed to improve investigation across all streams.

**Below is a statistical overview of all security incidents** reported by members of Solent NHS Trust, it covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons for the periods 2017/2018 to 2018/2019.



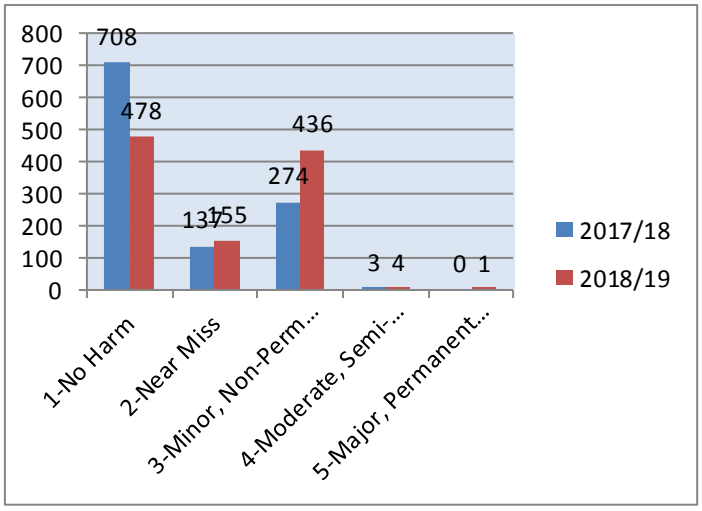

## Summary

Solent has seen an overall decrease in incidents reported by 48. When reviewing the data there are no notable year to year trends

### Security Incidents by Actual Impact

Below are the risk ratings of all security incidents reported by members of Solent NHS Trust covering the overall number of incidents reported and identify general reporting trends against year to year comparisons for the periods 2017/2018 to 2018/2019. The significant drop of No Harm reported incidents has been reflected in the minor increase of near miss and the 37.1% increase of Minor Non Perm-Harm incidents.

During 2018/2019, the ASMS believes that working with staff at GP surgeries, reception desks and admin teams to actively report vexatious behaviour from patients accurately and to police is currently being reflected in the ratings.




### Top Cause One Incident

Focus this year has been on high cause groups reported, ensuring investigations are undertaken where needed support to improve measures where possible to reduce further incidents

Violence and Aggression “Patient to Staff” remains the highest reported category

| Cause 1 | 2017/18 | 2018/19 |
|---|---|---|
| Violence Patient to Staff | 345 | 264 |
| Aggressive, Verbal Gesture Patient to Staff | 156 | 256 |
| Violence Patient to Patient | 95 | 71 |
| Aggressive, Verbal Gesture Other to Staff | 96 | 59 |
| Lack of Security | 36 | 40 |
| Legal Substance Not Permitted | 8 | 35 |

Violence and Aggression "Patient to Staff" prevention work undertaken includes:

- New Conflict Resolution Training package in creation with Learning and Development and Prevention and Management of Violence and Aggression (PMVA) lead to provide training to staff in how to recognise, deal and de-escalate conflict.
- Solent's current support is via Rob Pollock, Solent NHS Trust lead PMVA trainer
- Inpatients, patient to staff incidents reviewed where staff have been assaulted and/or restraining techniques are used
- Variety of collaborative works taking place between the ASMS, PMVA lead and Services

The ASMS continues to examine incidents reported through Safeguard or Ulysses to establish reported cases of crime and acts of violence, whether they are physical or non-physical, against the Trust staff, patient and visitors.

## Section 5: Annual Fire Management Report 01 April 2018 – 31 March 2019

**Fire Risk Assessments**

The Trust Fire Risk Assessments provides Estates with monitoring and feedback for remediation and assurance. Evidence of these assessments is held on the Trust MICAD system. Quarterly assurance reports are generated and sent to the Trust Health and Safety Group who oversee specific issues and actions.

Further operational checks are carried out inclusive of, but not limited to weekly fire alarm testing, monthly emergency light testing, annual portable fire equipment checks and annual fire evacuation drills. Evidence of these checks is held on the Trust MICAD system, also on the maintenance contractor Kier electronic recording system.

Risk ratings from both Fire Risk Assessments and operational checks are allocated against each site and a Kier weekly tracking meeting of identified fire safety related risks is held with an Estates Officer. This process assists the production of the Maintenance Contractor Assurance Report presented at a monthly meeting with the Solent Estates Maintenance Management team who oversees the Trust maintenance contract.

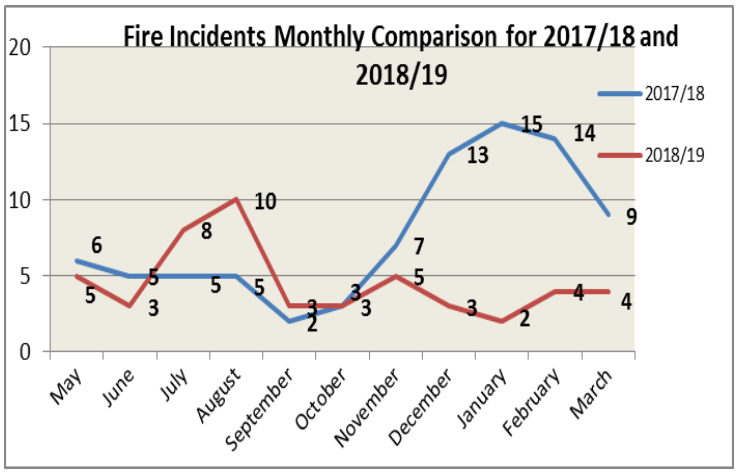
In addition to the above record keeping, Kier in consultation with the Trust Fire Advisor, are currently revamping the premise fire log books to be more pertinent to a community healthcare Trust requirements. The premise fire log books are now installed at all Solent owned or controlled buildings inside new red wall mounted boxes close to the premise main fire panel.

Compliance with The Regulatory Reform (Fire Safety) Order 2005 and the Fire Safety (Employees Capabilities) Regulations 2010, all Fire Risk Assessments (FRA) are subject to an FRA review on a periodic basis. Below are the recommended time periods between reviews as per Trust Fire Safety Policy:

- High risk premises, (e.g. inpatient sleeping risks) within each calendar year period a fire risk assessment
- Medium risk, (e.g. client areas, health centres) annual FRA review form, with a full FRA document every 3 years
- Low risk (e.g. non-client area, offices, and low risk stores) periodic FRA review form, with a full fire risk assessment document produced at least every 5 years.

All properties are provided with a Fire Risk Assessments (FRA). During 2018-19 period we have seen significant estates build work or refurbishment programmes, where possible any identified FRA items have been included into this work by Project Estates Officers. The majority of items detailed above are dealt with by the Maintenance Estates Officers and positive progress has been made with good liaison and co-operation between two different spheres of Estates

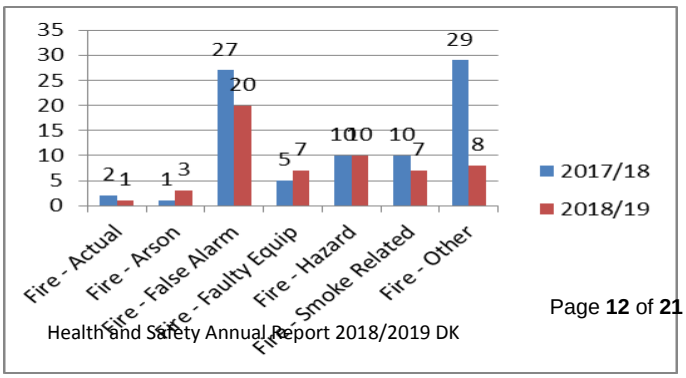
Below is a statistical Fire overview of all Fire related incidents reported by members of Solent NHS Trust, this comparison covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons. This also sets out the current position in relation to an overview of reported incidents during 2018-2019, inclusive of the most reported cause one incidents.




The chart indicates reporting rates across the last two years. This shows the total number of incidents reported down from 84 to 50.

Of the 50 incidents reported 6 were attributed to a community setting "not in SOLENT demise"). During 2018/2019 the reported rates remain fairly static, the main decrease in reported incidents across the two years is attributed to the spike shown during December, January and February of 2017/2018 (Total 39 incidents), of those 30 were reported within our rehabilitation unit and all were smoking related incidents, following the introduction of the Trust-wide smoking ban.

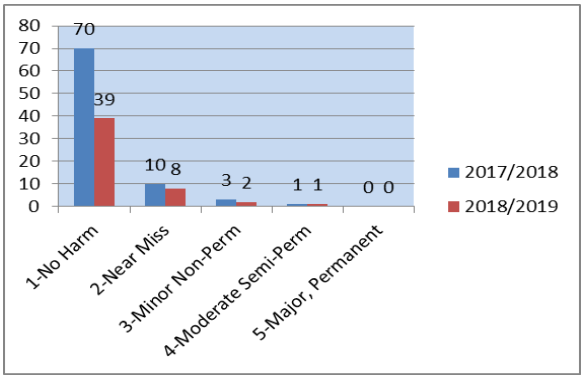
**Top Cause One Incident**




**Top Cause One Incidents**

There has been a marked positive decrease of false alarm activations, the remaining cause groups are generally static but it is clear that during 2018/2019 staff awareness of the type of incidents being reported are better known due to the High 72.5% reduction of Fire other reported.

**Risk Ratings**




We are now seeing a fall in the number of false alarms since fitting staff key operated fire call points at mental healthcare in-patient wards earlier this year. The cause one chart also shows the reduction of 'fire other' incidents where staffs have been reporting under this section unexplained false alarms.

There is an increase in 'Fire Arson'; however two of these incidents were incidents in the community that affected Solent patients and were then reported by community nursing staff onto the Solent Incident Reporting system. This is an item now identified to be discussed with the Trust Quality assurance team, as these outside incidents influence Solent NHS Trust figures when in fact they have not actually involved Trust property or staff.

There was a fall of 'Fire Actual' from 2 down to 1; this one fire of 2018/19 also accounts for the remaining fire arson incident. This fire was in a patient bedroom and after investigation by the Trust fire safety advisor it was proved as a deliberate act. The incident was passed to the police who referred the case to the CPS. The bedroom damage was significant causing a large expenditure for Estates. A complete evacuation of the building was necessary at the time of the incident that occurred in the early hours of the morning, the fire service attended and extricated the patient who suffered smoke inhalation and is fully recovered. Multi service debrief sessions have taken place, lessons learnt have been circulated to all Trust staff, the affected bedroom was repaired and back in use, other recommended building improvements are in progress or factored into future Estates budget.

## Section 6: Annual Estates Management Report 01 April 2018 – 31 March 2019

**Background** Since October 2014 Estates Maintenance Services have been provided by Kier Workplace Services. Their principal responsibility is to provide Mechanical, Electrical and Fabric, Reactive and Planned Preventative Maintenance to relevant Mandatory and Statutory requirements. They also provide a useful labour source for our Minor Works procedure with pre-determined hourly rates.

Kier Workplace Services are monitored through Key Performance Indicators, (KPI's) and stringent Service Level Agreements (SLA's) with monthly reporting. After some initial issues Kier has consistently achieved the expected standards and targets set out under their contract terms. Site visits are undertaken with departmental and/ or building managers to assess building condition, identify any apparent shortfall and praise good works/practice. At these visits the Building Manager or departmental lead completes a "customer satisfaction survey" which is scored and discussed at the monthly contract review meeting. The contract with Kier Workplace Services is now in the final year of a 5 year term relationship due to terminate in October 2019.

Statutory and mandatory maintenance is carried out to comply with Good Industry Practice and NHS Requirements and guidelines. For the reporting period the table below represents the planned and reactive maintenance activity;

| Maintenance Activity April 2018 – March 2019 | |
|---|---|
| **Planned Preventative Maintenance** Tasks scheduled and completed. | **4,549** |
| **Reactive/Corrective Maintenance** Tasks requested and completed. | **4,211** |
| **Damage/Misuse** related tasks associated Reactive calls. | **285** (7% of reactive activity) |

The Solent Estates Team, have the responsibility for maintenance of all compliance documentation. To ensure these records are kept up to date and are accurately stored, they are held on a property database software system, MICAD. This platform is managed by the Estates Asset Management Team.

In addition to the Trusts Freehold Properties, Solent occupies a number of premises as Leasehold or Licenced Tenants. An annual exercise is continuing to contact landlords to ensure they are adequately meeting their obligations in accommodating Trust staff.

**Current**

Work is on-going to ensure that information regarding compliance evidence from all parties is uploaded onto the MICAD system. This will highlight any omissions and areas where action may be required.

**Estates Backlog Maintenance and Strategy**

The Trust has identified, in collaboration with its maintenance service provider, a backlog (long-term) maintenance programme and is now working to enhance the current 5 year plan to an established strategy for the coming 10 years. The Trust Board has adopted the current programme and is supporting the programme through financial investment.

The backlog programme is risk assessed using the 5x5 risk matrix and reviewed annually in consultation with Trust key-stakeholders in order to prioritise and where necessary re-prioritise works to be authorised.

The backlog programme of works forms part of a larger programme of works, including client minor works request and reactive work repairs collated via an Estates Action Tracker that are regularly reviewed, monitored and reported on.

**Water Safety management and risk assessments**

To comply with our legal duties, employers and those with responsibilities for the control of premises should identify and assess sources of risk, this includes checking whether conditions are present which encourage bacteria growth e.g. adverse water temperatures outside recommended standards and infrequently used outlets.

Legionella control and measures are being carried out at grass root level with on-going performance monitoring as part of the remit of Water Safety Group. Over the last year Water Hygiene Risk Assessments have been re-prioritised by the Water Safety Group, based upon risk, for all retained properties have been completed by the Trust appointed FM Provider (Kier), and specifically TWC Services Ltd as their named subcontractor. Response processes, action plans and remedial works have been implemented in accordance with TWC Services Ltd recommendations. Evidence of these assessments is held on the MICAD system and by the Estate Maintenance Management Team.

A number of more frequent tests are routinely carried out to ensure that premises are being maintained to reduce the risk from either contaminated water or water temperature. These testing regimes are required to be carried out monthly and form part of the Planned Preventative Maintenance (PPM) schedules as compliant with the due diligence testing as recommended by HTM 04-01 part B and Health and Safety Doc L8 (HSG 274). Microbiological testing is on-going at identified outlets and has indicated an improved condition and overall reduction in the number of recorded positive outcomes from the previous review period.

Part of the Water Management System written within the 'Control of Legionella Bacteria in Water Systems and Pseudomonas Aeruginosa Assurance Policy' includes a defined process of immediate notification, action and supervision by selected Trust Personnel in the event of a suspected 'high count' or confirmed case of Legionella or similar. Those personnel who will be informed to ensure a suitably weighted and proportionate response include the Responsible Person (Water), Head of Infection Prevention and Control, the Trust Health and Safety Manager, Head of Estates and Director of Estates and Facilities and remaining membership of the Trust Water Safety Group. The remodelling of the HTM 04-01 during 2016 placed a greater emphasis on the efficacy of the Water Safety Group and the requirement for members to be kept informed and collaborate to achieve identified responses to any high count or outbreak.

Quarterly update meetings are also held with Infection Control representatives. A potential weakness that has been identified across all health estate is the flushing of low and infrequently used outlets. Flushing of low use outlets is our primary and most effective water management control measure used in our water safety strategy. The flushing is currently being carried out by several different Facilities organisations; i.e. Intersperse, Southern Health and our own Domestics with no central reporting database and no central management. The estates team and Water Safety Group are proposing a centrally managed process and strategy to facilitate this process. A greater level of awareness around the importance of flushing is being provided by the Estate Maintenance Department and Responsible Person (Water) utilising the opportunity to educate IPT Link Advisors and service users alike with a series of awareness presentations.

**Asbestos Management**

The control of asbestos is covered under a number of items of legislation; every non domestic building is required to have an asbestos register, containing an asbestos management surveys and known materials of concern. The MICAD system hosts the asbestos registers for those buildings owned and operated by the Trust which satisfies the requirements of the Control of Asbestos Regulations 2012. As part of the Trusts on-going Backlog Maintenance Programme, the Estates Team have completed full Asbestos Management Surveys of all premises known to present a high or significant risk in terms of inadequate information. These re-inspections of known or presumed asbestos locations have provided status updates on the presence and condition of any asbestos and any actions required to reduce the risk of contamination. Any Capital Works are subject to a full Refurbishment and Demolition Survey, and Contractors are directed to the asbestos registers and surveys before carrying out any works.

A formal programme of Asbestos Awareness Training has been delivered for all estate operations and project managers to include allied support teams and key individuals.

**Other associated Estates Health and Safety Issues**

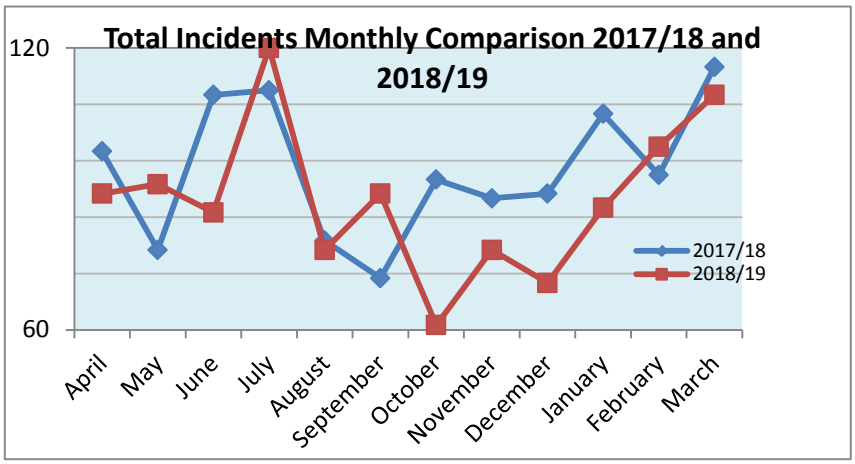
In addition to the work programmes for fire, water and asbestos management noted above, a full programme of other compliance procedures is also undertaken. This includes, but is not limited to gas, electrical installations, lifts and display energy certificates, details of which are held on the MICAD system.

An external assessment of our property portfolio using the NHS Premise Assurance Model (PAM) is being scheduled for 2019 to align with NHS Improvement directives.

## Section 7: Risks and Issues

Below is a statistical health and safety overview of all health and safety incidents reported by members of Solent NHS Trust, this comparison covers the overall number of incidents reported and identifies general reporting trends against year to year comparisons. This also sets out the current position in relation to an overview of reported incidents during 2018-2019, inclusive of the most reported cause one incidents.

**Graph 1 Total health and safety incidents reported Year to Year Comparisons**

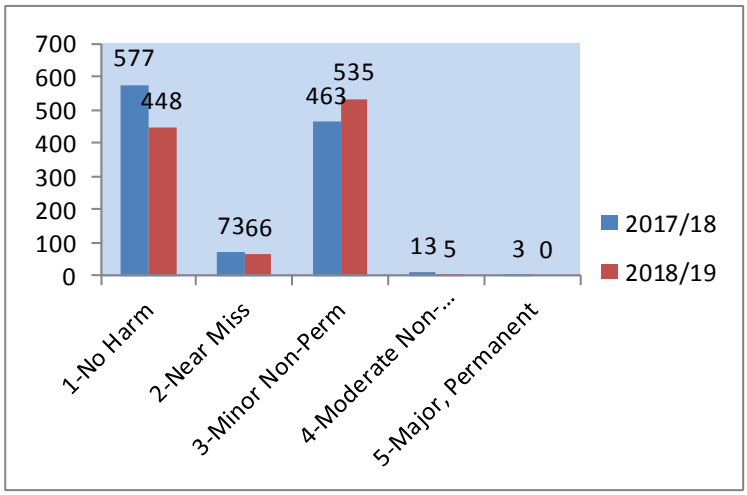



**Summary**

Solent has seen an overall decrease in incidents reported of 6.7%

When reviewing the data there are no notable year to year trends

**Risk Ratings**



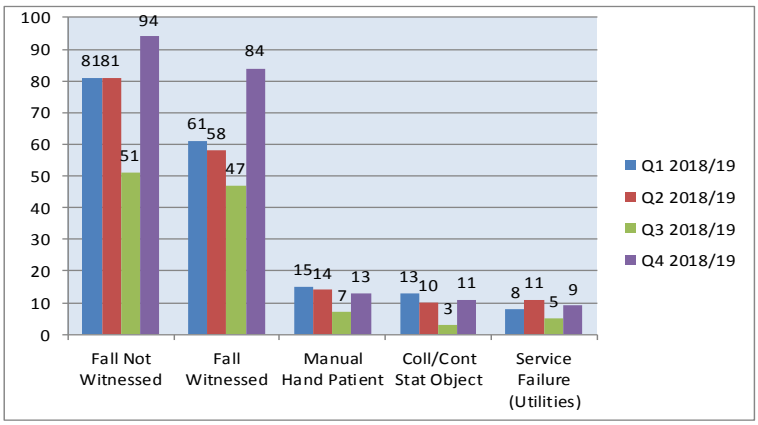

**Summary**

The risk ratings has shown two positive decreases from 3 to zero for Major, Permanent Harm and 13 down to 5 for Moderate Non-permanent Harm; however of the total decreases reported incidents shown (136) for no harm and near miss 72 of those incidents have been reflected with the increase shown in minor non-permanent harm.

The total numbers of reported incidents remain similar and come from all services which indicate a culture of positive reporting of incidents improving patient safety, this is an encouraging position.

Focus this year has been on high cause groups reported, ensuring investigations are undertaken where needed support to improve measures where possible to reduce further incidents

## 2018/209 (Top 5 cause groups)




As with the previous years the highest reportable incidents were falls not witnessed 29.3% and fall witnessed 23.7%. The ratio of falls witnessed against falls not witnessed has again improved for the second year running.

Below is a breakdown of the comparisons for our inpatients areas ONLY:

| Department | Falls Witnessed Total | Falls Not Witnessed Total |
|---|---|---|
| Brooker (The Limes) | 88 | 91 |
| Kite Unit | 15 | 9 |
| Spinnaker | 22 | 19 |
| Lower Brambles RSH | 14 | 18 |
| Fanshawe (RSH) | 14 | 37 |
| Snowdon (WCH) | 14 | 23 |
| Jubilee House | 4 | 29 |
| Hawthorns | 5 | 4 |
| OPMH SJH | 6 | 8 |

Falls Prevention Work undertaken:

- The Policy for the Prevention and Management of Patient Slips, Trips and fall with supportive falls protocol flow charts etc. is now in use
- Falls Champions have been created for all in patient areas
- Inpatient falls meetings being held with the In patients falls Champions to discuss falls reviews, looking at any trends / patterns
- Moderate incidents or above are being provided to Falls Clinical Lead Physiotherapist (Southampton) and Falls Thematic Lead (Solent) to support investigations
- Installation of Hover Jack in high fall area
- Bed Safety Rails – Risk of entrapment assessment review undertaken
- Evaluation of bed exit alarms

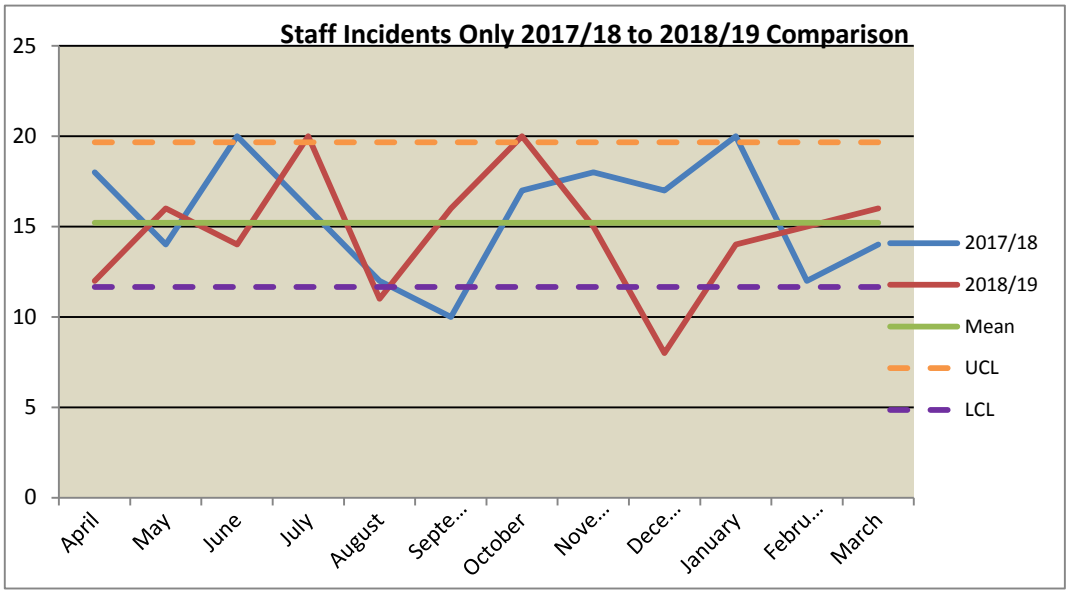
**Manual Handling:** This year has seen a reduction in the number of incidents involving inanimate objects (7.7%) and a decrease in the number of patient handling incidents (24%).

However there has been an n increase in the total number if staff incident s of 24%. During 2018/2019 Learning and development have allocated two new manual handling trainers working very closely to cover the specific needs of each team in accordance with Relevant clinical guidelines, NHS Knowledge and Skills Framework (all core and health and wellbeing specific dimensions), Manual Handling Operations Regulations and the Guide to handling people 6th edition

## Staff incidents ONLY

**Staff ONLY Incident by Service line year to year comparisons 2017/2018 to 2018/2019**

## Staff Only Year to Year Comparisons



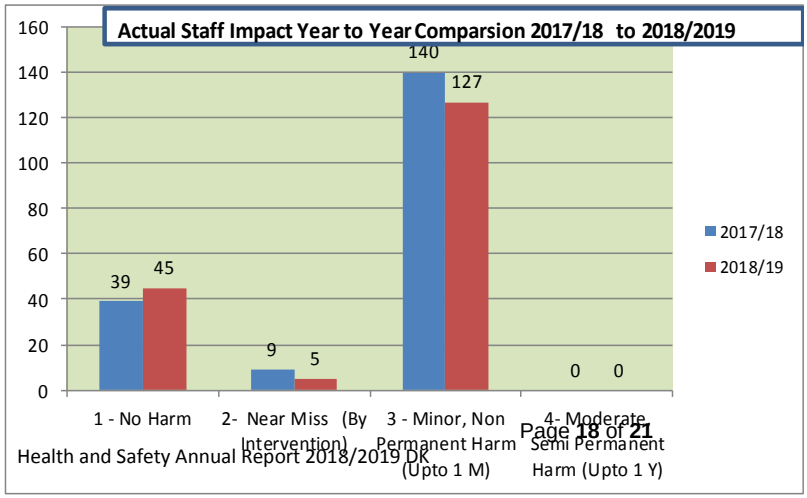

**Staff Incidents Only 2017/18 Compared to 2018/19**

**Summary**

Year to year comparison show a minor decrease of the total number of reported incidents of circa 6% down from 188 to 177.

There are no obvious year to year trend comparisons however during 2018/2019 in August shows a 50% decrease of reported incidents which coincides with annual leave with a similar pattern in December.
Total number of incidents has remained within the upper and lower limits

## Risk Rating Staff incidents ONLY



Breaking down the data for the second consecutive year there were no Moderate, Semi Permanent Harm incidents recorded, there is a positive decrease of reported Minor non-permanent harm incidents by 9.2%, the remaining data is similar of the previous year and no significant changes and or trends observed.

**Summary**
It should be noted that not all incidents were graded correctly at the reporting level and these were amended by line managers. Continued training and promotion of incident reporting is helping to overcome this issue.

The type of reported incidents over the last two years across the geographical expanse of Solent clearly shows that each service line report incidents and are very similar which indicates that the use of the on-line web based reporting system is well known.

## Section 8: Looking Ahead

Health and Safety Manager will be focusing on the following areas of activity during the next 12 months:

- Support the AMH/OPMH ligature reduction Programme and work in partnership with estates colleagues to map through ligature points that can be mitigated whilst the major project refurbishments taking place. Provide anti-ligature ligature point training and ligature cutters training.

- The compliance team will continue undertaking more 'Pop up' training sessions requested by service for staff to achieve the required competencies

- Support the continued development in updating the NHS Premises Assurance Model (PAM) assessment

- Inspection/ Assessment/ audits programmes

  Workplace inspections, complete priority one properties
  Medical gas store external/ internal inspections
  Disability Discrimination Act assessments for Solent own properties
  Complete Lockdown assessments/ procedures
  CAS alert audit

- Combine the compliance team expertise with the Emergency Planning and Business Continuity Lead to mapped through the progression of the new appointed ASMS and Emergency Planning , Response and Resilience Deputy

- Support services in lone working assessments and management and use of lone working devices. Undertake a cost analysis and option appraisal in regards to other lone working devices on the market that could be adopted.

- The Compliance team will continue to work closely with Estates and Facilities Management Team as a key stakeholder in all new build, refurbishment projects or acquisitions of new buildings. Providing expert advice and support and authorised compliant sign off to issues that are identified within sites that relate to statutory compliance with appropriate legislation and Health Technical Memorandums.

We have engaged and formally consulted with our employees and staff side representatives in regards to health and safety management ensuring we remain compliant with the requirements of health and safety legislation.

*The progress of the past year has only been possible through the collective efforts of the Compliance team and colleagues across the Trust. It has been a busy and demanding year, and we thank them all for their continued support*

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**Author: David Keates**
**Job Title: Health and Safety Manager Solent NHS Trust**
**Date June 2019**

**APPENDIX A**

## HEALTH AND SAFETY POLICY

## STATEMENT OF INTENT

This Health and Safety Policy Statement of Intent identifies the commitment of Solent NHS Trust to provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, patients, visitors and other persons affected by the Trust 's undertaking or omissions.

Health, safety and welfare are the responsibility of all staff and are an integral important part of their duties. The Trust's commitment to health and safety therefore ranks equally with all other aims, objectives and activities.

The Health and Safety Policy establishes both general and specific arrangements relating to the Trust's undertaking and extends to all premises, buildings, areas and activities throughout the Trust.

A copy of the Health and Safety Policy is made available to all employees at induction and subsequent training. It is also available on the Trust intranet SolNet. The Trust ensures that all employees are fully aware of their legal obligations to take reasonable care for their own health and safety and that of any persons who may be affected by their acts or omissions at work. All employees are legally required to co-operate with their employer in health and safety matters.

Where employees do not have access to SolNet, line managers are to make such arrangements as may be necessary to ensure employees have access to this policy.

To enable the effective implementation of the health and safety policy and the performance of all tasks safely and without risk to employees, patients or visitors, staff will be provided with suitable and sufficient information, instruction and training.

To encourage and promote effective consultation, communication and co-operation between management and employees, all departments shall develop appropriate systems by which the contributions and concerns of employees can be raised at departmental management meetings, and the Health and Safety Group

This Health and Safety Policy Statement of Intent shall be reviewed and amended periodically, or as dictated by changes to legislation, working procedures, policies or conditions, whichever is the sooner.

Sue Harriman
Chief Executive Officer
Solent NHS Trust

September 2018

Solent NHS Trust

Item 18

**Exception and recommendation report**

| Committee /Subgroup name | Assurance committee | Dates of meeting | 23rd May 2019 |
|---|---|---|---|
| Chair | mick tutt | Report to | Trust Board |

**Key issues to be escalated**

We received substantive written reports and further verbal material up-dates regarding action taken to address the **concerns raised by continued problems experienced with the** (3rd party) **Wheelchair provider** and the **risks arising from access to the** (3rd party) **county-wide Equipment store.** The verbal material up-dates provided substantially more assurance than that available in the written report – demonstrating real progress since papers were submitted. We were, however, clear that further written up-dates were required; to ensure both the committee and Board remained sighted on the risks associated with the problems experienced by people requiring assistance with wheelchairs or other equipment
We noted that this action was also being tracked through our Board Assurance Framework (BAF)
In further discussion, we were assured that urgent management action; to understand how local people might be impacted by similar 3rd party concerns regarding services commissioned for people with a Learning Disability – brought into sharp focus by recent media coverage – was in hand

We received the **Annual Research & Improvement report**, together with **quarterly reports on the experience of people** who access services provided by the Trust and, sometimes their carers, **and Safeguarding activity**. We noted, overall, the quality and richness of information providing substantive assurance of the range of activity presented – and discussed, also, further developments which would refine this assurance further in future reports
The positive impact, upon the experience of people accessing services and their carers, of the research and improvement activity was emphasised – together with the contribution this activity had in demonstrating that staff were, rightly, proud of the quality of service they provided
The data required from the Learning from Deaths activity is appended
The current concern regarding the up-take of one particular part of the Safeguarding training; because of changes in requirement, was noted – together with the assurances received that this would be addressed within the requisite time-frame

We received our standard **exception-reporting from the Quality Improvement & Risk** (QIR) **group and our Chief Operating Officers:-**

- the progress with **delivery of the End of Life strategy** was discussed, in some detail – and we were informed that the planned strategy will now be delivered in Quarter 3. We were up-dated on the progress made and further consultation planned; including meetings with carers, families and carers of past families, discussions with system-wide colleagues and faith groups

- in similar vein, we were up-dated (later in the meeting) of progress with the review of the process previously known as the Equality Impact Assessment. We received assurance that our recently-appointed Equality, Diversity & Inclusion lead was

undertaking a thorough **Equality Analysis**; which would assist in future consideration of the commitment to, and assurance of our achievements in relation to equality, diversity and inclusion. This would be subject to future Board discussion and, in the interim, the ED&I lead was involved in all consideration of policies recommended for ratification

- we noted that the Portsmouth COO's report was more detailed than previously; because of her increased sensitivity to some of the **risks** she perceived – including that **related to waiting lists, across a number of services**. We received assurance of the action being taken to address these risks and agreed to review the position in future reporting

**Decisions made at the meeting**

We endorsed the **final draft of the Quality Account** – noting, as with previous iterations, that this year's version was driven by service-aspiration and had already been subject to consultation across a broad range of stakeholders – subject to minor typographical changes. We, further, endorsed the **final version of the Annual Governance Statement**
We agreed these endorsements would be confirmed for the Board meeting scheduled for 24th may

We also endorsed the **current, relevant, BAF entries** and the **proposed Annual Report**

The following policies were ratified by the Committee, including this following approval via chair's action:-

- Intravenous Policy
- Policy for Security and Management of Violence and Aggression
- Moving and Handling of People and Inanimate Load Policy
- Complaints, Concerns, Enquiries and Compliments Policy
- Duty of Candour Policy
- The Management of Mobile Devices Policy
- Tissue Viability Policy
- Records Management and Information Lifecycle Management Policy
- Information Request Policy
- Data Protection Compliance Policy
- Safe Use of Display Screen Equipment and Mobile Device Policy

The Learning from Deaths Policy was ratified subject to confirmation that requested amendments had been made.

**Recommendations to the Trust Board**

**The Board are asked to**

- **note the issues set out above**

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

None of note

Item 21

**Exception and recommendation report**

| | | | |
|---|---|---|---|
| **Committee /Subgroup name** | **Community Engagement Committee(CEC)** | **Dates of meeting** | 3rd May 2019 |
| **Chair** | **Stephanie Elsy** | **Report to** | Trust Board |

**Key issues to be escalated**

The committee received and update from the Equality, Diversity and Inclusion Group EDIG. It was agreed that both EDIG and CEC need to work closely together and a meeting has been arranged between the Lead Executives of both Committees to discuss the cross-over of agendas, to ensure that objectives are aligned. Pamela Permalloo-Bass will be a member of both the EDIG and CEC.

The Committee discussed the Service User Activity Report and CEC would like board to note the following:

- There is robust data for age, sex and ethnicity
- There is a very high rate of non-completion for data on religion or belief
- Only Sexual Health services collect data on sexual orientation

It was noted that initial discussions with clinicians on low rates of data collection could be summarised into three areas

- SystemOne access to the primary care record
- Lack of confidence/understanding to ask the right questions
- Service User reluctance to complete forms

It was agreed that it remains important that ethnicity data for service users should me matched against local population data profiles.

It was agreed that the service user and workforce data reports are to be shared with colleagues across the Trust in order to check their accuracy, build awareness of the issues and ownership of the action plan for addressing data gaps and determining next steps. The plan is to commence discussions at Trust Management Team.

**Decisions made at the meeting**

The Committee reviewed the delivery plan and agreed that the following two priorities would be considered in the first instance

- BAME service access in Mental Health (Portsmouth)
- A review of Primary Care – Nicholstown Practice (Southampton)

**Recommendations to the Trust Board**

**The Board are asked to**

- **note the issues set out above**

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

None of note

Item 26.1

NHS Solent NHS Trust

# Governance & Nominations Committee Annual Report 2018-19

## Introduction

The Governance & Nominations Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2019.

## Meetings

During 2018-19 the following meetings were held:

- 19th July 2017
- 27th September
- 10th December 2018

## Membership & Attendance

Attendance by members is outlined as follows:

| | Meeting | | | |
|---|---|---|---|---|
| **NAME** | **19th July 2018** | **27th September 2018** | **10th December 2018** | **% attendance** |
| **Dr. Alistair Stokes – Chair** Chairman | P | P | P | 100% |
| **Mick Tutt** Non Executive Director | P | P | P | 100% |
| **Sue Harriman** Chief Executive | P | P | P | 100% |
| **Jon Pittam** Non Executive Director | A | P | P | 66% |

P= Present A= Apologies

## Terms of Reference

The Terms of Reference (TOR) for the Committee were reviewed at the July 2018 meeting. Consideration of the Committee's TORs will be given at the July 2019, following the Trust's new Chair commencing role from 1st April 2019.

## Status against the achievement of the Committee's Objectives

| Objectives | End of Year status |
|---|---|
| **To review non-executive membership of Board Committees upon appointment recommending changes to the Board as appropriate** | *Committee membership was considered and agreed at the July 2018 meeting. It was acknowledged that the newly appointed Trust Chair will wish to consider Board Committee membership (to be discussed at the July 2019 Governance and Nominations Committee)* |
| **To review executive portfolios upon new appointments /resignations to ensure appropriate coverage, succession planning and management of director remits** | *Changes to portfolios were agreed and noted at the July 2018 meeting.* |
| **To consider governance arrangements in light of future organisational changes and the emerging Health and Social Care environment** | *The emerging governance arrangements of the ICPs are acknowledged and considered by the Committee alongside appropriate engagement of Trust officers and NEDs* |

| | |
|---|---|
| **Undertake a comprehensive review of board effectiveness taking into account the requirements of the Well Led Framework.** | *The Committee was assured of an established process to carry out self-assessments and address raised action plans. It was agreed at the December 2018 meeting that timescales to conduct the next stage of developmental reviews be reviewed at the July 2019 meeting following the appointment of the Trust's new Chair from 1st April 2019 and following receipt of the CQC Well-Led Inspection formal report.* |

**Summary of business conducted in year**

The main business conducted by the Committee is summarised as follows;

July 2018

- The Committee reviewed NED Membership to Board Committees.
- The Committee noted that the future frequency of Assurance Committee meetings were to be reduced once recommendations from the recent internal audit were embedded.
- Executive port folios were reviewed and changes agreed.
- Chairs action was taken outside of the meeting to recommend to the Board the reappointment of Mick Tutt as Deputy Chair and Jon Pittam, Senior Independent Director until July 2019 (to coincide with the first scheduled meeting, following the appointment of the Trust's new Chair).
- The Chairman confirmed his intention to resign at the end 31st March 2018, the natural end of tenure. It was agreed that NHSI be notified accordingly and to request commencement of the Chairs appointment process. All NED tenure dates were also noted.
- The Committee agreed to defer consideration of a third party review of the well-led self-assessment to Feb 2019, in light of the forthcoming CQC inspection.
- The Committee were briefed on succession planning processes.

September 2018

- The meeting was held specifically to consider the Chair succession plan and imminent recruitment process led by NHSI – including consideration of the job description, information pack, stakeholder event and recruitment timetable.

December 2018

- The Committee reviewed Board Committee membership and it was agreed not to make any changes at this stage and a further review will be undertaken once the new Trust Chair is settled into the role. Membership and Lead NED roles are summarised on the following page.
- The possibility of the recruitment of a Chief Information Officer following comment from the Secretary of State was discussed and it was agreed that further consideration is required by the Executives.
- The departure of the Mental Health Act and Mental Capacity Act Lead was noted and consideration was given to the future management arrangements for the role. It was agreed that further consideration is required by the Executives.
- The Committee discussed the tenure renewal of the Deputy Chair and SID roles due to expire in February 2019 and it was agreed to extend the current tenure periods until 12th July 2019 (the next Committee meeting date) at which point the new Chair will take a view.
- It was agreed that further consideration with regards to the timing of the next stage of Well Led Development reviews be conducted at the July 2019 meeting to coincide with consideration of the CQC Well Led report outcomes and to allow the incoming chair to take a view.
- An update was provided with regards to the recruitment process for the Chair position.

| **Proposed draft objectives for 2019-20 to be agreed at the forthcoming 12th July 2019 meeting:** |
|---|
| • *To continue to review the composition and frequency of Board Committees ensuring consideration given to balance of skills and experience, and in light of internal audit recommendations concerning the MHASC.*<br>• *To continue to seek assurance regarding succession planning*<br>• *To give due consideration concerning the appropriate timing of the next stage (external review) of the Well Led Development review.*<br>• *To consider emerging governance arrangements in light of future organisational changes and the emerging Health and Social Care environment* |
| **Conclusion** |
| The Committee has complied with its Terms of Reference during the period under review. |

| | |
|---|---|
| **Report Author(s)** | Governance & Nominations NED members<br>Jayne Jenney, Corporate Support Manager and Assistant Company Secretary |

Item 26.2

Solent NHS Trust

# Assurance Committee Annual Report 2018-19

## Introduction

The Assurance Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference (ToR) and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2019.

## Meetings

During 2018-19 the following meetings were held:

- 17th April 2018
- 15th May 2018
- 19th June 2018
- 17th July 2018
- 18th September 2018
- 16th October 2018
- 20th November 2018
- 17th January 2019 [1]
- 21st March 2019

## Membership & Attendance

Attendance by members is outlined as follows:

| | Meeting | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NAME** | 17th April | 15th May | 19th June | 17th July | 18th September | 16th October | 20th November | 17th January | 21st March | **% attendance** |
| **Mick Tutt – Chair**<br>Non Executive Director | P | P | P | P | P | P | P | P | P | 100% |
| **Mike Watts**<br>Non Executive Director | P | A | P | P | P | P | A | P | P | 78% |
| **Francis Davis**<br>Non Executive Director | P | P | P | A | P | P | A | A | P | 67% |
| **Jon Pittam**<br>Non Executive Director [2] | P | P | P | P | | | | | | 100% |
| **Sue Harriman**<br>Chief Executive Officer<br>or<br>**Andrew Strevens**<br>Director of Finance | P | A<br><br><br>P | A<br><br><br>P | P | A<br><br><br>P | P<br><br><br>P | P<br><br><br>P | P | P<br><br><br>P | 100% |
| **Jackie Ardley**<br>Chief Nurse | P | P | A | P | P | P | A | P | P | 78% |
| **Sarah Austin**<br>Chief Operating Officer<br>or<br>**Matthew Hall**<br>Deputy Chief Operating Officer | A<br><br><br>P | P | P | P | P | P | P<br><br><br>P | A<br><br><br>P | P | 100% |
| **Dan Meron**<br>Chief Medical Officer | P | P | P | P | P | P | P | A | P | 89% |
| **David Noyes**<br>Chief Operating Officer | P | P | P | P | P | P | P | P | P | 100% |

[1] from January 2019 the committee, having previously met 10 times per year, moved to a bi-monthly meeting cycle

[2] Jon Pittam ceased to be a specified committee member, following the change in the Terms of Reference, from September 2018

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Rachel Cheal** Associate Director of Corporate Affairs and Company Secretary | P | P | P | P | P | P | P | A | P | 89% |

P= Present A= Apologies

**ToR**

The ToR were amended at the May 2018 meeting to reflect the recommendations of Internal Auditors, PwC following an internal audit to review the effectiveness of the assurance process.

**Status against the achievement of the Committee's Objectives**

| Objectives | Year end |
|---|---|
| **The outcome of the Internal Audit review of the effectiveness of overall assurance process will be actioned during Q1 2018/19** | *Q1 - NED committee membership reviewed and reduced*<br>*Q2 – relevant Board Assurance Framework (BAF) extracts provided for agenda*<br>*Revision of the Terms of Reference to change the committee to bi-monthly meetings from Q4* |
| **Any urgent matters of safety, or Freedom to Speak-Up concerns will be reported to the committee, at the commencement of each meeting** | *Agenda planned accordingly. Quarterly written repor was provided by the Lead Guardian which was presented after 'urgent matters'. Frequency of reporting was changed in March 2019 to 'invitation to each meeting' plus formal reporting on 6 monthly basis, with annual reporting to Audit and Risk Committee (for oversight of process).* |
| **Exception reports from the COOs and the Chair of QIR will be received at each meeting** | *It was agreed to continue with the same format of exception report following a review in January 2018* |
| **A series of 'deep dives' into specific areas of Governance and Regulatory Compliance will be received at each meeting.** | *Agenda planned accordingly* |
| **Other reports will be received following agreement by the Chair, CMO and CN** | *On going* |

**Summary of business conducted in year**

Highlights of the main business conducted by the Committee for the period April 2018 to and including March 2019 are summarised as follows;

- An update on urgent matters of safety and any issues associated with Freedom to Speak Up (F2SU) were noted at each meeting. A full F2SU report was noted in November 2018 and in March 2019, it was agreed to receive a formal written report to the Assurance Committee at six monthly intervals, with an annual report presented to the Audit and Risk Committee.
- The Committee received regular updates on the Wheelchair Serious Incident and an external review report was shared and discussed during a confidential Assurance Committee meeting in June 2018. It was agreed to continue to continue to receive updates in addition to the risk detailed within the Board Assurance Framework (BAF). there will be a further, detailed, update at the May 2019 meeting
- An overview was provided to the May 2018 committee of the internal audit report conducted by PwC, on the review of the effectiveness of assurance processes. Consequential changes to the committee Terms of Reference were approved.

- Regular learning from deaths updates were provided and a full 'Learning from Deaths' (LfD) report was presented to the July 2018 meeting. subsequently, it was agreed that LfD reporting would be an integral part of an overall quarterly report on the experience of people accessing solent services, and their carers/representatives
- The committee received regular CQC updates and the October 2018 meeting received an update on the planned Inspection activities. A review of actions arising from the Inspection process was discussed at the March 2019 meeting.
- The November 2018 and March 2019 Committee meetings received quarterly Quality Impact Assessment (QIA) review reports.
- A regular update of the BAF was provided and a Quality and Professional Standards risk deep dive was reported to the March 2019 meeting.
- A Draft Quality Accounts Priorities for 2019/20, developed by services lines were shared and endorsed at the March 2019 meeting, following endorsement of the process for confirming the Priorities and overall Framework.

The Committee received the following annual reports:

| | |
|---|---|
| Wessex Trust SAS Development | June 2018 |
| Assurance Committee | May 2018 |
| Complaints | September 2018 |
| Infection Prevention and Control | July 2018 |
| Safeguarding | July 2018 |
| Patient Experience Annual Report | October 2018 |

- Each meeting agreed items for escalation to the Board and items for cascading to services.

A committee exception report was presented to the Board following each meeting.

**Objectives for 2019-20**

- **Any urgent matters of safety, or Freedom to Speak-Up concerns will be reported to the committee, at the commencement of each meeting. The Freedom to Speak-Up lead will have an open invitation to attend all meetings and will be invited to present a formal written report on a 6-monthly basis.**
- **Exception reports from the COOs and the Chair of QIR will be received at each meeting.**
- **A series of 'deep dives' into specific areas of Governance and Regulatory Compliance, according to a planned programme of activity, will be received at each meeting.**
- **Other reports will be received following agreement by the Chair, CMO and CN.**

**Conclusion**

The Committee has complied with its Terms of Reference during the period under review.

| | |
|---|---|
| **Report Author(s)** | Mick Tutt, Non Executive Director and Assurance Committee Chair<br>Jayne Jenney, Corporate Support Manager and Assistant Company Secretary |

**Appendix 1 – List of Policies agreed by Assurance Committee 2018-19**

| | |
|---|---|
| **APRIL 2018**<br>No policies to ratify | **MAY 2018**<br>• Secondment Policy<br>• Relocation Policy |
| **JUNE 2018**<br>• Infection Prevention and Control Framework<br>• Deteriorating Patient and Resuscitation Policy<br>• Locked Door Policy<br>• Policy for Aseptic Technique and Aseptic Non Touch Technique<br>• Managing Absence and Wellbeing Policy | **JULY 2018**<br>• Policy for the Prevention and Control of Clostridium Difficile Infection (CDI)<br>• Sharps and Contamination Policy<br>• Health Surveillance Policy<br>• Managing Stress at Work Policy<br>***Approved via Chair's action:***<br>• Business Continuity Policy |
| **SEPTEMBER 2018**<br>• Hot Desk / Shared Desk Policy<br>• Sustainability Policy<br>• Procurement Policy<br>• Healthcare Workers Screening and Immunisation Policy<br>• Staff Recognition/Reward Policy<br>• Learning and Development Policy<br>• Health & Safety Policy<br>• Access & Transport Policy<br>• Drug, Alcohol and Substance Misuse Policy<br>• Lone Working Policy<br>***Approved via Chair's action***<br>• Controlled Drugs Policy | **OCTOBER 2018**<br>• Missing and AWOL Patients Policy for Psychiatric Units and Community Teams<br>• Transportation of Clients / Colleagues by Staff in Vehicles Policy<br>• Pre-employment Health Assessment Policy<br>***Approved via Chair's action:***<br>• Use of Unlicensed and Off-Label Medicines Policy |
| **NOVEMBER 2018**<br>• Travel and Subsistence Policy<br>***Approved via Chair's action***<br>• Searching Patients, the Property and Inpatient Units Policy | **JANUARY 2018**<br>• Energy and Water Policy<br>• First Aid at Work Policy<br>• Local Counter Fraud, Bribery and Corruption Policy<br>• VIP Visitor Policy<br>***Approved via Chair's action:***<br>• Policy for the Development and Implementation of Procedural Documents (aka Policy on Policies)<br>• Policy for Management of Diarrhoea and Vomiting<br>• Emergency Lockdown Policy |
| **FEBRUARY 2018**<br>No meeting held | **MARCH 2018**<br>• Infant Feeding Policy<br>• Safeguarding Children, Young People and Adults at Risk Policy<br>• Domestic Abuse Policy<br>***Approved via Chair's action:***<br>• Staff Recognition Policy<br>• Surveillance Camera System Policy (CCTV Policy) |

Item 5.2

**Exception and recommendation report**
**Learning from Deaths (LfD) Quarter 4 2019**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Committee /Subgroup name** | *Learning from Deaths* | | | | **Date of meeting** | | *Q4 January to March 2019* | |
| **Chair** | *Dan Meron* | | | | **Report to** | | *Assurance Committee* | |
| **Well Led KLoEs** | **W1** leadership Capacity & Capability | **X** | **W2** Vision & Strategy | **X** | **W3** Culture | **X** | **W4** Roles & Responsibilities | **X** |
| | **W5** Risks and Performance | **X** | **W6** Information | **X** | **W7** Engagement | | **W8** Learning, improvement & innovation | **X** |

**Key issues to be escalated**

The committee is asked to note that this report is a summary of quarter 4 information.

- The trust learning database continues to ensure that we are capturing our Trust wide learning and sharing the end product to demonstrate the change that has occurred as a result of a patient's death.
- VERTO continues to be the method on capturing and tracking this learning and updates and developments are discussed at each LfD panel to ensure that trust wide learning is shared and discussed.
- The Professional Leads are now able to use the live VERTO system and monitor and track learning directly associated with their service line.
- There have been no recommendations or actions requested by the Coroners court over the last quarter.
- The mortality dashboard process was reviewed at the end of Q3 and it was agreed with the Clinical Directors and Professional leads to amend the process to improve the quality of reporting. This has resulted in data being reported a month in arrears and has enabled services to ensure that the data is reviewed and submitted accordingly.
- The updated LfD policy has been written and is currently in the final stages of consultation before submission to the June Assurance Board for final agreement and approval.
- Within this policy, it is made clear that families and carers are to be considered an equal partner in the LfD processes.

**Decisions made at the meeting**

- Agreement that the trust approach to LfD is in accordance with national guidance including CQC, suicide prevention and National Quality Board.
- The importance of using a different clinical judgement tool when reviewing mental health care. This is addressed in the new policy and the service are currently piloting the tool endorsed by the Royal College of Psychiatrists before the launch of the new policy.
- Agreement that the inclusion criteria for review of learning from deaths needed updating. As of January 2019, Special Care Dentistry will only report by exception. The criteria's for future inclusion are clearly identified in the updated policy.

**Recommendations**

The Assurance Committee is asked to note the actions that continue to further improve and develop the Trust's processes for Learning from Deaths and to recognise the continued work undertaken by all service lines and corporate teams to achieve this.

| |
|---|
| **Other risks to highlight** (not previously mentioned) |
| Nil noted |

# Trust-wide Mortality Report, Q4 2019

**Number of deaths reported YTD**

| Number of Deaths Reported |
|---|
| 1867 |

**Quarterly Count of Deaths Reported**

| monthname | Number of Deaths Reported |
|---|---|
| January | 181 |
| February | 170 |
| March | 170 |

**Quarterly Count of Deaths Reviewed via CJT* or MDT***

| monthname | Reviewed via CJT or MDT |
|---|---|
| January | 48 |
| February | 60 |
| March | 59 |

**Quarterly Count of Deaths SI Raised**

| monthname | SI |
|---|---|
| January | 0 |
| February | 1 |
| March | 0 |

**Quarterly Count of Deaths of Learning Disability Patients**

| quarter |
|---|
| 1 |

**Quarterly Count of Deaths Reviewed by Another Provider**

| monthname | Reviewed by Another Provider |
|---|---|
| January | 0 |
| February | 9 |
| March | 19 |

| Reporting terminology; |
|---|
| Considered for review = reviewed by service to decide whether an in-depth mortality review is indicated |
| Reviewed = in-depth review via clinical judgement tool or death subject to root cause analysis |
| MDT* = Multi Disciplinary Team |
| *CJT = Clinical Judgement Tool |

| Data sources; |
|---|
| Dates of death and patients extracted from SystmOne (as per Service Line definitions), confirmed against Spine, confirmed by Service Lines |
| SI data provided by Quality Team (inclusion = date of death within reporting period) |
| Primary Care Services consits of: Solent GP, Musculoskeletal and Podiatry |
| Sexual Health Data provided by Sexual Health Team (inclusion = date of death within reporting period) |
| Learning Disability data provided by Learning Disability Team (inclusion = date of death within reporting period) |

| Author; |
|---|
| Data Warehouse Team |
| Process: Mortality Reporting |

| Main categories of deaths not reviewed via CJT or MDT by Service Lines: |
|---|

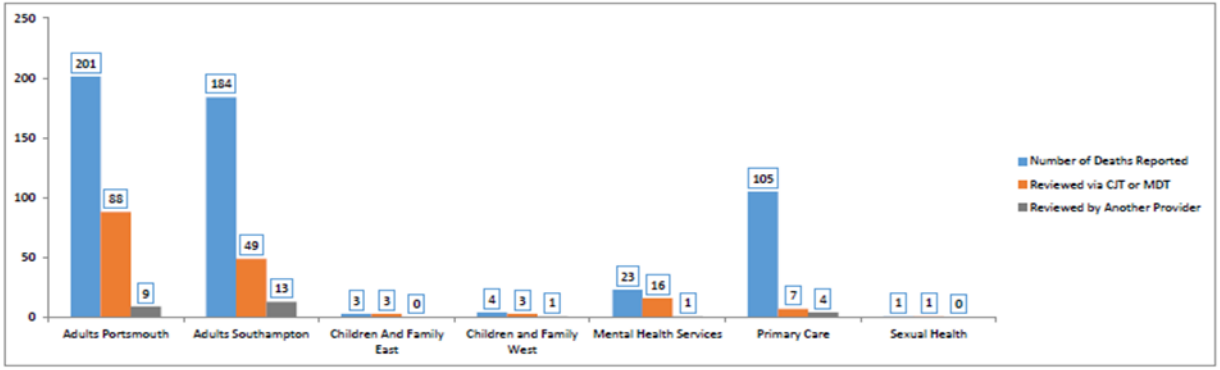
**Q4 Deaths Reported and Reviewed by CJT* or MDT* or by Another Provider by ServiceLine**

| service line | Number of Deaths Reported | Reviewed via CJT or MDT | Reviewed by Another Provider |
|---|---|---|---|
| Adults Portsmouth | 201 | 88 | 9 |
| Adults Southampton | 184 | 49 | 13 |
| Children And Family East | 3 | 3 | 0 |
| Children and Family West | 4 | 3 | 1 |
| Mental Health Services | 23 | 16 | 1 |
| Primary Care | 105 | 7 | 4 |
| Sexual Health | 1 | 1 | 0 |

Business Intelligence
Adding value through business insight

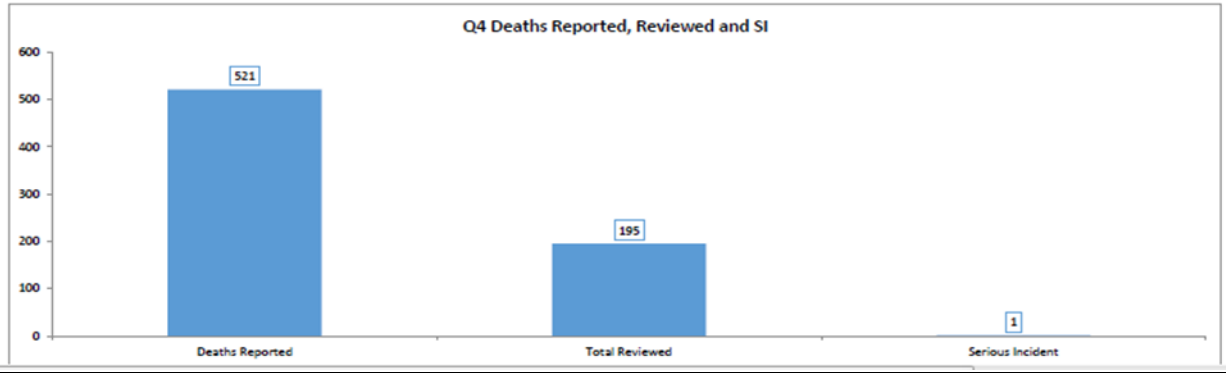
**Learning Disabilities**

| Considered for Review via CJT or MDT* |
|---|
| 1 |




**Quarterly Deaths Reported and Reviewed either by CJT*, MDT* or Another Provider and SI**

| Category | Count |
|---|---|
| Deaths Reported | 521 |
| Total Reviewed | 195 |
| Serious Incident | 1 |



**Learning from coroner's inquests**

In Q4 there were a total of 6 Coroner's Inquests (5 in Adult Mental Health, 1 in Adults Portsmouth) and of these 2 required no attendance by a witness. The Trust is still awaiting Coroner recommendations on 2 of these cases. It should be noted that none of the inquest outcomes indicate any inadequate care by the Trust. There has been internal learning for the Trust with regards to the unexpected death process and this will be included in the new policy.

**What has changed as a result of Learning from Deaths during Quarter 4**

In this quarter, the following improvements and changes have been noted from VERTO:

| Service | Learning-Improvement and Change |
|---|---|
| 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 | We have improved the process for the support of staff involved with a child who dies unexpectedly. 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 | Clear 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 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 |

Item 26.3

NHS Solent NHS Trust

# Audit & Risk Committee Annual Report 2018-19

## Introduction

The Audit & Risk Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activities for the year to 31st March 2019.

## Meetings

During 2018/19 the following meetings were held:

- 24th May 2018
- 2nd August 2018
- 8th November 2018
- 7th February 2019

## Membership & Attendance

Attendance by members is outlined as follows:

| | Meeting | | | | |
|---|---|---|---|---|---|
| **NAME** | 24th May 2018 | 2nd August 2018 | 8th November 2018 | 7th February 2019 | **% attendance** |
| **Jon Pittam- Chair** Non Executive Director | P | P | A | P | 75% |
| **Stephanie Elsy** Non Executive Director | P | P | P | P | 100% |
| **Mike Watts** Non Executive Director | P | A | P | P | 75% |

P= Present A= Apologies

An additional private meeting was held in Feb 2019.

## Terms of Reference

The Committee reviewed and approved the Terms of Reference at the May 2018 meeting.

## Status against the achievement of the Committee's Objectives

| Objectives | End of year review status |
|---|---|
| To liaise with the Chairs of the Finance Committee and Assurance Committee to seek assurance that proper budgetary and management accounting systems and procedures are in place and are being complied with. | *Standing agenda item to receive assurance from other Board Committees.*<br><br>*Status: ongoing* |
| To monitor the position in respect of the Trust's Break Even Duty (acknowledging the need to understand the treatment of a | *The May 2018 Committee received a Break Even Duty Report and noted that although the Trust had achieved an in-year surplus, it had failed in* |

| | |
|---|---|
| deficit position for three consecutive years). | *its breakeven duty. The position was monitored during the 2018/19 financial year. A surplus is expected at the end of 2018/19.* |
| To liaise with the Chair of the Assurance Committee to seek assurance that proper risk management procedures and monitoring are in place and notably to conduct a deep dive review to seek assurance that the recommendations identified by the Internal Auditors concerning Risk Management have been addressed and are being embedded. | *An in-depth report on progress with the Implementation of Risk Management Framework and previous Internal Audit Recommendations was provided to the July 2018 Committee meeting. The report was shared with the September Board.* |
| To be kept appraised if risks associated with partnership working. | *The February Committee meeting received a Board Assurance Framework Deep Dive Report on the Third Party Contractors risk.* |
| To continue to ensure that the Internal and External Auditors continue to be fit for purpose. | *There were no concerns to note.* |
| To seek assurance that there are robust processes in place regarding Freedom to Speak Up / Whistleblowing and the Trust is compliant with its policy | *A FTSU briefing was regularly provided and a written report presented to the May 2018 and February 2019 meetings. The Chair of the Audit and Risk Committee is the designated lead NED for FTSU and regularly meets with the FTSU Guardian and CEO. No concerns regarding the FTSU process have been identified to date and an action plan is in place to secure best practice standards,* |
| To ensure compliance with any new requirements regarding Audit Panels and the appointment of auditors. | *Currently compliant.* |

**Summary of business conducted in year**

The main business conducted by the Committee is summarised as follows;

<u>Internal Audit</u>

The Trust's internal auditors PwC presented the Internal Audit Progress Report to the February meeting. A summary of progress against the 2018/19 Internal Audit Programme is as follows:

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

The following audit opinions were issued at the February 2018 meeting:

| Audit title | Report classification |
|---|---|
| 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 |
| Mental Health Act Scrutiny Committee Review | Medium Risk |

External Audit

- The May 2018 Committee noted the external Audit Results Report for the year ending 31st March 2018.
- The August 2018 Committee received the Annual Audit Fee letter 2018/19 and an unqualified opinion issued on 29th May 2018 was noted. Trust Board approval of the Audit Letter of Representation was noted.
- The Committee noted the annual Audit Plan and there were no significant risks to highlight associated with the Value for Money (VFM).
- A briefing was given on 2019 materiality calculations.
- The February 2019 Committee agreed to review the external audit timetable due to planned work at the end of April 2019.
- UK Audit Market information was shared. The report was noted to recommend the introduction of a new regulator following the collapse of Carillion.
- The Committee discussed the implications of Brexit and were assured that should centrally mandated guidance be received, it would be reviewed as part of usual business planning processes.

Internal Control

- The May 2018 Committee received the Internal Audit Annual Report and Head of Internal Audit Opinion.
- The Committee received regular updates on inspections/reviews and unannounced visits.
- The draft Quality Accounts were received at the May 2018 and approved subject to noted amendments for onward approval of the Board.

The Committee received a deep dive on the progress on implementation of the Risk Management Framework and previous audit recommendations.

Financial Assurance

- Regular updates were provided on single tender actions and losses and special payments at each meeting.

- The Committee received regular updates on the Trust's financial status and the year-end financial timetable for 2018/19 was noted at the May 2018 meeting.
- The Committee noted a revaluation being undertaken of property, plant and equipment and expected timescales for implementation.
- A breach in Breakeven Duty due to the accumulative deficit position was explained to the May 2018 meeting.
- The Committee was briefed on controlled total discussions within the Hampshire and Isle of Wight, Portsmouth and South East and Southampton systems. It was confirmed at the February 2019 meeting that the control total for 2019/20 was break even with no joint control at this stage.

Counter Fraud

- Progress reports were provided at each meeting.
- The Counter Fraud Annual Report and Annual Plan were presented and noted at the May 2018 meeting.
- The Committee was briefed on progress in key strategic areas including work with NHS Counter Fraud Authority to influence the future of counter fraud.

Clinical Audit

- A six monthly review of the Clinical Audit Annual Plan was presented in May 2018. The Committee was briefed on ongoing work to improve quality issues and improvement planning in this area.
- The November 2018 Committee received a Clinical Audit update in particular, regarding themes of concerns raised across various audits associated with data recording within electronic patient records (EPR). Plans to review information governance audits were also noted.

Freedom to Speak Up

- Regular updates on F2SU activity were provided at each meeting.
- A self-assessment on process was shared at the August 2018 meeting.

Specific Assurance Areas / Other items

- The Annual Audit Letter 2018/19 was noted at the May 2018 meeting.
- The draft Annual Report including the Annual Governance Statement was shared at the May 2018 meeting for onward recommendation of Board approval.
- The Committee was briefed on a governance review undertaken and noted assurance that the Trust's committees' were appropriately constituted and functioning in accordance with their Terms of Reference.
- A deep dive on a BAF risk associated with Third Party Suppliers was shared with the Committee.
- The November 2018 meeting received the following additional reports:
    - CGI Asset Control Report
    - Brexit Preparedness Report
    - Business Continuity Plan Audit

A private meeting was held with internal and external auditors on 7th February 2019.

Exception reports of Committees were presented to the Board following each meeting.

| **Objectives for 2019-20** |
|---|
| • To liaise with the Chair of the Finance Committee and Assurance Committee to seek assurance that proper budgetary and management accounting systems and procedures are in place and are being complied with.<br>• To monitor the position in respect of the Trust's Break Even Duty and accumulated deficit.<br>• To liaise with the Chair of the Assurance Committee to seek assurance that proper risk management procedures and monitoring are in place.<br>• To continue to test the effectiveness of the Board Assurance Framework.<br>• To be kept appraised of risks associated with partnership working.<br>• To continue to ensure that the Internal and External Auditors continue to be fit for purpose.<br>• To monitor Freedom to Speak Up and ensure that the Trust remains compliant with its policy and best practice guidance. |
| **Conclusion** |
| The Committee has complied with its Terms of Reference during the period under review. |

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|---|---|
| **Report Author(s)** | Jon Pittam, Non-Executive Director and Audit Committee Chair<br>Jayne Jenney, Corporate Support Manager, Assistant Company Secretary |