Agenda
Solent NHS Trust In Public Board Meeting

Monday 7th October 2019, 9:30am – 13:45

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

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	10mins	***Minutes meeting 5th August 2019, matters arising and action tracker** *To agree*	Chair	To agree
3	09:45	30mins	**Patient Story** *To receive*	Chief Nurse	To receive
4	10:15	10mins	**Reflection on Patient Story**	Chair	To discuss
5	10:25	20mins	**Staff Story – Talking Change** *To receive*	Chief People Officer	To receive
6	10:45	10mins	**Reflection on Staff Story**	Chair	To discuss
7	10:55	10mins	**Safety and Quality First and Feedback from Board to Floor Visits** *To receive*	Chief Executive / Chief Nurse	To receive
8	11:05	10mins	**Break**		
Strategy & Vision					
9	11:15	30mins	**Chief Executive's Report** *To note*	Chief Executive	To receive
10	11:45	30mins	**Performance Report** - *to note* *Including:* • *Operations* • *Quality* • *Financial* • *Workforce* • *Research* • *Self-Declaration*	Executive Leads	To receive

11	12:15	10mins	**Community Engagement Progress Report** *To note*	Chief Nurse	To receive
12	12:25	10mins	**Emergency Planning Resilience Response Annual Report** *To note*	COO Southampton and County	To receive
13	12:35	10mins	**Brexit update** *To note*	COO Southampton and County	To receive
14	12:45	10mins	**Information Governance Briefing Paper** *To note*	COO Southampton	To receive
Reporting Committees and Governance matters					
15	12:55	5mins	**Assurance Committee Exception Report from 19th September meeting** *To note* *Including:* - *Complaints Annual Report* - *Learning from Deaths Quarterly Report*	Committee chair	To receive
16	13:00	10mins	**Complaints Panel Exception Report from 3rd September meeting** *To note*	Committee chair	To receive
17	13:10	5mins	**People and OD Committee Exception Report from 12th September meeting** *To note* *Including:* - *People and OD Annual Report 2018-19* - *Workforce and Organisational Development Committee Terms of Reference*	Committee chair	To receive
18	13:15	5mins	**Community Engagement Committee Exception Report from 26th September meeting** *To note*	Committee chair	To receive
19	13:20	5mins	**Mental Health Act Scrutiny Committee Exception Report from 22nd August meeting** *To note*	Committee chair	To receive
20	13:25	5mins	**Finance Committee - non confidential verbal update from 23rd September meeting** *To note*	Committee chair	To receive
21	13:30	5mins	**Audit & Risk Committee from 1st August meeting** *To note*	Committee chair	To receive

22		----	**Charitable Funds Committee** *No meeting held since last*	----	----
23		----	**Governance and Nominations Committee** *No meeting held since last*	----	----
Any other business					
24	13:35	5mins	**Reflections** • **lessons learnt and living our values** • **matters for cascade and/or escalation to other board committees**	Chair	-
25	13:40	5mins	**Any other business & future agenda items**	Chair	-
26	13:45	---	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chair	-

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Date of next meeting:

- *2nd December 2019 – In Public Board Meeting*

Minutes

Solent NHS Trust In Public Board Meeting

Monday 5th August 2019, 09:30am-12:20pm
Kestrel 1&2, 2nd Floor, Highpoint Venue, Bursledon Road, Southampton, SO198br

Chair: Catherine Mason, Trust Chair (CM)	
Members: **Sue Harriman,** Chief Executive (SH) **Andrew Strevens,** Director of Finance (AS) **Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Jackie Ardley**, Chief Nurse (JA) **Helen Ives**, Chief People Officer (HI) **Mick Tutt,** Non-Executive Director (MT) **Jon Pittam,** Non-Executive Director (JPi) **Mike Watts,** Non-Executive Director (MW) **Stephanie Elsy,** Non-Executive Director (SE)	**Attendees:** **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **Jayne Jenney,** Corporate Support Manager and Assistant Company Secretary (JJ) **Stephanie Clarke**, Head of Quality and Professions (SC) (Item 6 only) **Jo Pinhorne**– Operational Director Adults Southampton (item 9) (JoP) **Apologies:** **Dan Meron,** Chief Medical Officer (DM)

1	**Chairman's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	CM welcomed attendees to the In-Public meeting. Apologies were noted as above. There were no further updates to the register and declaration of interests and the meeting was confirmed as quorate.
2	***Minutes of Extra Ordinary Board meeting 24th May 2019 and last Board meeting 3rd June 2019, matters arising and action tracker**
2.1	The minutes of the Extra Ordinary In-Public Board meeting held on 24th May were agreed as an accurate record and In-Public Board on 3rd June were approved subject to minor amendments.
2.2	The following actions were confirmed as complete: AC000953, AC000954, AC000955 and AC000956.
2.3	Action AC000954 – SH informed the Board that JA will be providing an amendment to the wording provided to reflect the care taken by the Trust to avoid falls. It was agreed the action can then be closed.
2.4	Action AC000956 – JA shared an e-mail received from the carer of the June Board patient story who had passed on thanks for the communication received following the Board that made her feel that her attendance was worthwhile.
3	**Safety and Quality First and Feedback from Board to Floor Visits**
3.1	Board to Floor Visits - Fanshawe Ward AS briefed the Board on his visit and of an exercise session attended. AS highlighted positive encounters with staff. SE also shared her attendance at an Occupational Therapist assessment during her visit.

3.2	CM shared her experience of her visit to Brambles and Fanshawe wards and of the differences in age and lay out of each. CM reported on being impressed with the consistency of the quality of care and enthusiasm of staff on both wards. CM commented on the care of an elderly patient and shared her observation of a gap in social care intervention for those not requiring health care. SH reported that this is being addressed through the NHS plan through health and social care and health and wellbeing interventions. JA also shared ongoing work within Portsmouth to review the needs of the whole community.
3.3	There were no further matters of safety to report.
4	**Annual Self Declaration on Same Sex Accommodation**
4.1	JA provided assurance that the Trust is compliant according to the Department of Health guidance whilst recognising that best practice would be to provide separate wards. MT explained the difference in the interpretation of compliance within Mental Health settings in accordance with the Mental Health Act Code of Practice and confirmed that Orchards, The Limes and Kite are compliant. **The Board approved the self-declaration on same sex accommodation.**
Strategy & Vision	
5	**Chief Executive's Report (part 1)**
5.1	SH presented the newly formatted CEO report and asked for feedback in order to ensure appropriate content. Material updates since the circulation of the report was provided. SH briefed the Board on the celebrations of successes awarded to Trust staff and of being privileged to attend the Parliamentary Awards with Pam Campbell who won the Lifetime Achievement Award. JA informed the Board of a further gold award presented to Pam Campbell by Ruth May, Chief Nurse, England, for her lifetime commitment to homeless people.
5.2	<u>Jubilee House Proposed Move</u> SH drew attention to the appendix provided regarding the relocation of Jubilee House and provided assurance that the paper was not confidential as the paper suggests, having been shared with the recent Health Overview Scrutiny Panel in Portsmouth. The confidential watermark is to be removed from the document. **Action: JJ**
5.3	<u>Corporate Risk Register / Board Assurance Framework</u> SH highlighted the numerous references and long standing issues associated with wheelchairs. JA provided an update on progress. It was noted that the Trust is meeting regularly with Portsmouth and Southampton CCGs. The escalation of two children's cases due to concerns of potential harm was noted. JA confirmed that the SI process has been followed and a formal letter sent to the CCG for escalation to the provider. Two patient stories are now available via video and consideration is to be given on how to share across the Trust and CCGs. JA to circulate to the Board. **Action: JA**

5.4	CM asked if the Board could provide more support. JA confirmed that the issues are discussed within the appropriate forums and highlighted the good work undertaken by Fay Prestleton to pursue. SH commented on distress still being experienced by staff in relation to delays in wheelchair provision and actions being taken to ensure matters are escalated. JP enquired about additional funding required to alleviate pressures by the wheelchair provider. JA informed the Board of investments in waiting list initiatives in both cities by commissioners and of the tendering process. JA explained that the Trust is aware of numbers of children and adult patients on waiting lists cared for by the Trust however not of the whole system, including those being referred to directly via Primary Care. It was agreed that JA undertake a more forensic review including investment by Solent and trajectory and report back to the Board. **Action: JA**
5.5	<u>Trust Management Team Meeting (TMT)update</u> The TMT held a positive focus session on workforce using an interactive tool 'Glisser', hosted by HI. SH highlighted the work undertaken by HI on the future of workforce. Varying opinion and appetites within the system was noted as well as the need to be mindful of moving forward on matters that Solent can partner with colleagues on in order to join up resources on programmes to increase effectiveness. It was agreed that the Board workshop receive a further update at the beginning of the next calendar year. *The CEO report item was paused to receive the patient story.*
6	**Patient Story – Child & Family Services**
6.1	JA introduced the patient's mother and carer Mrs S, to the Board. Mrs S shared a drawn picture of her daughter's life and achievements. Mrs S provided a comprehensive background of her daughter's healthcare needs and the care provided from when she was born and throughout her life. The Board was briefed on her regular attendance at Mary Rose School via bus where she is very happy enjoying the activities and exercise. Mrs S informed the Board of private physiotherapy provided via funds awarded for her daughter's care that has made a significant difference to her back strength, straightness and chest growth. Mrs S also shared her gratitude for the carers provided during the night to monitor her daughter's breathing which allows her and her husband to have rest and sleep.
6.2	JA asked if there is anything the Trust could have done better. Mrs S suggested carers for a few hours during the evening would help to allow quality time with her other children. Mrs S informed the Board of the many years spent with the Mary Rose school and of the good relationship with professionals who feel more like family. She also complimented the 'amazing' continued care service provided. JA thanked Mrs S for sharing her family's story.
6.3	CM thanked Mrs S for giving up her time to tell the story and commented that professionals focus on the individual with needs however it is important to recognise the impact on the whole family.

6.4	SH enquired how care planning arrangements with nurses and carers are managed. Mrs S confirmed regular meetings held at the school with the multidisciplinary team to discuss any issues or changes to care and every few weeks with social services. It was explained that the outcome of all meetings are shared with the long term carer. There is also a number to call if assistance is needed. Mrs S shared her appreciation for the long term carer.
7	**Chief Executive's Report (part 2)**
7.1	*The Board returned to the CEO report.* SH highlighted deterioration in Southampton Urgent Care performance and of reasons being looked into with partners to address. It was confirmed that a remedial system action plan is in place to address.
7.2	<u>STP update</u> SH informed the Board of plans to move toward and integrated care system from April 2020 and of work being undertaken to develop a strategic plan in accordance with the Long Term Plan requirements Regarding Appendix 2 – the STP Annual Report, MT enquired about the reference to Side by Side. SH clarified this group as not being Solent's Side by Side Group and confirmed the intention of the STP wishing to engage more broadly.
7.3	MT congratulated SA for the relationship gained between the Recovery College and University and highlighted the value of experienced people and professionals working together with the added value of being within an academic setting. SA explained that the Recovery College is open to 150 University students as part of a wider offer of emotional support. Numbers are expected to expand from the beginning of the next academic year.
7.4	JP queried the impact of the Provider Sustainability Fund allocation on the Trusts Control Total. AS provided explanation. **The Board noted the CEO Report and TMT Terms of Reference.**
8	**Performance Report**
8.1	<u>CPMO</u> It was noted that the tabled figures on page 4 were incorrect and will be amended. AS summarised the key areas of objective achievements and of two rolled over. It was noted that objective progress to date is as expected for this financial year.
8.2	<u>Operational Performance – Portsmouth</u> • SA updated the Board with regards to Jubilee noting a review to be undertaken with the possibility of reopening half of the facility. • It was noted that COAST is to remain closed until early Autumn. • SA informed the Board that a business case for a long term CAMHs liaison service within the Emergency Department has been approved by Unified Executives as well as a longer term solution within PHT.

8.3	<u>Operational Performance – Southampton</u> • DN informed the Board of Urgent Care challenges within the system particularly within the ED at UHS and shared possible reasons. DN briefed the Board on Trust measures being taken to assist. • DN confirmed the close monitoring of the Equipment Store and emergency transport due to poor patient feedback. • The Board was updated on Primary Care Network progress. • It was noted that individual service lines are monitoring staff vacancies with plans to address. • Speech and Language Therapy waiting times are increasing. • DN informed the Board of an estate opportunity for Children's Services in the Swan Centre, Eastleigh that will also be used by the Sexual Health Service. • The Dental Service was noted as maintaining a focus on the expected CQC visit. Port Willow has been opened and transport arranged to assist with GA waits. Patients continue to be triaged.
8.4	CM asked how complaints regarding the accessibility of Sexual Health are going to be addressed. DN shared open access considerations and mailed tester kit initiatives. It was acknowledged however that complaints will not significantly reduce. MT confirmed that this is being monitored by the Assurance Committee. JA suggested further alleviation of complaints by being more open about expected waiting times. SH highlighted the importance of service innovation due to the reduction in contract value and emphasised the need for commissioners to understand and agree service provision requirements under agreed budgets.
8.5	SH enquired about mitigation plans to address the potential staffing issues within Dental West due to staff absences and planned retirement. DN confirmed successful recruitments made to resolve. It was also noted that all issues with Dental Nursing have been addressed.
8.6	SH referred to page 16 of the Performance Report and enquired if the NHS Improvement Single Oversight Framework (SOF) is different from the Improvement Scale and queried the level achieved. It was agreed that AS check the information and provide clarification. **Action: AS** **Post meeting note:** *The reference to the regulatory performance at the bottom of page 16 of 37, should have stated that the Trust is rated level 1 on the Single Oversight Framework. This will be corrected for future performance reports*
8.7	<u>Quality</u> JA brought to the Board's attention the achievement of the Trust's Freedom to Speak Up Index Score of 86%, the highest index score for 2018 for combined Mental Health/Learning Disability/ Community Trusts. Members of the Board commented on the positive result achieved. SA commented on theF2SU Team being incredibly responsive to particular issues and referred to a case in Jubilee as an example. JP highlighted a safety issue shared at the Audit and Risk Committee that was dealt with within 2 hours. It was agreed that the results are a clear indication that the process is working.

8.8	• JA briefed the Board on the Portsmouth CCG visit to Spinnaker Ward and of the positive report received. Recommendations were noted however there are no matters of concern. The CCG also visited Jubilee. • A comprehensive development programme led by the Associate Director of Professions and Regulation, has been mapped against new nursing standards and will be rolled out across the organisation. • JA updated the Board on complaints received and provided assurance of a robust process through the Complaints Panel.
8.9	SE commented on the quality of information reported in the Performance Report and of the content being a reflection of the excellent work of the Trust. SE congratulated executives for sharing across the wider teams.
8.10	<u>Finance</u> Financial performance was noted and it was agreed that updates will be reported to the Confidential Board.
8.11	<u>Workforce</u> Hi highlighted sustainable workforce to be a key issue however commented that the Trust is performing well compared to other organisations. HI shared feedback received indicating that people are choosing Solent as an organisation to work for. It was noted that the Trust has been approached by NHS Employers as an exemplar for health and wellbeing and a national case study is being written.
8.12	CM queried the reporting procedure for the NHS Provider Licence. RC explained the process of annual sign off and inclusion within the Performance Report at each Board for noting.
8.13	CM commented on being impressed by the recent Research Conference attended and of the number of people engaged in research. CM endorsed encouragement of getting more people involved. **The Board received the Performance Report.**
9	**Freedom to speak Up Annual Report**
9.1	Jo Pinhorne (JoP) attended for this item. SH informed the Board of her attendance at the F2SU Committee with JP and of the detailed review undertaken on activity. SH confirmed that future reports will include further interpretation and intelligence of the data presented.
9.2	JoP highlighted significant activity reported in the year which is a positive reflection of the staff survey. The Board was informed of an increase in people speaking up across the Trust, particularly within Corporate Services.
9.3	MT commented that the Trust has a more comprehensive network of guardians and leaders who effectively engage with staff compared to other organisations.
9.4	JP reported that concern was raised with regards to the need for more outreach when pursuing partnership working. **The Board approved the strategy and noted the annual report.**

10	**Designated Body Annual Report and Statement of Compliance**
10.1	CM referred to section 6 of the report and asked which Non-Executive Director had joined the monthly Decision Making Group as a lay person. This was confirmed to be Mike Watts. **The Board approved the Annual Report.**
11	**Brexit Preparedness**
11.1	DN updated the Board with regards to the latest Brexit preparations for a 'no deal' exit. It was noted that the Health Resilience Partnership have met and an internal Trust Working Group meeting is to be re-instated and attended by representation from across the Trust. It was noted that business continuity planning is complete and the biggest risk identified is a potential grid lock on Portsea Island. DN briefed the Board on current EU staffing numbers and confirmed that 50% have taken up the registration scheme. Assurance was also provided that the Third Party Supplier contract insurance has been achieved thanks to the Commercial Team. It was confirmed that no clinical trials will be affected and national arrangements were confirmed to be in place for Pharmacy.
11.2	SE informed the Board of a detailed review of plans with the Emergency Planning and Business Continuity Lead and enquired if financial implications have been considered. DN confirmed that financial matters are included within the list of actions however there has been no information received from the centre. AS confirmed that financial matters will be dealt with on a national basis. Workforce implications will also be addressed nationally.
11.3	It was agreed to receive a Brexit update at the October Board meeting.
Reporting Committees and Governance matters	
12	**Board of Directors Terms of Reference and Code of Conduct**
12.1	<u>Code of Conduct</u> **The Board approved the code of conduct.**
12.2	<u>Terms of Reference</u> RC explained changes made to simplify the Board Terms of Reference and confirmed the inclusion of constitution and statutory requirements. HI suggested the inclusion of the Board's responsibility for ensuring a Freedom to Speak Up culture and RC informed Board members of the inclusion to reference the annual Board effectiveness review. **The Board approved the Terms of Reference subject to additions identified.**
13	**People and OD Committee**
13.1	• MW reported that the Committee received a deep dive on the Board Assurance Framework (BAF). It was agreed to review again at a later date. • Further risks were highlighted with regards to E-rostering and it was noted as being reviewed as part of an internal audit.

	• The flu vaccine target was reviewed and it was acknowledged to be a challenge to achieve. • The performance of Occupational Health was noted. • Sickness and absence issues were agreed to be discussed further. • It was noted that the purpose of the meeting is to be reviewed to ensure the correct and appropriate assurances are provided. **The Board noted the exception report and further update.**
14	**Assurance Committee**
14.1	MT informed the Board that the logo of the Safeguarding Annual report was designed by one of the Trust's practitioners. It was noted that the Committee had amended and agreed the Terms of Reference, although it was acknowledged that the Committee's remit is to also explicitly reference patient experience following comment from CM. MT reported that he, JJ, JA and new Associate Directors within the Quality Team are to meet and agree reports and timings for future meetings – the terms of reference to then be amended further.
14.2	CM referred to Page 6 of the Safe Staffing Report and asked if the Spinnaker gym remains closed. SA explained the flexed use of the gym according to system needs and confirmed the gym to be open. **The Board noted the Committee exception report, Patient Experience Annual Report, Safe Staffing Six Monthly Report, Safeguarding Adults and Children's Annual Report and Assurance Committee Terms of Reference.**
15	**Audit & Risk Committee**
15.1	• JPi reported that the Committee reviewed single tender waivers and discussed if they are used appropriately. • Reports were received from internal and external auditors. • The final summary of the financial accounts was received and there were no matters of concern raised. • Improvements to Counter Fraud reporting were noted. The Committee agreed to closely monitor concerns raised regarding people working when on sick leave. • An update was also provided on matters regarding Freedom to Speak Up. **The Board noted the update provided.**
16	**Finance Committee (non-confidential) Chairs Updates**
16.1	There were no matters to report to the In-Public meeting.
17	**Complaints Review Panel**
17.1	There were no further updates to report. **The Board noted the exception report.**
18	**Charitable Funds Committee Minutes & Chairs update**
18.1	MT explained the review and approval of changes to the use of funds as detailed within the exception report.

	MT informed the Board that the first initiative agreed is to fund the multi-use games area at the Orchards.
18.2	Support was given to the long term stewardship of charitable funds agreed by the Committee. **The Board approved the Committee Annual Report and noted the exception report.**
19	**Governance and Nominations Committee**
19.1	CM informed the Board of decisions made at the Committee for interim arrangements since the departure of a Non-Executive Director. The Terms of Reference were also noted as being simplified. **The Board approved the Terms of Reference and noted the exception report.**
20	**Community Engagement Committee**
20.1	SE reported on being encouraged by the Committee and of the good appointments and progress made. CM commented on looking forward to receiving substantive reports in due course. SH suggested engaging with the team in a seminar environment. This was agreed. **The Board noted the Committee exception report.**
Any other business	
21	**Any other business & future agenda items**
21.1	JA invited Board members to sign up to a Rainbow NHS Badge and explained the requirements in order to do so.
21.2	HI informed the Board of the submission of the Workforce Disability Quality Standards.
21.3	SE reported on an arranged visit to St Mary's to look at construction work progress.
22	**Reflections**
22.1	The Board reflected on the meeting. SH commented on the well-received patient story. SA informed the Board of her intension to communicate with the Continuing Care Team on behalf of the Board to provide feedback on the story received. SH emphasised the importance of being open and honest and living to Trust values and of the need to receive less positive stories.
22.2	There was no further business discussed and the meeting was closed.
23	**Close and move to Confidential meeting**

Action Tracker

Overall Status	Source Of Action	Minute Reference/ Additional URN	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	3	AC000953	BOD1 - Board Reflection on Patient Story	CM asked if the Board formally wrote a letter of thanks to people who attend to provide a patient story. It was agreed that JA draft a letter for CM to sign.	Jackie Ardley	21/07/2019 - update - Complete
On Target	Board meeting - In Public	18	AC000955	BOD1 - Learning from Deaths Dashboard	MT commented that the Learning from Deaths dashboard should have been appended to the Assurance Committee exception report. It was agreeed that this be circulated for information and attached / reuploaded onto the website	Jayne Jenney	22/07/2019 - update - Learning from Deaths report circulated and papers re-combined and uploaded onto the website.
On Target	Board meeting - In Public	28	AC000956	BOD1 - Reflections - Lessons Learnt and Living our Values	SA raised a question with regards to how staff may have felt during the patient story. It was agreed that JA discuss further with AA and the staff group in attendance to gain feedback and understand how or if the Board could improve discussions. It was also agreed that the staff be approached to consider whether they wished to present their story at a future Board meeting (potentially within the confidential session if appropriate).	Jackie Ardley	21/07/2019 - update - JA and AA discussed feedback. With future sessions a feedback session will be arranged post Board to discuss impact and learning. 26/09/2019- Closed to be taken in future Board Meetings
Completed/Closed	Board meeting - In Public	5.2	AC001109	BOD1 - CEO Report	SH drew attention to the appendix provided regarding the relocation of Jubilee House and provided assurance that the paper was not confidential as the paper suggests. The confidential watermark is to be removed from the document	Jayne Jenney	26/09/2019 - closed. Watermark removed from the document.
On Target	Board meeting - In Public	5.3	AC001110	BOD1 - CEO Report	Two patient stories connected to wheelchairs are now available via video and consideration is to be given on how to share across the Trust and CCGs. JA to circulate to the Board to agree.	Jackie Ardley	26/09/2019- Action with the Executive on next steps.
On Target	Board meeting - In Public	5.4	AC001111	BOD1 - CEO Report - Wheelchairs	JA explained that the Trust is aware of numbers of children and adult patients on wheelchair waiting lists cared for by the Trust however are not of the whole system. It was agreed that JA undertake a more forensic review and look at investment and trajectory and report back to the Board	Jackie Ardley	26/09/2019- Update as part of the report in October meeting.
Completed/Closed	Board meeting - In Public	8.6	AC001112	BOD1 - Performance Report	SH referred to page 16 of the Performance Report and enquired if the NHS Improvement Single Oversight Framework (SOF) is different from the Improvement Scale and queried the level achieved. It was agreed that AS check the information and provide a clarification notification to the Board.	Andrew Strevens	26/09/2019 - Complete - Post meeting note provided in the August minutes.
Completed/Closed	Board meeting - In Public	14.1	AC001113	BOD1 - People and OD Committee	A discussion on People's Practice to be planned for a future Board Workshop. RC to add to the agenda cycle.	Rachel Cheal	26/09/2019- Complete

Item 9

CEO Report – In Public Board

Date: 30th September 2019

This paper provides the Board with an overview of matters to bring to the Board's attention which are not covered elsewhere on the agenda for this meeting. The Board is asked to note the content of this report. Operational matters and updates are provided within the Performance Report, presented separately.

Section 1 – Things to celebrate

Diabetes Team receive award from Wessex Academic Health and Science

Representatives from The Wessex Academic Health and Science Network visited Solent's Diabetes team in Southampton to present them with an award for development of a new tool to improve care and safety for housebound patients.

The Award, which was presented on World Patient Safety Day, celebrates the innovative work of the team who have developed a new tool known as C.R.A.S.H. (Chronic Kidney Disease, Risk of Frailty, Amputations, Steroids, Hypo/Hyperglycaemia). The tools helps community nurses, who are caring for patients requiring insulin, to identify and escalate issues and concerns quickly, which helps prevent delays in treatment changes and development in diabetes-related complications. The tool has resulted in quicker and safer treatment for those housebound patients who do not have access to care within GP surgeries or hospitals.

Rainbow badges are launch within Solent

During the summer, we launched NHS rainbow badges within Solent. Over 600 colleagues, from across the Trust, have made a pledge to wear a NHS rainbow badge to show their support for all who identify as lesbian, gay, bisexual, transgender and all other identities (LGBT+). Launching the badges within Solent demonstrates our commitment to being an open, non-judgemental and inclusive place for LGBT+ patients and colleagues, and an organisation where everyone counts.

The Trust's Sexual Health Service, along with colleagues from Solent, attended Southampton Pride on Saturday 24 August 2019, together with our partners, No Limits – a charity which supports children and young people- to promote the badge.

Healthcare Financial Management Association (HFMA) South Central Branch Award for Innovative Partnering Award

During September, the Trust and Portsmouth Clinical Commissioning Group were awarded with the

Innovative Partnering Award at the HFMA South Central Branch Annual Conference. The award was for the 4 year transformation plan agreed for the Portsmouth Community and Mental Health teams.

Wellbeing Discovery Event and Annual General Meeting (AGM) 2019

Employees, stakeholders, patients and members of the public joined up for our 2019 community event and AGM in September. The official AGM was proceeded by a wellbeing discovery event, focused around keeping your whole self well; mind, body and soul. The event featured services from across the Trust who hosted interactive Pods, giving people the opportunity to explore how Solent services help to keep people safe and well at, or close to, home. The interactive Pods included the opportunity for people to find out about comfort boxes, have a go at mindful colouring, try Tai Chi, discover experiential exercises, taste and learn about healthy eating options, and find out how to keep active and well. There was also a chance to try therapeutic planting and growing.

The formal AGM was opened by the Chessel Chanters and Breathe Easy Choirs, made up of people with long terms conditions, many of whom are Solent service patients. Young Shaper, Ella Riley, also spoke during the AGM; sharing her experience of working with Solent to improve children's services.

Feedback from the event has been incredibly positive and will be shared with those who attended and on the Solent NHS Trust website shortly.

Section 2 – Internal matters (not reported elsewhere)

Capital Notification

NHS Trusts and Foundation Trusts were informed on 19th August 2019 to revert to the original capital plans following the Prime Ministers announcement regarding capital investment in the NHS, having previously been asked to reduce all plans by 20%. Whilst this revision is welcome, the process has created a delay in approving individual schemes.

We are in the process of reprioritising our capital pipeline to ensure that essential schemes are funded appropriately.

St Mary's redevelopment

It is planned that by the time of our meeting, the refurbishment of both blocks B and C at St Mary's Community Hospital will have been completed and handed over to the Trust. There will then follow a two week period of systems testing before clinical services commence occupation.

Healthcare worker flu vaccination

The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. Last year we achieved a frontline healthcare worker flu vaccination uptake of 73.5%, comparing favourably to our partner Trusts in the Hampshire and Isle of Wight Sustainability and

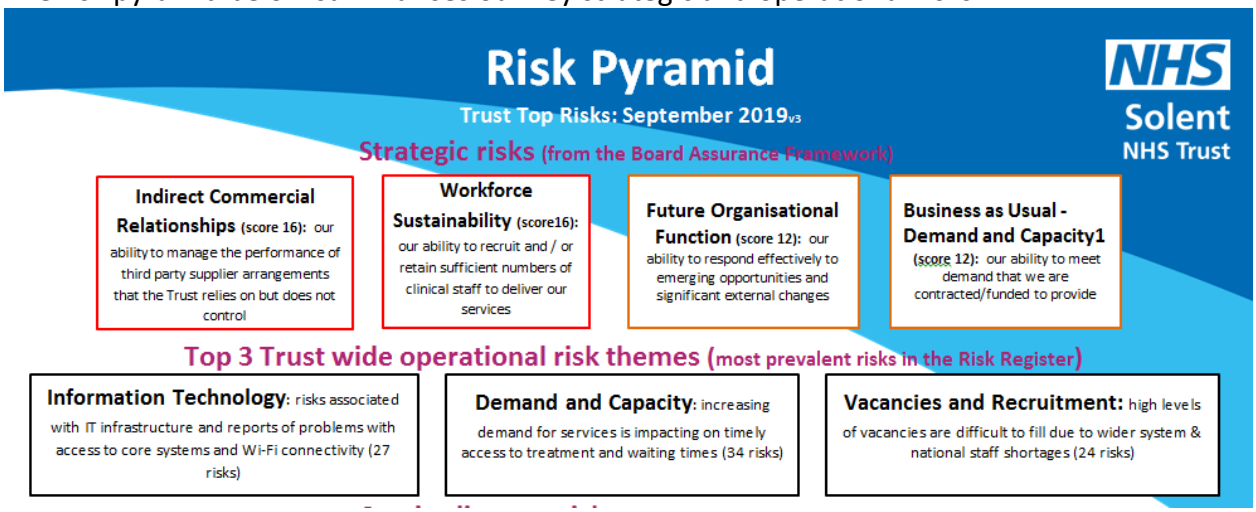
Transformation Partnership. (Seasonal Flu vaccine update 2018-19 data from Public Health England on all Trusts can be found on the Gov.UK Website).
NHS England and NHS Improvement have written to all Trusts asking that we complete a self-assessment, which will inform them on our plan to ensure that all of our frontline staff are offered the vaccine and we will achieve the highest possible level of vaccine coverage this winter. We are required to publish our self-assessment before the end of December 2019, and intend to do this within our December In Public Board papers. Our plan this year is to vaccinate 80% frontline health workers.

Jubilee House

Following formal Health and Oversight Scrutiny Panel meeting, the Trust is proceeding to seek the most appropriate future provision for the care at Jubliee House. Plans being considered include both an interim option and a build alongside Spinnaker and in addition, the onward care for individuals undergoing Continuing Health Care (CHC) assessments, in appropriate care homes.

Corporate Risk Register / Board Assurance Framework

The risk pyramid below summarises our key strategic and operational risks:



There is no change to the Trust's overall risk profile: recorded ICT risks associated with IT infrastructure and reports of problems with access to core systems and Wi-Fi connectivity, staffing problems linked to recruitment and retention and capacity and demand are still the most prevalent risk areas on the Risk Register.

A summary of the highest risks within the Board Assurance Framework are summarised below:

BAF number	Concerning	Lead exec	Raw score	Mitigated score (Current score)	Movement since last reported (and previous score)	Target score
63	Indirect Commercial Relationships	Sarah Austin	20	16	↔	6
55	Workforce Sustainability	Helen Ives	20	16	↔	9
58	Future organisational function	Sue Harriman	20	12	↔	6
59	Business as Usual - Demand and Capacity	David Noyes & Sarah Austin	16	12	↔	6

We held a positive discussion at the September Board working regarding Risk Appetite, which the executive team will reflect on consideration of the BAF and we will hold a further session with Board in the near future.

Update from Trust Management Team (TMT) meeting:

A TMT meeting was held on 25th September; a summary of business discussed is outlined below;

- On behalf of the CEO, the Deputy CEO and Director of Finance and Performance provided a briefing to members on current topical issues, including system and national updates.
- Building on the inspirational talk delivered by Lord Patel on 18th September, the main part of the meeting was dedicated to an interactive session on Community Engagement, where members were asked to give honest feedback in response to questions posed concerning, why community engagement is important, perceived barriers to conducting engagement activities, what is needed to support productive engagement and reflections on personal experiences of receiving healthcare , either as a direct patient or as a carer. The feedback from the session has been incorporated into the Board report, presented separately and will be considered in relation to delivery plans.
- Policies ratified at the meeting include:
  - Policy for the Prevention and Management of Patient Slips, Trips and Falls
  - Nutrition and Hydration Policy
  - Induction and Essential Training Policy
  - Clinical Audit and Service Evaluation Policy
  - Control of Substances Hazardous to Health (COSHH) Policy
  - Central Alert System Policy
  - Trust Was Not Brought and Did Not Attempt Policy for Children and Adults
  - Media Policy
  - Uniform and Dress Code Policy
  - Verification of Expected Deaths Policy

Sealings

None to report since last report to Board.

Signings as reported to Finance Committee since last Board meeting

None to report since last report to Board.

Section 3 – Matters external to the Trust – including national updates, system and partnership working

Publication of revised guidance for implementing the Friends and Family Test

Following an extensive review, NHS England have implemented changes to the way providers are required to carry out the Friends and Family Test. The revisions, which will take effect from 1 April 2020, aim to make the FFT a more effective tool for supporting service improvements and to ensure it is more accessible to a broader range of people, including children and those with a learning disability. We will continue to collect data under the current processes until the end of March 2020.
Further information is available via NHS England's website

Introduction of Medical Examiners

As consequence of the Governments' consultation in 2016 on the *Introduction of Medical Examiners and Reforms to Death Certification in England and Wales,* NHS England and NHS Improvement informed all Trusts in September 2019 of the intended introduction of Medical Examiners to scrutinise all non-coronial deaths. A regional structure to support local examiners (which are likely to be hosted by Acute

Trusts) is being implemented with regional officers being recruited, for a phased roll out for deaths in secondary care by end of March 2020, and for all deaths by the end of March 2021.
We will work with partner Trusts to ensure we comply with the requirements and the new system as further information emerges.

Southampton Systems update

The Better Care Steering Board are holding an evening workshop on 1 October along with the Clinical Directors of all Southampton Primary Care Networks to work through the common areas where we can improve integration and collaboration in the city. We continue to support the integration agenda across the city and provide weekly senior managerial support to each of the three localities. The Southampton system itself is experiencing significant pressure in the Urgent and Emergency care area. Operationally our teams are operating over and above normal levels to support the wider system, and we have offered several suggestions to the system of ways in which, with small enhancements, we could help to alleviate the pressures; these continue to be either developed in partnership with University Hospitals Southampton NHS Foundation Trust (UHS), or where already proven, considered for investment. An Urgent Care Summit for the System, led by the System partners will be held on 4th October, a verbal update will be provided at Board.

Portsmouth and South-East Hampshire (PSEH) Systems update

There are a number of operational pressures in the PSEH system focused largely on urgent care and mental health in Portsmouth Hospitals Trust (PHT). The numbers of medical fit patients at PHT is significantly off target in September. For the Portsmouth system there have been significant staffing problems over summer which has in part contributed to the current position. At the time of writing this report the position for Portsmouth has improved significantly with performance returning to plan.

An Urgent Care Summit was held with all PSEH partners on 23rd September- from that Summit it was agreed that plans for additional capacity in Hampshire are now required to ensure we improve performance and safely address urgent care pressures over the Winter.

The plan for a mental health assessment unit has been withdrawn as final agreement to the clinical model could not be achieved although an element which co-locates the two crisis teams from Southern and Solent out of hours, in Havant has been in place for some months. There are now concerns about the immediate sustainability of the psychiatric liaison service in PHT which is being discussed by the Unified Executives.

Hampshire & Isle of Wight Sustainability & Transformation Partnership (HIOW STP) including STP Long Term Plan Development

The HIOW STP has published an update paper on the process and progress in developing an NHS Long Term Strategic Delivery Plan for Hampshire and the Isle of Wight. Importantly, the STP is proposing that a Committee in Common is established to *enable a collective decision to be taken with regards to the HIOW Long Term Plan.* This will be discussed in full in the Confidential Board.

Presentation to	X	In Public Board Meeting		Confidential Board Meeting				
Title of Paper	Trust Board Performance Report – August 2019							
Author(s)	Alasdair Snell		**Executive Sponsor**	Andrew Strevens				
Date of Paper	28/09/2019		**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.

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1.1 NHS Improvement Single Oversight Framework

Month: Aug-19

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Quality of Care Indicators						
Organisational Health	Staff sickness (rolling 12 months)	I	4%	4.7%	F	
	Staff turnover (rolling 12 months)	I	12%	14.1%	F	
	Staff Friends & Family Test - % Recommended Employer	I	80%	73.0%	F	
	Proportion of Temporary Staff (in month)	I	6%	6.4%	?	
Caring	Written Complaints	I	18	11	?	
	Staff Friends & Family Test - % Recommended Care	I	80%	85.0%	P	
	Mixed Sex Accommodation Breaches	E	0	0	P	
	Community Friends & Family Test - % positive	E	95%	95.8%	P	
	Mental Health Friends & Family Test - % positive	E	95%	94.9%	?	
Effective	Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	E	95%	100.0%	?	
	% clients in settled accommodation	I	59%	81.1%	P	
	% clients in employment	E	5%	4.1%	?	
Safe	Occurrence of any Never Event	E	0	0	P	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0	P	
	VTE Risk Assessment	E	95%	100.0%	?	
	Clostridium Difficile - variance from plan	E	0	0	?	
	Clostridium Difficile - infection rate	E	0	0	?	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0	P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0	P	
	MRSA bacteraemias	E	0	0	P	
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0	P	
Operational Performance						
	Maximum 18 weeks from referral to treatment (RTT) – incomplete pathways	E	92%	98.4%	P	
	Maximum 6-week wait for diagnostic procedures	E	99%	100.0%	?	
	Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	P	
	People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50%	93.8%	P	
	Data Quality Maturity Index (DQMI) - MHSDS dataset score	E	95%	73.3%*	?	
	Improving Access to Psychological Therapies (IAPT)					
	- Proportion of people completing treatment moving to recovery	E	50%	53.6%	P	

- Waiting time to begin treatment - within 6 weeks	E	75%	99.7%		
- Waiting time to begin treatment - within 18 weeks	E	95%	100.0%		
Use of Resources Score					
Use of Resources Score	E	2	3		

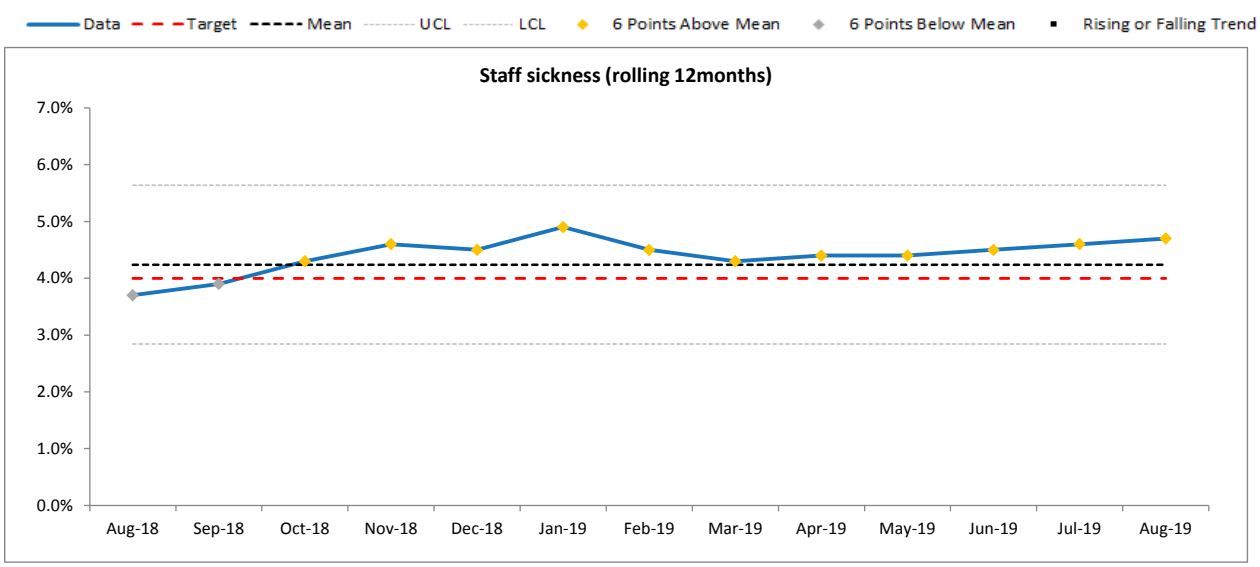
* Data reported 3 months in arrears due to NHS Digital publication timescales

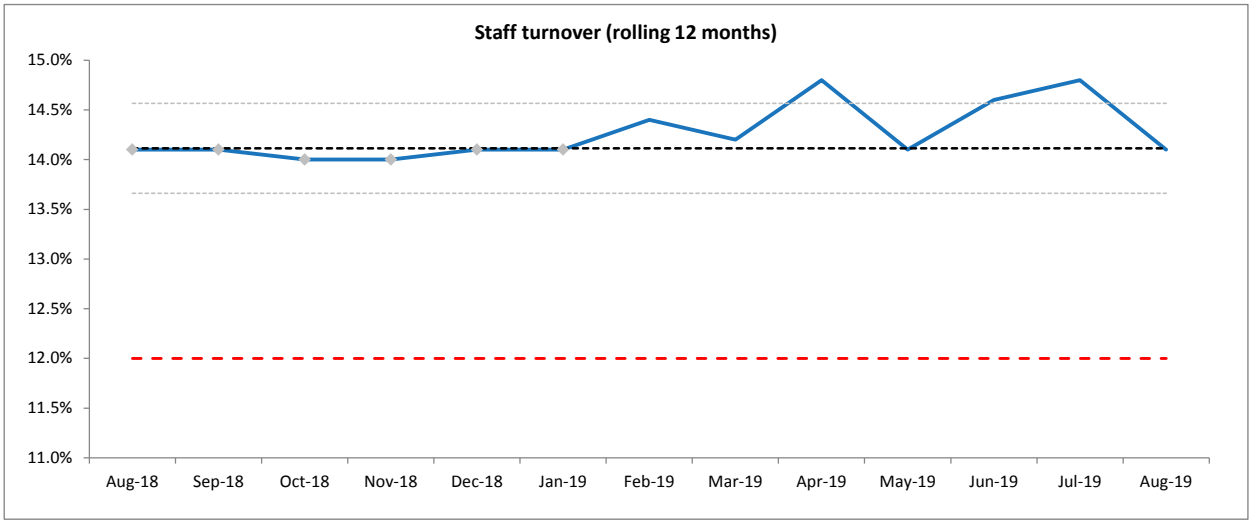
Key

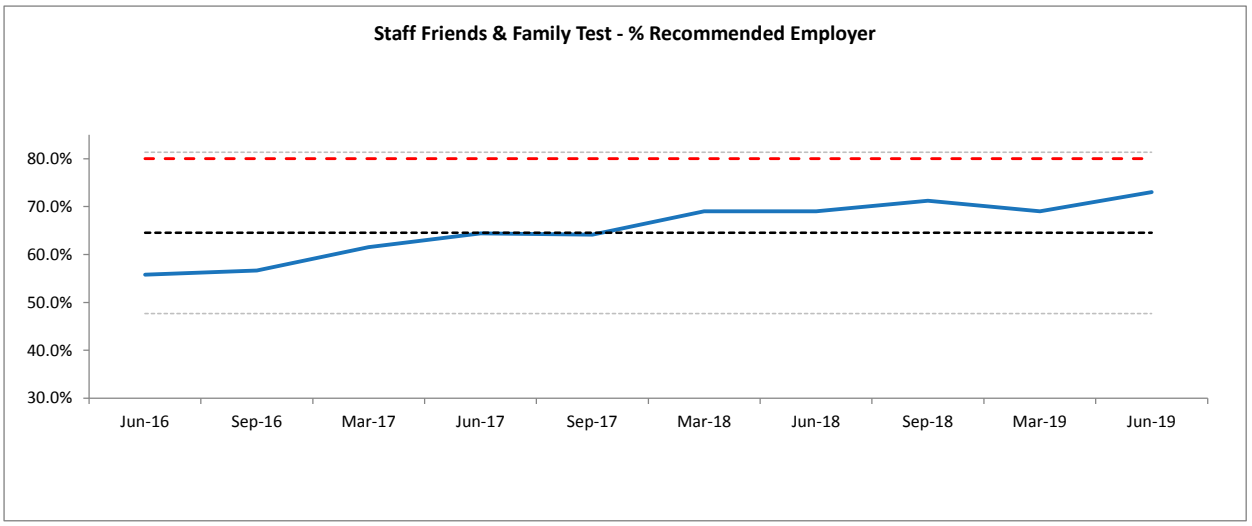
Capability		Consistantly acheiving target	Target acheived for 6 consecutive data points
		Achieved and missed target intermittently	Periodic changes in the data that are random
		Consistantly missing target	Target missed for 6 consecutive data points
Variance		Special cause note - High	High special cause concern is where the variance is upwards (for 6 data points) for an above target metric
		Special cause note - Low	Low special cause note is where the variance is downwards (for 6 data points) for a below target metric
		Common cause	Periodic changes in the data that are predictable and expected
		Special cause concern - Low	Low special cause concern is where the variance is downwards (for 6 data points) for an above target metric
		Special cause concern - High	High special cause concern is where the variance is upwards (for 6 data points) for a below target metric

Items of Significant Negative Exception

Quality of Care Indicators







1.2 Operations Dashboard

Month: Aug-19

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Community / Mental Health	Accepted Referrals (in month) *	I	14,804	14,547	?	
	Attended Contacts (in month) *	I	68,675	71,867	P	
	Discharged Referrals (in month) *	I	14,804	16,119	?	
	DNA'd Appointments (in month) *	I	8%	3.1%	P	
	Caseload Size (month end)*	I	208,692	215,000	P	
Inpatients	Occupancy Rate (in month)	E	85%	89%	P	
	Delayed Patients (in month)	I	29	36	?	
	Delayed Days (in month)	E	4.5%	7.4%	F	
Performance	KPIs Achieved (YTD)	I	90%	65%	F	
	Waiting List Size - RTT (month end)	I	1,071	1,016	P	
	Referral to First Appt < 18 weeks	I	95%	98%	P	
	Referral to First Appt < 52 weeks	I	100%	100%	P	

Performance Hotspots

High Priority

- Mental Health Sickness
- Speech and Language Therapy Capacity and Demand
- Mental Health Environmental Issues
- Increase DTOC Rates in Portsmouth
- Wheelchair Quality Concerns

Medium Priority

- Jubilee House Quality Concerns
- Waiting Times - A2i / Paediatirc Therapies / Specialist Services
- Sexual Health Data Quality
- Security Concerns at Royal South Hants
- Vacancies - Childrens / Primary Care / Dental

Improving

- Waiting Times - CAMHS Neurodiversity / Dental GA's
- COAST Service Closure
- Looked After Children KPI Performance

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

1.3 Performance Subcommittee and Regulatory Exceptions

Portsmouth Care Group

The previously reported issues at Jubilee House are being appropriately managed and are now reducing. A clear action plan to address areas of sub-optimal practice is being implemented and will be regularly reviewed, allowing the service time to make all the necessary changes and address the concerns. The ward continues to operate on reduced bed capacity to ensure staff are supported to maintain appropriate standards.

Pressures on services within the Care Group continue to impact waiting times for patients in a number of areas:

- Demand for the Assessment to Intervention (A2i) service continues to increase with waiting times at 5 weeks from referral to assessment, against a 4 week target. There is potential to revise the service specification to have a waiting time target of 6 weeks instead of 4 weeks. Expressions of interest have been asked of our staff within the Crisis Resolution Home Treatment Team to undertake a 3 month secondment to support the waiting list reduction.
- There is an increased demand for our specialist services, such as the Enhanced Community Heart Failure Nursing Service, which is difficult to manage within small teams. A review of these services and a strategy on how to make these more sustainable is going to be developed over the next few months.
- The waiting times for the CAMHS Neurodiversity service have improved in month, following additional investment to help manage the waiting list.
- Waiting times KPIs for the Paediatric Therapy services in Fareham and Gosport and South Eastern Hampshire CCGs have deteriorated below target as a result of increasing demand. In particular, there has been a dramatic increase in the number of Education, Health and Care (EHC) plans and requirements for the service to undertake, which is a statutory requirement to complete. Discussions are taking place with commissioners about demand and resources to mitigate moving forwards.

The COAST service remains closed in Portsmouth with the CCN service prioritising urgent cases. The recruitment to vacancies has been successful and the service is on track to be able to provide a partial service by October. Conversations, with staff and external partners, are ongoing regarding the development of a revised model for the service.

New KPIs for the Looked after Children service have been implemented monitoring the timescale to appointment offered date. These show a much more favourable reflection of our performance as they reduce the impact of Social Care delays on the KPIs and demonstrate the services capacity.

A number of environmental concerns have been raised and appear on the risk register for AMH. These include issues with outstanding ligature risks, fixture and fitting issues, space issues and the need to review the alarm system which is out dated and requires significant changes. To resolve these, Hawthorn ward is being decanted into the currently vacant Oakdene ward, and Maples Ward moved into Hawthorns.
Long-term sickness in the Mental Health service line is at the highest across the Trust at 5.7%. This has contributed to the high level of agency staff used during August. The service line are producing an updated workforce plan to detail how they plan to improve this, including utilising newly qualified staff differently to try and improve retention rates.

Delayed Transfers of Care (DTOCs) have increased across Portsmouth which can be mainly attributed to limited Social Care support over the summer period. Delays have begun to decrease during September.

Southampton & County Wide Care Groups

There continues to be concern about security at the Royal South Hants Hospital. A formal letter has been sent to the site's landlord, NHS Property Services, to highlight concerns, and as a result, a full site security audit has been completed by NHS Property Services (PS), with an action plan. However, this plan is not sufficient to allay concerns and further discussions are taking place.

An increase in waiting times for speech and language therapy services has been noted across the Trust where there is a mismatch between capacity and demand. This has led to delays in service and at least two Serious Incidents (Sis) being reported. The Chief Nurse is leading a review across the Speech and Language Therapy services to be presented in January. Immediate action is being taken to mitigate the risks for vulnerable patients.

Solent is now sharing robust and validated data with Millbrook Wheelchair Services (MWS) and is working collaboratively to help improve the provision of wheelchairs. The CCGs have been working with MWS to revise the current care pathway and outline expectations for wheelchair services going forward. Whilst Solent notes that the service is not currently achieving these timescales in full, this does clearly outline the commissioning expectation and target the investment of Waiting List Initiatives to achieve this long-term.

The Sexual Health service continues to experience issues with the availability and quality of data being reported from their patient record system. A number of issues have contributed to this, but the primary issue is between CGI (our IT provider) and Equinti (the patient record system host). Data feeds have been temporarily interrupted, causing the service to have delayed and limited oversight of their activity to enable sufficient planning. Planned changes to move to a central Cloud based platform in Q4 should mitigate these issues moving forwards.

The financial forecast for year-end for the Adults Southampton service line is deteriorating month on month, partly due to the increased agency usage within the Community Nursing service. There is a plan in place to recruit substantive staff and reduce the agency usage over the next few months which should help to alleviate the pressure on the year-end forecast.

There has been a reduction for the past six months consecutively in the number of substantive posts within the Children's service line, despite active recruitment campaigns. This is impacting the capacity to deliver safe services across a number of services. There are specific risks within the Occupational Therapy service where safe staffing reviews have identified significant gaps in capacity.

There have been an increase number of Information Governance breaches within the Primary Care service line, which correlates to the increasing demand and reduced capacity within the MPP services.

There are increasing challenges within the Specialist Dental Service to achieve our Units of Dental Activity (UDAs) and General Anaesthetic (GA) targets for the year as a result of sickness, maternity leave and career breaks which is creating a potential financial risk.

The Specialist Dental Service has been prioritising the patients waiting for GA appointments longer waits and has reduced the waiting list down as a result. Patients are being clinically triaged to ensure waits are safe for patients where appropriate.

Local Performance (Operations Dashboard, section 1.2)

The new Operations Dashboard included in section 1.2 shows a number of key pieces of operational information from across the Trust. The thresholds specified are mostly internally set and are still under development in this new Dashboard. A large proportion of the thresholds are currently set at the average activity levels seen during 2017/18, to enable comparison to the same activity from two years previous.

In line with the Single Oversight Framework (SOF) (section 1.1), the new Operations Dashboard now includes Statistical Process Control (SPC) analysis. The CQC recommends Trust Boards review SPC analysis to ensure that the right data is being looked at in the right way. It aims to make the messages simple and obvious, and give a more effective approach to assurance. The new style SOF reduces the amount of data provided, but highlights those areas of statistical significance, meaning that these areas are given sufficient focus, and non-statistical significant variation is not given unnecessary attention. Each indicator is given two ratings, one based on the capability of the target being achieved, and the other identifying whether the variance in performance is significant or not.

Narrative is provided for items of significant negative exception and for any items which have newly been identified as a significant positive exception.

Significant negative exceptions on this month's Operations Dashboard:

Delayed Days (in month)

As reported in the Portsmouth Care Group narrative above, the proportion of bed days lost to delayed transfers of care was high during August, however this has been flagged by the SPC indicators as a 'Fail' against the capability rating, meaning that without significant intervention, the target will not be achieved.

KPIs Achieved (YTD)

The KPIs achieved indicator shows that without significant intervention, this target will not be achieved. There are still a significant number of KPIs that are now outdated, are process rather than outcome based and do not reflect current practice or increasing demand on the services. Good progress has been made with Portsmouth CCG to refine the reporting burden of these and to update them with up to date service specifications. However, progress has been limited on this front with Southampton City CCG (SCCCG), with significantly higher contractual reporting requirements than our other CCG commissioners. There is a comprehensive service specification review taking place collaboratively between Solent and SCCCG, but little progress has been made in reducing and refining the KPIs in place. Consequently, a number of the historically set standards are no longer realistic or relevant to current service provision.

Regulatory Performance

The Trust has achieved a level 1 on the NHS Improvement Single Oversight Framework, where level 1 is the best and level 4 the most challenged. This is a great result for the trust.

Significant negative exceptions on this month's Single Oversight Framework:

Quality of Care Indicators

Staff Sickness

The staff sickness indicator shows that without significant intervention, the target will not be achieved. As the 4% target is an internal target which was set several years ago, it has been agreed that the People and OD Committee will review this and potentially propose an amended target which is aspirational but achievable in the coming months.

Staff Turnover

The staff turnover indicator shows that without significant intervention, the target will not be achieved. Similarly to the staff sickness indicator, the 12% target is an internal target which was set several years ago. The People and OD Committee will also review this and propose an amended target which is aspirational but achievable in the coming months.

Staff Friends and Family Test - % recommend employer

This indicator shows that without significant intervention, the target will not be achieved. This means that the organisation need to make a change in order to positively impact performance against this metric, otherwise the 80% target will not be achieved. Whilst the 80% target is internally set, this is not something the Trust is likely to

reduce in order to achieve it as this would not be in the best interest of our staff. The graph shown in section 1.1 shows that since June 2016 performance on the Staff Friends and Family Test has continually increased and is now at 73%, which is closer to the target than ever before.

New significant positive exceptions on this month's Single Oversight Framework:

Quality of Care Indicators

% clients in settled accommodation

In June, this indicator was reported as having special cause for concern as the performance had been reducing for the past 6 months. This has rectified in month, with August performance showing an upward trend, and making the variance due to common cause. The target for patients in settled accommodation is internally set at 59%. This is based on the England position from the February 2019 Mental Health Services Dataset publication by NHS Digital. Our performance remains considerably higher than this benchmark.

Use of Resources

The Use of Resources score has achieved a level 3 in month. This is reflective of the planned financial deficit at this point in the year.

2.1 Chief Nurse Commentary August

Current Events to Note

- Earlier in the year, the Board heard Paul's story, a gentleman who developed Guillain-Barre syndrome and who as part of his recovery, was able to receive hydrotherapy, supported by our physiotherapists and colleagues in Portsmouth Hospitals Trust, while still being ventilated. At our AGM on 16 September 2019, we were delighted to hear and see the progress Paul has made and the impact this approach to his rehabilitation had in his journey to full recovery which is ongoing. Paul and his wife expressed sincere gratitude to all of the people across both Trusts that made this happen.
- The safeguarding children's specialist nurses provide the health navigator role in the Southampton Multi-Agency Safeguarding Hub (MASH). Over the past year, the team has experienced a steady growth in the numbers they are required to navigate which is due to a combination of factors in the children's social care team as well as a change in criteria. This is having an impact on the team's ability to complete navigations within the timeframes and is also affecting the quality of the information they are able to collate. The teams, following discussion with commissioners and colleagues in children's social care have agreed some interim measures whilst options for a more sustainable solution are agreed across the partnership. An options paper has been submitted to commissioners and the outcome is awaited. If there is no solution agreed in the near future, the team will be required to consider additional actions needed to ensure they do not compromise the safety of themselves and of vulnerable children. This issue is being monitored by the Associate Director of Professional Standards and monitored through the Safeguarding Steering Group. It is currently identified as a risk on the risk register.
- In the previous report, we provided a summary of actions taken in response to the changes and concerns relating to Jubilee House. The development programme is completed with the mop-up sessions due to conclude at end of September. The staff who have completed the programme are currently working through their competencies and are receiving support from the new clinical manger who commenced in post at the end of July 2019.
- We have closed the risk relating to the gap in Non-medical Prescribing clinical lead following the successful recruitment to the substantive position.
- The Southampton Tissue Viability Nurses have been nominated for a Nursing Times Award and have recently provided a presentation to the panel. The winners will be announced at the awards ceremony on 30 October 2019.
- All eligible NHS trusts in England participate in the NHS Patient Survey Programme, asking patients their views on their recent health care experiences. The findings from these surveys provide organisations with detailed patient feedback on standards of service and care, and can be used to help set priorities for delivering a better service for patients. The survey results are also used by the Care Quality Commission (CQC) to measure and monitor performance at both local and national levels. The current programme includes mental health and GPs and provides one important element of the range of ways people who use our services can tell us about their experiences. In the future we will extend the use of the feedback from these surveys as we move to a more integrated way of understanding and acting on the experience of people who use our services. On receipt of the survey results, a briefing report will be prepared by the survey lead and presented to Board. The results will be used to inform the quarterly engagement and experience report identifying those things we do well and those we need to improve.
- The NHSI Quality Improvement collaborative relating to Transition has commenced and the Solent team is being led by Stephanie Clark, Head of Quality and professions in Children's services. This work will also contribute to the priorities of both the CCGs and the Local Safeguarding Partnerships (children) and the Local Safeguarding Adult Boards following a number of serious case reviews where transition was identified as a key issue.
- Sharon McCann, Head of Quality and Professions, Adult Services Portsmouth is leading a team from Solent as part of the NHSI Pressure Improvement Collaborative. The collaborative was launched in September in London and the team are looking forward to working together on this very important aspect of patient care.

- There will be a gap in the Infection Prevention Control team which may impact on performance with the impending retirement of the Head of Infection Prevention and Control. Interim arrangements will be in place while the recruitment process in completed.

Complaints Update

In July and August 2019, the Trust received a total of 18 formal complaints. The complaints are broken down by service line in the tables below:

Service Line	July 2019	August 2019
Adults Portsmouth	1	1
Adults Southampton	0	1
Children's Services	0	0
Primary Care	1	5
Sexual Health	0	0
Adult Mental Health	3	3
SPA	0	0
Special Care Dentistry	2	1
Corporate	0	0
Infrastructure	0	0
Total	**7**	**11**

The themes remain unchanged from those previously reported and which relate to communication and quality of care received. Changes are being made to the current reports and from quarter 2 there will be an integrated engagement and experience report which will include the outcomes, learning and any actions as a result of complaints. In this reporting period, the reduction in the number of formal complaints received has been noted and this situation will be monitored closely.

A service concern received in August 2019 by the Trust has been escalated to a complaint following a request from the complainant who wished to receive a response from an Executive. The team have also de-escalated four formal complaints following discussion and agreement with the respective complainants.

The Trust currently has one active case with the PHSO for their consideration and awaits further information at time of writing.

Incident Updates

The work to develop the new approach to data reporting continues and a proposal has been taken to Assurance Committee for approval.

The incident data for July and August has shown a slight increase from the data reported previously and year to date, there is also an increase compared to the same period last year. The majority of incidents reported are patient related incidents but the trend remains that the majority are categorised as no harm or near miss incidents and is consistent with previous years reporting. There is no change to the profile of incident reporting with Adults Portsmouth and Adults Southampton remaining the highest reporters of incidents.

Some concerns have been raised in relation to the capacity and demand across the trust relating to the Speech & Language Therapy services and the potential impact on patient safety. A strategy discussion is planned to consider the risks in detail and to ensure appropriate mitigations are put in place.

There was a drop in hand hygiene compliance in July 2019 due to a lack of submission of data from a small number of teams. Action has been taken and the audits have been completed.

Compliance with MRSA screening has been maintained and the improvements seen in VTE assessments has also been sustained achieving 99% and 100% in July and August respectively and a year to date position of 99% against a target of 95%.

Serious Incident (SI) Update

During July and August, twelve serious incident investigations were registered which is consistent with the previous two months. The categories are detailed below:

Category	July	August
Unexpected death	4	0
Delayed diagnosis	2	0
Safeguarding Vulnerable Child	1	0
Treatment Delay	1	0
Information Governance Breach	1	0
Pressure Ulcer	1	1
Slips/Trips/Falls	0	1

The outcomes and learning from these investigations will be shared and discussed at the SI panels in October and November and themes and learning identified will be reported in the quarterly patient safety reports.

Friends and Family Test (FFT)

The contract for our current patient experience feedback system is coming to an end. A process is underway, led by the Associate Director for Community Engagement and experience, to procure a system from April 2020. The new system specification was been designed to:

- Improve access for people who wish to provide feedback
- Ensure ease of access to reports by people who provide our services
- Ensure we are able to integrate data related to the experience of using our services from other sources including the national experience survey programme, Care Opinion and NHS net
- An internal assessment of shortlisted providers has been completed with full engagement of service lines and a preferred provider proposed. Final financial review is being undertaken prior to the provider being agreed.

For July and August, the following should be noted:

- FFT continues to be consistent with year to date position of 96% reporting that are extremely likely to recommend Solent services (97% in July and 95% in August)
- Inpatient areas continue to have difficulty gathering feedback from patients and their families with Mental Health services being most challenged. There are a number of contributory factors to this which include the patient acuity as well as some difficulties with the technology.

Staff Friends and Family Test (FFT)

The Staff FFT data is collected during September and the results will be available in the next Board report. In addition the annual staff survey will go live in October 2019.

3.1 - Financial Performance — August 2019/20

Performance

£169k Deficit in Month
£147k Adverse to plan

£934k Deficit YTD
£151k Favourable to plan

£0k Breakeven Year End Forecast (adj)
£0k Achieving control target

Purchase Orders and Debts

Eligible invoices raised in month **906**

868 Purchase orders raised in month

Purchase orders raised in month against eligible invoices **96%**

£5,965,915 Total debt month end

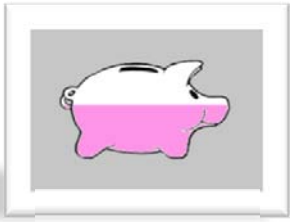
£609,494 Total debt over 90 days month end **10%**

Savings

£3,044,000 Savings Target YTD

£1,643,000 Savings Delivered YTD

£611,000 QIA Savings Delivered YTD

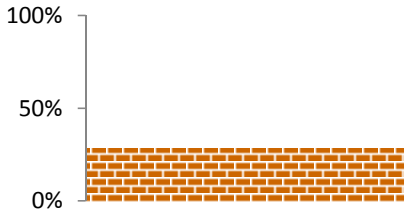


54% Savings Achieved

Capital Finance Summary

£1,867,000 YTD Spend

£6,649,000 Year end plan



28.1% Spend against year end plan

3.2 Finance Commentary August 2019

Month 5 Results

The Trust is reporting an in-month adjusted deficit of £169k for month 5, £147k adverse to plan and a year to date adjusted deficit of £934k, £151k favourable to plan. The Trust is confident to achieve the quarter 2 control total and therefore has recognised £693k Provider Support Funding (PSF) and Financial Recovery Funding (FRF) income in the year to date result. The Trust has received an additional £207k PSF for 2018-19 which is not included in the adjusted deficit.

Whilst the Trust has made a deficit of £934k in the first five months of this year, the full year control total is breakeven, with CIP schemes planned for the second half of the year and additional PSF and FRF (71% between Sept 2019 and March 2020).

Discussions are ongoing with particular services regarding the ability to deliver their plan; particular pressures lie in Adults Southampton and Estates.

CIPs

CIP delivery in month 5 was £317k (£329k adverse to plan) and year to date £1,643k (£1,401k adverse to plan). Most service lines under delivered on CIP schemes, although made up for the shortfall by non-recurrent means. 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 5 is £1,867k. Projects totalling £3,997k have been approved and are in progress, with the exception of Adelaide Reconfiguration which will be delayed into 2020-21 due to timescales in agreeing the works with the landlord. This allows other projects, such as the potential Jubilee ward move and Eastleigh Hub to be prioritised in 2019-20.

The Trust received £4,768k PDC funding for Phase 2 project at St Marys and St James hospitals in September, £3,113k of which has been spent YTD.

The cash balance at 31 August 2019 was £12m. The balance includes £645k in respect of AfC pay deal 19/20 for local authority contracts received from NHS England in August. Two of the Trust loans, totalling £7.8m are due for repayment in early 2020. The Trust is in discussions with NHSI with regards timing of the loan repayments and potential rollover.

Aged debt

Whilst total debt increased during August by £100k to £5.9m, debt over 90 days overdue decreased by £582k since July. This was largely due to Southern Health paying £280k for PICU bed days and £240k from NHS England for the M12 2018/19 Specialist Service Contract. The Trust is 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. Certain debts are now being referred to an external debt collecting agency if SBS debt collection unsuccessful.

4.1 - Workforce Performance — August 2019/20

There were **2,911.9** FTE in post this month, which equates to 3,519 staff in post.

A decrease of **20.3** since last month

82% YTD mandatory training compliance

69% YTD information governance training completed

50% YTD appraisals completed

Bank and Agency

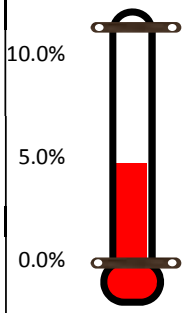
32,738 Hours requested in month

18,943 Hours filled by bank in month **£262,743**

11,014 Hours filled by agency in month **£310,513**

2,780 Hours requested not filled

In month, Solent are above agency ceiling by **£275,360**



4.7%

Sickness & absence

Rolling 12 Months

93.8%

budgeted establishment (FTE) worked in month

6.2% *vacancy factor*

FTE Posts **193.9**

12 month rolling turnover is **14.1%**

50 (42.8FTE) new starters in month

57 (45.1 FTE) leavers in month

4.2 – People & OD Commentary August 2019

Sustainable Workforce

Full time equivalent (FTE) in post for August (M5) was 2,912, which is an increase of 3 FTE since M3. The vacancy factor in August was 6.2%, a reduction from 6.5% in June. Our nursing vacancy rate is currently 4.9%, again a reduction from 5.3% in June.

Recruitment has been successful during months 3 and 4, resulting in a high number of new starters due in September and October. Key areas of focus for recruitment efforts are band 5 RMN vacancies, medical staffing in Mental Health and hard to fill vacancies in Children and Family Services, Specialist Dental and Primary Care. There is a new Recruitment plan in place with a new leadership model and the People & OD (POD) Group will monitor its effectiveness.

The sickness rate in month is 5%, which is an increase from 4.5% in June. Due to the trend increasing over the last year a deep dive / SPC analysis has been undertaken. Findings were reported through to the People and OD Committee and a full evaluation of service lines together with an integration action plan from HR Consultancy and Occupational Health will be brought to TMT.

During the summer months, a high vacancy rate and the higher sickness absence rate has impacted adversely on our agency usage. In addition, the Bank team itself, which is a small service, experienced a high degree of churn and this impacted service delivery. In-month agency spend for August was £555,360, an increase of £125,656 compared to June, and this does not compare favourably to the same period of £372,000 in 2018.

Our agency staffing in month is 2.3% of the whole workforce, which still compares favourably with the peer median of 3.9% in the Model Hospital. We will address the use and cost of agency in our workforce optimisation programme, which reports into Workforce & OD (WOD) Committee. A paper on future options for the sustainability of our own Bank team will also be brought to Directors.

The HIOW Collaborative Bank continues implementation; however benefits will not be seen from this project until 2020. Our Roster Improvement Programme continues; in the next business planning round, consideration will be given to increasing resources to manage rosters locally. The scope for the internal audit has also been approved, which will focus on rostering and its effects on workforce sustainability.

Average annual staff turnover is 14.1%, a reduction from 14.6% in June and the nursing turnover rate for August is 14.6%, which is a significant and sustained improvement. The Retention Improvement programme will now reconvene to determine the most important next actions to make another step change, which will be presented through POD Group and WOD Committee.

Following on from the STP-wide analysis of the risk created by the pension tax limit, and increased proportion of the workforce approaching retirement, a suite of information and awareness sessions have been commissioned for delivery in Q3. These include Tax and Annual Allowance sessions delivered by KPMG, a series of two day workshops for staff covering all aspects of pensions and retirement. In addition, NHS Pension Awareness sessions are planned for all staff, these sessions will be delivered in partnership with our Payroll provider NHS Shared Business Services. These will enable an informed choice on retirement and pension options, including the options to retire and return, or take flexi retirement aligned to our Flexible Working Standard Operating Procedure.

Learning & Development

The statutory and mandatory training rate in August was 82.1% against a target of 90%. Information Governance (IG) and Performance Appraisal (PA) rates are increasing since returning to 0% at the start of the year. A report into non-compliance has been provided for immediate action, which will be monitored by the WOD Committee.

Our new Learning and Development Strategy is going through the final stages of governance approval and the business case for investment into infrastructure will be presented at Directors. Establishing learning infrastructure is a key part of the operational plan (Year 1). August saw the completion of the new Learning and Research hub at St Mary's Health Campus, Portsmouth. The state of the art learning centre comprises of practical training rooms, space for online learning, and a large space for up to 65 learners. It also includes private study space for self-directed learning.

The second cohort of our Registered Degree Nursing Apprenticeship has been recruited to, starting in September. As part of our newly drafted Learning and Development Strategy the expansion of our apprenticeship provision into an academy model is being considered.

Leadership, Culture & Values

835 staff members have made pledges of support and to champion inclusion across the Trust in July and August for LGBT+, to reduce the discrimination faced by the LGBT community accessing healthcare. Staff have received a rainbow badge to signify this and a further 500 have been ordered.

It is Black History month in October and we are recognising this though several events, including a visit on 22nd October from TED speaker, Don Jon, founder of Black History Month Southampton. These are two examples from the Diversity & Inclusion Plan that is being governed across the Workforce & OD and Community Engagement Committees.

Four senior leaders and five operational leaders are currently undergoing assessment for cohort two of the Level 7 Senior Leaders Apprenticeship (MBA) and 5 Chartered Managers Degree Apprenticeships at Solent University.

The highly accredited 2020 System Leadership Programme will commence in September for Portsmouth and South East Health and Care System, with Solent taking the lead for delivery. Participants are from a wide variety of public sector organisations, and the focus will be on innovation in Mental Health Services. Staff from across Solent services will participate alongside colleagues from other NHS Trusts, members of Hampshire Constabulary, Armed Services, Local Authority, and Voluntary Sector.

There is a significant investment underway to implement the findings from Improving People Practices Review. This includes additional staffing into the HR team, redeploying one of our managers to focus on leadership mentoring and development and the creation of a new Leading with Heart programme for our middle managers. The business case for this new programme will be brought to Directors. Leading with Heart currently continues with bespoke programme delivery for our service line triumvirates to support them with leadership development for their organisations.

Health and Wellbeing

Our Health and Wellbeing strategy, `Thriving at Work` includes mental wellbeing, flu and general wellbeing / healthy lifestyles. We continue to build our self-help resource suite and develop innovations to support a prevention and early intervention approach. Activities, events and programmed activities across the Trust are being promoted through a health and wellbeing calendar to raise awareness. Our Wellbeing Practitioners are helping to further engage people in the wellbeing agenda, promoting positive messaging through induction, self-help tools and sign posting, a healthy lifestyles screening tool and intervention programme offering wellbeing training/support programmes for individuals, managers and teams.

The Flu programme launched mid-September and vaccination clinics commence October 1. There is a comprehensive communication and implementation plan in place to work toward the challenging target of 80% of staff in contact with patients. Governance will be through the Workforce & OD Committee.

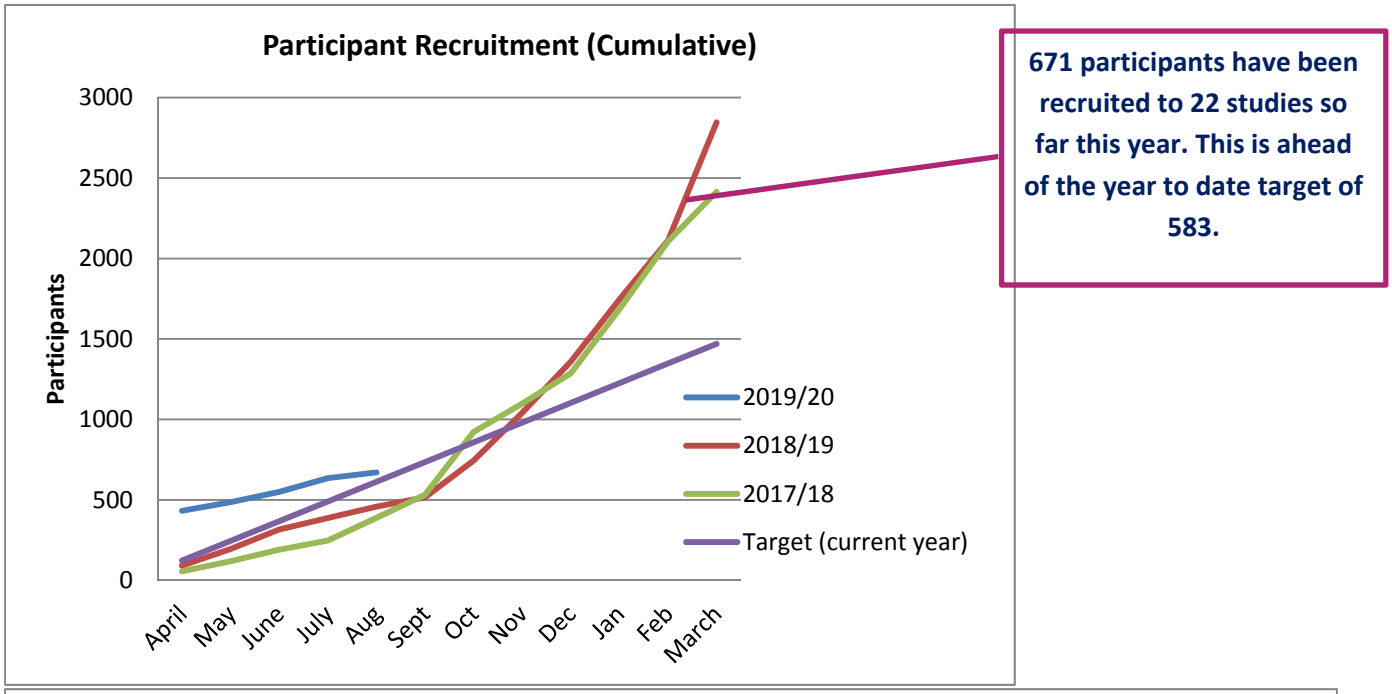
Communication & Engagement

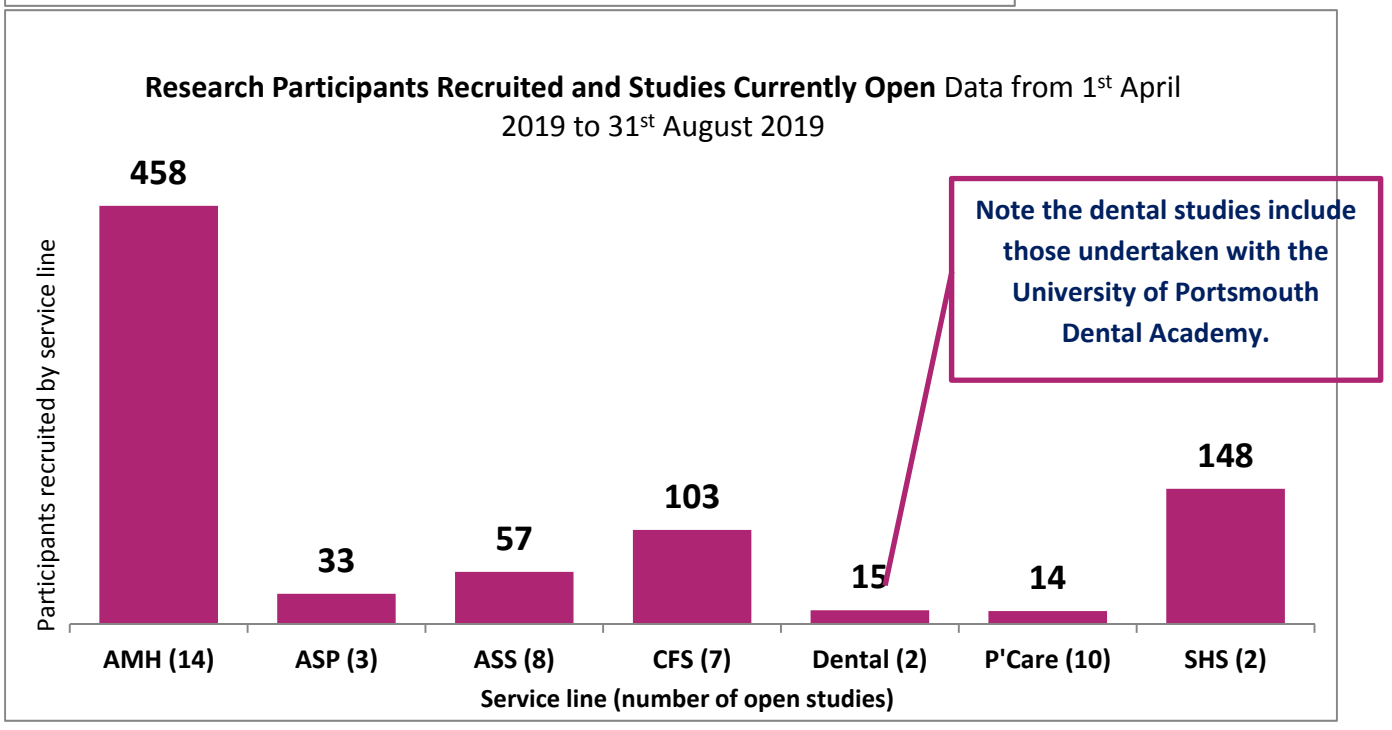
The AGM in September will be proceeded by a wellbeing discovery event, designed to link to our purpose of keeping people safe and well, focussing both on physical and mental health.

During Q2, the Trust has had coverage in 34 positive online and print articles published, and received a total of £34.5k Advertising Value Equivalent (AVE) in the print media. There were also 16 radio or television broadcasts, including coverage of HPV vaccines for boys and a facility for students in Portsmouth to help them manage their own mental health; a joint public relations activity with Portsmouth University. A national journal, the Nursing Times, reported on an Award presented to the Southampton Diabetes Team, on World Patient Safety Day.

5.1 Academy of Research and Improvement

As an NHS organisation, Solent's research performance is measured by the number of participants recruited into studies. Between April 01 and August 31 this year, we have recruited 671 participants into research studies. There are open studies in each of our Service Lines, but the most research active are our mental health, children's and sexual health services.





Clinical Audit and Evaluation – Completion against Plan

April 01 - August 31 2019-20

	Number on Plan	Completed projects	Completion rate
Adults Portsmouth	6	2	33%
Adults Southampton	36	6	17%
Child & Family	34	2	6%
Mental Health	22	0	0%
Primary Care - GP	2	0	0%
Primary Care - MPP	35	8	23%
Sexual Health	25	9	36%
Specialist Dental	18	1	6%
Totals	**178**	**28**	**16%**

The Audit and Evaluation Completion rate against plan for the first five months of 2019 is 16%.

The number of projects on the plan for Adults Portsmouth remains low. Overall,

- There have been s significant increases in the number of projects working in partnership with patients.
- A re-audit of completeness of referrals from GPs to podiatry has shown an increase of "mostly or fully complete" from 64% to 86%.
- An evaluation of new same day appointments in sexual health has shown that 86% of staff responders reported a better sense of well-being (due to lower waiting times)

Solent wins International Accolades at the IUSTI

Dr Raj Patel, Consultant in Genito-Urinary Medicine within the Solent Sexual Health Services has been awarded the **European Medal Of Merit by the IUSTI (International Union against Sexually Transmitted Infection).** This highly prestigious award was in recognition of outstanding achievement in research, and as the Scientific Chair. It was presented in September at the International Meeting in Estonia.

Two medical students also won awards at the conference - Miss Rafia Miah She won first prize for the Best Oral Presentation for her work 'Are clinicians accurately taking and handling samples for STI diagnosis?'. She recommended that a standard operating procedure should be introduced which could be utilised nationally for training and reviewing clinicians. This work was deemed of great importance and was highlighted in the closing address summarising the most important presentations at the conference.

Miss Anya Mann was awarded first prize for the Best Clinical Case Presentation. She presented the 3 recent congenital syphilis cases from low risk mothers we have had in the past year in the Solent region. She illustrated her presentation with images of bone X-Rays and teeth abnormalities in these children reminding the audience to consider syphilis as a differential diagnosis in sick newborns. This has recently been added to the usual 'TORCH' screen of sick neonates in the Solent region.

Publication

Richardson T. & White, L. The Impact of a CBT-Based Bipolar Disorder Psychoeducation Group on Views about Diagnosis, Perceived Recovery, Self-Esteem and Stigma. *Cognitive Behaviour Therapist*, Vol12 e43

This showed the group improved sense of recovery and factors such as perceived sense of control of their diagnosis, feeling more confident they could prevent relapse.

6.1 NHS Provider Licence - Self Certification 2019/20

No.	Requirement	Response (Confirmed / not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
Condition G6 – Systems for compliance with licence conditions				
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	The Board is not aware of any departures or deviations with Licence conditions requirements. The effectiveness of internal control systems and processes are reviewed on an annual basis and documented within the Annual Governance Statement as presented to the Audit & Risk Committee and incorporated within the Annual Report. In addition, assurance to the Board is supported by opinions from Internal Auditors and External Auditors. Annually the Trust declares compliance against the requirements of the NHS Constitution	
Condition FT4 – Governance Arrangements				
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate.	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSI.	
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation	Confirmed	The Board is not aware of any departures from the requirements of this condition. On an annual basis the Trust has implemented a process of governance reviews (via the Governance and Nominations Committee) including; - Reviewing composition, skill and balance of the Board and its Committees - Reviewing Terms of Reference - The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business conducted in year. A mid-year review of each Committee is also conducted. The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quorarcy as well as any recommendations made following Internal Auditor (or other external review) – including the outputs of the Audit concerning the effectiveness of the Assurance Committee and Quality Improvement and Risk Group, and more recently the Mental Health Act and Scruitiny Committee. We are actively recruiting to our current NED vacancy, as well as proactively recruiting into our clinical NED role in accordance with succession planning. We are also recruiting into our Chief Medical Officer role as the incumbent is due to leave in December 2019. The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.	

No.	Requirement	Response (Confirmed / not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements. .	Confirmed	For 2018/19 Our agreed control total is £1.0m deficit. At month 6, a revised forecast of £0.4m was submitted; the movement of £0.6m is made up of an internal improvement of £0.2m, which creates £0.4m of additional PSF. Internal control processes has been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls. The Board is not aware of any other departures from the requirements of this condition.	Concerning CQC compliance: We continue to address actions and monitor compliance with requirements made following our 2016 comprehensive inspection and subsequent inspections.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. Concerning Board level capability – we are actively recruiting to our current NED vacancy, as well as proactively recruiting into our clinical NED role in accordance with succession planning. We are also recruiting into our Chief Medical Officer role as the incumbent is due to leave in December 2019.Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies. Established escalation processes allow staff to raise concerns as appropriate.	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Item 11.1

Presentation to	**Public Board**		
Title of Paper	Community Engagement Progress Report		
Author(s)	Sarah Balchin, Associate Director of Community Engagement and Experience John Bashford, Framework Lead Pamela Permalloo-Bass, Strategic Lead, Diversity and Inclusion Sarah Williams, Associate Director of Research and Improvement	**Executive Sponsor**	Jackie Ardley, Chief Nurse
Date of Paper	26 September 2019	**Committees presented**	
Link to CQC Key Lines of Enquiry (KLoE)	[ ] Safe [ ] Effective [ ] Caring [ ] Responsive [X] Well Led		

Well Led KLoEs								
	W1 Leadership Capacity & Capability	X	**W2** Vision & Strategy	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 Community Engagement Strategy was published in July 2018 and outlined the Trust ambition to *"make community a core part of how we do things, so that it becomes embedded in the culture and practice of the organisation at all levels"* with diversity and inclusion at its core.

This paper summarises:

- The national policy context and evidence base
- Local engagement needs identified for workforce and service users
- The Solent Community Engagement Strategy and our approach to delivery
- Diversity and Inclusion – Maturity Model and draft Diversity and Inclusion Strategy
- Solent Academy – recent developments
- Pilot projects progress
- Supporting our engagement ambition

Board Recommendation
The Board is asked to note the report.

Community Engagement – A progress report

1. National policy context

The origins of community engagement, diversity and inclusion lie within the principles of democratic participation and involvement. Within health and social care community engagement and inclusion have been variously associated with consultation and the empowerment of diverse disadvantaged people or groups and as a means by which the health needs of particular communities or groups are identified and addressed:

"Community engagement is built on the principles of equality and social justice. It acknowledges that barriers to public health and social care services exist for many people and that those barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities. It further recognises that within some communities there is a lack of awareness about a range of health and social care issues and services."[1]

Whatever the policy framework or origin, there has been a consistent theme to interpretations of community engagement, diversity and inclusion that encompasses empowerment, active citizenship and involvement and participation in decision-making. Over the last two decades there has been greater commitment to the inclusion and involvement of diverse service users and communities in health and social care policy. NHS England published guidance on patient and public participation in commissioning health and care, in which it states:

"Effective participation comes from our mindset and culture. It moves beyond process and embraces people, carers and patients in the design, delivery and assessment of care. It should be a natural part of the way we work."[2]

Community engagement, diversity and inclusion has also come to be increasingly recognised as essential components of ensuring the quality, safety and effectiveness of health services. For example, in speaking about the learning from the events at Mid-Staffordshire Robin Morrison, Chair of Engaging Communities Staffordshire stated:

"In those tough early days of dealing with the aftermath of the Stafford Hospital tragedy, we learned many things; most importantly to give the public a voice on health and social care issues and, of course, to act upon what they told us."[3]

The NHS Long Term Plan states that action by the NHS is a complement to - not a substitute for - the important role of individuals, communities, government, and businesses in shaping the health of the nation. Local health systems will be expected to engage communities in their planning and as part of the shift towards more integrated ways of working. This will include looking beyond healthcare provision, to the wider role that NHS organisations will have to play in influencing the shape of local communities, improving health inequalities and acting as anchor institutions. In particular, NHS England will:

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[1] Winters, M and Patel K (2003) Community Engagement: Report 1 The process. Preston: University of Central Lancashire

[2] NHS England (2017) Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England. London: NHS England

[3] Community engagement: a positive power for change. https://www.england.nhs.uk/blog/community-engagement-a-positive-power-for-change/

- Continue to target a higher share of funding towards ***geographies with high health inequalities*** (2.25)
- Support local planning to ensure national programmes are focused on health inequality reduction, and set out ***specific, measurable goals for narrowing inequalities***, including those relating to ***poverty (2.26)***
- Develop an enhanced and ***targeted continuity of carer model*** to help improve outcomes for the most ***vulnerable mothers and babies (2.28)***
- Further ***increase the number of people with SMI receiving physical health checks to an additional 110,000 people per year by 2023/24***(2.30)
- Do more, across the NHS to ensure that all people with a ***learning disability, autism, or both can live happier, healthier, longer lives***. (2.31)
- Invest up to £30 million extra on meeting the needs of ***rough sleepers***, to ensure that the parts of England most affected by rough sleeping will have better access to ***specialist homelessness NHS mental health support, integrated with existing outreach services***. (2.32)

Respect, equality and diversity will be central to changing the culture of the NHS and will be at the heart of the workforce implementation plan, including the following:

- Through the ***Workforce Race Equality Standard***, progress in addressing these issues from the perspective of BAME staff is being made. However, two years is not long enough to achieve the necessary change and so NHS England will invest an extra £1 million a year to extend its work to 2025.

- ***Each NHS organisation will set its own target for BAME representation*** across its leadership team and broader workforce by 2021/22. This will ensure senior teams and Boards more closely represent the diversity of the local communities they serve.

- NHS England will also develop a ***new Workforce Disability Equality Standard*** with the aim of the NHS becoming a model employer in this regard. (4.42)

What is clear from the NHS Long Term Plan is that community engagement, diversity and inclusion will remain a priority and that there will be an increasing drive to make participation, involvement and partnership of diverse service users and communities a core part of the business of healthcare.

In its series on *Ideas that Change Healthcare* the Kings Fund produced a paper on building collaborative partnerships among professionals, patients, carers and communities that recognises how achieving collaboration will require changes in how the NHS works:

"Achieving a more collaborative dynamic will require a change in the way that all of us work. The ability to adapt, communicate and shift between roles will be important for all who seek to establish a new, collaborative relationship that puts safety and quality at the heart of health and care in our communities."[4]

Establishing these new, collaborative relationships requires NHS organisations and their public sector partners to change their culture and practices and to make evident their organisational strategies and commitment to community engagement. The need for this kind of change in community relationships is in evidence from the local context and is increasingly recognised as a priority amongst public sector partners. Within this national and local context the Trust recognises

[4] Seale, Becky (2016) Patients as Partners: Building collaborative relationships among professionals, patients, carers and communities. London: The Kings Fund

that new ways of thinking and behaving about community engagement, diversity and inclusion are necessary. In particular, health and social care can no longer be something that is 'done to or for' people; it must become something that is done 'with' people.

The purpose of engaging with individuals who use services and the wider communities in which they live is not to determine what is the matter with them, but what matters to them. That is the context within which community engagement, diversity and inclusion needs to be developed and understood. This is why the Trust has a strategy for community engagement and provides the rationale behind its current development of a new strategy for diversity and inclusion, which seeks to go beyond the legal commitment of the Equality Act 2010.

1.1 Local needs

To inform the development of our local approach to community engagement the data and information systems that can support prioritisation has provided the focus to identify activities and programmes of developmental work. This has included:

- A detailed review of current workforce data across protected characteristics.
- A review of recruitment data, with a view to identifying gaps and strengths in recruitment of a diverse workforce.
- Analysis of the current patient experience data across different community groups and those with protected characteristics.
- Analysis of patient activity data across those with protected characteristics and other vulnerable groups.

A brief summary of the findings from this review and analysis of these data and information systems includes:

1.1.2 Workforce

- The workforce is overwhelmingly female (87%) which is higher than the average for the NHS and significantly higher than the local populations served by the Trust.
- The Trust employs a broad range of age groups, though the majorly of staff are middle aged.
- The Trust is attracting higher numbers of young males as applicants, but these do not come through as appointments in the same degree.
- The Trust employs approximately 10% BME staff, which is an increase on previous years but is below the average for the two major conurbations of Southampton (15%) and Portsmouth (12.6%). The largest population growth in minority ethnic groups has been in the category White Other: Southampton (8%); Portsmouth (4.1%).
- The percentage of staff members identifying as LGB (1.9% is approximately in line with the latest population estimates by the ONS (2%), though it should be noted that the rates for people aged 16 – 24 are more than double (4.2%) and the South West region also has higher numbers identifying as LGB than other regions except for London. For sexual orientation and disability the Trust has very high rates of incomplete data. However, it is worth noting that these are much improved for the most recent recruitment data.
- Fewer than 3% of the Trust's workforce regards themselves as having a disability, which is lower than ONS estimates for numbers of people living with a disability.

1.1.3 Service user activity

There are limitations in the data, for example there are only complete data for age, sex and ethnicity across all service lines. In particular, action is needed to address:

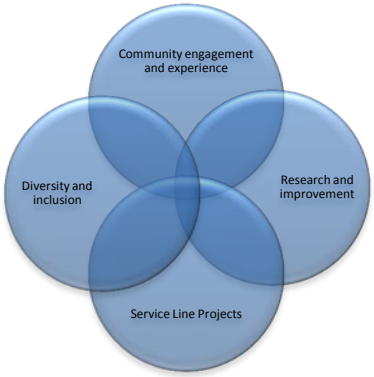
- Religion or belief – action is needed to improve the completion of these data across all service lines.
- Sexual orientation – this is only collected for Sexual Health Services and there is a need for this to be extended to other service lines.
- Disability – data on disability should be collected across all service lines including the nature of the disability, for example visual or auditory impairment, physical, mental and/or learning disability. This should be considered alongside preparations for the Workforce Disability Equality Standard, which is due to be implemented later this year.
- Gender reassignment – there is increasing recognition of the health inequalities and stigma experienced by transgender individuals, in particular mental health problems. A starting point for piloting data collection on transgender could be undertaken in Mental Health Services.
- Pregnancy and maternity and marriage or civil partnership is more relevant for workforce monitoring.

2. The Solent Community Engagement Strategy

The Community Engagement Strategy was published in July 2018 and outlined the Trust ambition to *"make community a core part of how we do things, so that it becomes embedded in the culture and practice of the organisation at all levels"* with diversity and inclusion at its core. This long term approach, requiring organisational commitment, is underpinned by an established method described by Lord Kamlesh Patel, and has enabled us to move towards a more integrated way of working across engagement and experience, diversity and inclusion, research and improvement and service line focussed projects

3. An integrated approach to delivery

Integrating the four key elements will support our community engagement ambition by ensuring we maximise opportunities to engage with people who use our services, their families and carers, access the



local community, their skills and knowledge, and make most effective use of the available resources.

3.1 Community engagement and experience

We have two key aims:

1: To better understand what *really* matters most to people who use our services, their families and carers.
2: To actively and meaningfully involve people in decisions related to their care and the design, development, delivery and evaluation of the services we provide, to reduce health inequalities.

3.1.2 Opportunities to provide feedback

Whilst service user feedback is overall positive, at 96% for community services and 89% for mental health services for FFT for example, there is a significant lack of data about who the people are who provide feedback about their experience. We know that Solent service users who responded to the national Mental Health Survey, were not representative of our local population; the 18-35 and 36 - 50 year old age groups were under represented and 91% of people who took part declared themselves as white British. People from the BAME communities and those with a disability are also underrepresented in the group which express a concern about their care. To address this in part the Trust has made good progress to procure a new system for patient feedback. A preferred provider has been identified and will be awarded the contract subject to financial assessment. Representatives from our local community, service line leads and corporate functions have been engaged in this process. This system provides:

- Increased ease of access to people with a wide range of communication needs
- Capacity to collect significantly more detailed data about people who respond, enabling us to identify who is using our systems and most importantly who is not.
- The capability to integrate data from a variety of sources; e.g. Friends and Family test, local surveys and feedback systems, Patient Opinion and national survey programmes, providing a whole view of experience of using our services.

The new system will be implemented from 1 April 2020.

3.1.3 Caring for Carers: supporting those who support others

Solent is participating in a Portsmouth system improvement project for adult family carers of service users, and those carers who are currently not known to services. This pilot project across health and social care aims to improve access by carers to preventative health and wellbeing services by working with them to co-design what good looks like. The outcomes of the pilot will provide the basis for roll out across Southampton and Hampshire in 2020 – 21.

3.1.4 Children and Young Peoples Services (CYP): putting the voice of the child at the centre

A programme of discovery events has been co-designed with representatives from the Young Shapers Group, to gather feedback from children, families, carers and third sector organisations about what matters most to CYP when they use our services. Discovery events are based on the principle of seeking the patient experience by enabling people to recount their experiences in detail

in their own words and in their own way, rather than using a traditional survey of formalised feedback system. The first event will be held in October 2019.

3.1.5 Towards real people participation: Community Partners Programme

Community partners are people who are able to offer us time, support, guidance and skills to help us better understand our services and drive improvement. Unlike traditional volunteering roles, the commitment is not fixed, and people are most likely to contribute to a specific project, event, group, committee or development. At the recent AGM, the Trust recruited fifteen new individual community partners with a wide range of expertise from older age exercise experts, a community supporter of people with dementia and a expert in diversity and inclusion. Community partners from Healthwatch joined the Community Engagement Committee in September, and will join the Complaints Scrutiny Panel in November. Further plans are being developed to include community partners in the Quality Review programme.

3.1.6 Voluntary Services: a new "Safe and Supported" Programme

Our volunteers make a great contribution to the experience of people who use our services and whilst the community of volunteers is growing in number, they do not yet fully represent our local community.. The "Safe and Supported Programme" will provide an opportunity from the New Year, to people with a variety of health and communication needs to access volunteering placements. This will form part of ambition to undertake a whole system review of volunteering, currently agreed with UHSFT.

4. Diversity and Inclusion

We are committed to an inclusive culture across the organisation to ensure that all members of our staff, patients, carers, volunteers and visitors feel valued when they connect with our services. The Diversity and Inclusion programme has four aims:

- We want to make it easy for our diverse communities to access our services.
- We want to recruit and retain the right staff from diverse communities.
- We want all our staff and those who use our services to be valued and respected as individuals.
- We want to offer and provide learning and development to our diverse workforce.

This section reports progress related to service user and community engagement, with workforce related issues being reported to the People and Organisation Development Committee.

4.1 The Solent Diversity and Inclusion (D&I) Maturity Model and Strategy

The Solent D&I Maturity Model has been published which describes how our emerging approach will support the development of our business. The draft Diversity and Inclusion Vision and Strategy 2019 – 24 outlines our commitment to further developing our organisation as accessible and inclusive, both for people who use our services and people who work in our services. It summarises the leadership framework in

place to support the delivery of this agenda, the governance arrangements for providing assurance to the Board and how we shall close the gap between our workforce and the population groups we serve.

4.2 Engagement activity

The Chair of Solent NHS Trust and the D&I Strategic Lead participated in Unity 101 local South Asian radio talk. The discussion promoted Solent services, our diverse workforce and how to engage with us directly. The show was well received through audio and streamed through social media, it can also be downloaded.

Members of our workforce attended the Southampton Mela, an established annual South Asian festival led by Art Asia. The event promoted Solent's various services locally and shared information on career opportunities.

Members of the LGBT+ resource group and LGBT+ allies attended Southampton and Portsmouth Pride events in June and September 2019 respectively. These events were supported by senior leaders and middle managers at Solent NHS including Sexual Health awareness stand run by our teams.

5. Solent Academy - Research and Improvement

The Solent Academy leads and facilitates improvement through research, innovation, learning and evidence based care across our communities in the Solent NHS Trust region.

5.1 Workforce & Leadership Development

As part of the community engagement strategy, the training offer for involving patients in improvement has been enhanced. The range of training and development activities that have taken place include the Quality Improvement (QI) training module. The module, designed for and by patients/ family members is nearing completion. This will be co-delivered with patients who have been part of the QI training programme, and will give an overview of how the organisation and the NHS works, a basic introduction to QI and some tips and techniques on getting your voice heard.

5.2 Involvement of community groups in service delivery, evaluation and development

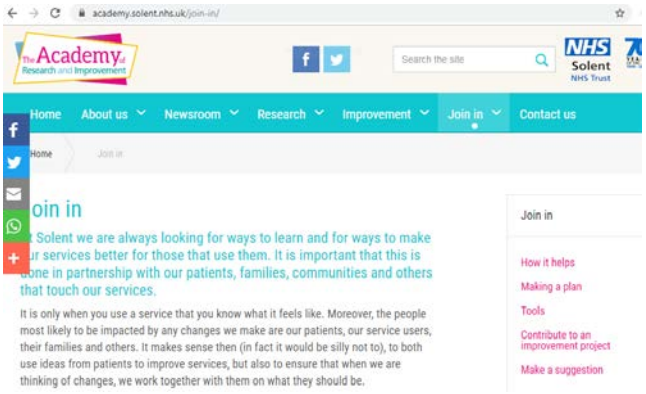
There has been a marked increase in the number of projects across the organisation in which improvements are planned and delivered in partnership with those that use our services. A mapping exercise is currently underway to capture the scope of this work. Infrastructure is being put into place to support this involvement.

5.3 Involvement in clinical effectiveness

The planning and approval for clinical effectiveness activity (audit, evaluation, outcomes) expects patient involvement to be evidenced. There have already been 8 evaluations that have involved patients in 2019/20.

5.4 The Join-in' toolkit

The tool kit has been launched on the www.academy.solent.nhs.uk website to support people to get involved. This gives a variety of tools, options for involvement and some case studies and videos of how other projects have benefitted from partnership working



5.5 Patient- partners reimbursement

The input from our patient partners is invaluable and it is important to ensure than no-one is "out of pocket" whilst supporting us in our research and improvement activity. A process for reimbursing or paying patient partners for their expenses or involvement has been successfully launched. This will be rolled out across the Trust.

5.6 Integrated Engagement and Improvement Post

A post to further support the integrated approach has been appointment been created and recruited to between Research and Improvement and Engagement and Experience. The focus of the role is to support service lines to further develop their practical approaches to actively involving services users.

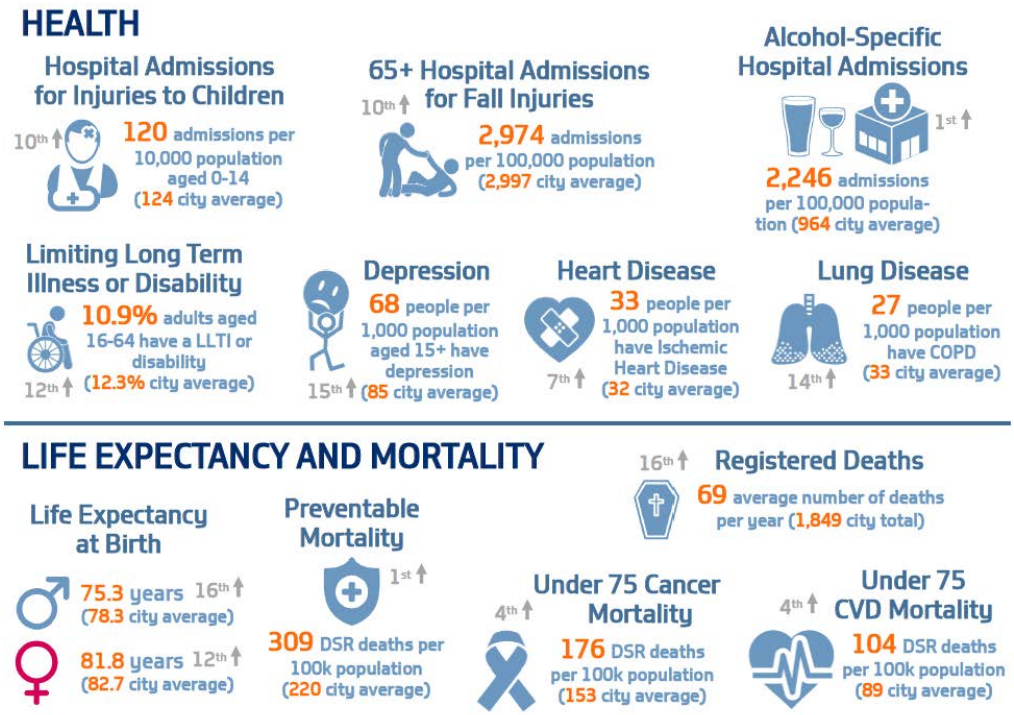
6. Pilot Projects

Local health outcome data indicated a need to improve access, experience and outcomes for four key population groups .

1. Nicholstown Surgery
2. Portsmouth Adult Mental Health Services
3. Socially Isolated in Portsmouth
4. Veterans and the wider Armed Forces Community

6.1 The Nicholstown Surgery Pilot

The Nicholstown Surgery, which is situated in the Royal South Hants Hospital, Southampton serves a particularly deprived area with a high Black, Asian and Minority Ethnic (BAME) population. The majority of patients at the surgery are Asian or Asian British (38.8%) followed by White Other (29.2%). Whilst the ward has a similar health profile to the City average, it has less favourable indicators for alcohol specific admissions to hospital and drug related mental health problems and higher than average all age mortality figures for preventable deaths.



The Nicholstown surgery pilot will provide a test bed for embedding a robust approach to community engagement within specific service lines. The pilot commenced in September and will use a Community-Interactors model, to build capacity in local community groups and communities and develop a new approach to collaboration and co-design and production between the service and local community groups based on the methods for community engagement developed by Lord Kamlesh Patel. Following a detailed review and assessment of the local data systems for patient activity and outcomes amongst diverse service user and community groups, local community members from target groups and communities will be recruited as Community-Interactors to take part in a focused engagement programme.

6.2 Portsmouth Adult Mental Health

Local health outcome data reflects the national picture with some groups known to experience greater mental health problems than others, for example:

- Some Black, Asian and Minority Ethnic (BAME) communities have higher rates of detention under the Mental Health Act in particular, young Black men of mixed race heritage. Bangladeshi women and the Gypsy, Romany and Traveller communities are reported to be at higher risk of suicide than other groups.
- Lesbian, Gay, Bisexual and Transgender (LGBT) individuals experience higher rates of mental health problems, including depression, anxiety, self-harm and suicide and substance use

problems. Transgender individuals are especially vulnerable to depression, self-harm and suicide.
- Suicide rates amongst young men are higher than for other groups and males are also known to be more reluctant to seek help for emotional and mental health problems.

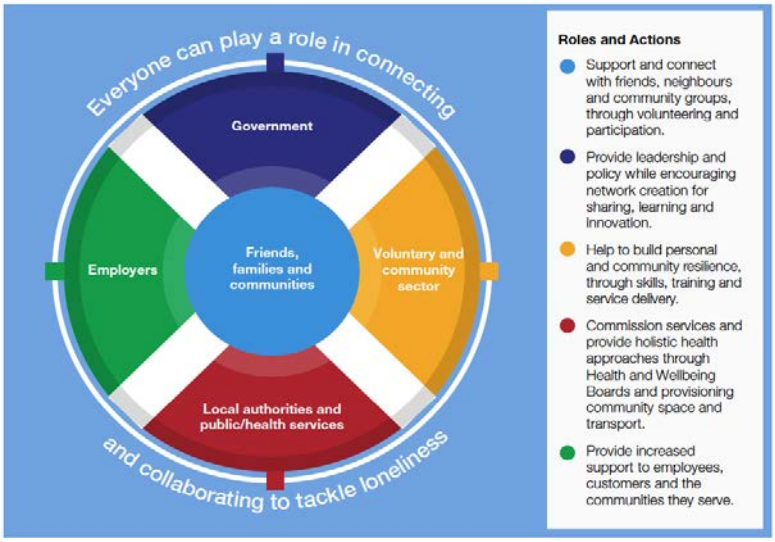
This project aims to:

- To reduce stigma associated with mental health problems to positively impacts on help seeking behaviours.
- To increase awareness about sources of support and what kinds of services are available.
- To reduce fears about perceived and actual discrimination from mental health services.
- To increase effective engagement with community and voluntary sector organisations that work specifically with different community groups.

The project commences in December 2019

6.3 Social Isolation Project

It is recognised that weak social connections can be as harmful as smoking 15 cigarettes a day (Holt-Lunstad et al., 2010). The Marmot Review into health inequalities found that "individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely." (Marmot, 2010). The Trust is working with Breaking Barriers Innovations (BBI) and Health Education England (HEE) as part of national series of pilot projects on place and the social determinants of health across England. The pilots seek to provide a facilitated and comprehensive approach to place based commissioning and service provision that can address the social determinants of health and wellbeing as part of place based strategic planning and action. The impact of social determinants on health is cumulative and it is often those facing multiple inequalities and hardship that experience the most injury to health and wellbeing. The programme is designed to work with one or all of these issues depending on the specific local context and needs. The Portsmouth North pilot is focused on social isolation and loneliness.



A Steering group for the pilot project has been established including representation from the Trust, Portsmouth CCG and Portsmouth Council (Adults Social Care, Children and Young People and Public Health). Three wards in north Portsmouth: Cosham, Drayton and Farlington and Paulsgrove have been identified and will have a focus on the workforce development needs for a family first approach that can better address social isolation and loneliness.

Data has been collected using interviews with 15 staff members with a further five planned. The interviews, alongside evidence from the national and local strategic context is being used to develop a detailed local action plan that will address the following:

- How a Family First approach and restorative practice can be used to improve social connectedness and family and friendship circles amongst individuals who are vulnerable as a result of social isolation and isolation
- Improving partnership with local community groups through an assets based approach to engagement that includes faith groups, community centres, social networks and schools
- Strengthening the local capacity for structural and functional support for addressing social isolation and loneliness including proactive development of natural social networks
- Enhancing community engagement as a mechanism for providing new avenues through which people can access social network supports and identify needs amongst vulnerable groups across the life course.

The first draft of the action plan will be presented to the Steering group at the end of October. This will be followed by a local stakeholder Round Table event and wider engagement with relevant organisation's and community partners. Learning from the pilot, alongside the other pilot programmes in Cornwall, Somerset and Kent will be used to inform the next iteration of the NHS People Plan, with a particular focus on the social determinants of health. Early in 2020 a national event will be held with HEE and MCLG to share findings and actions with a wide range of organisations from across England.

6.4 Veterans and family members and the wider Armed Forces Community

Our programme under our Force4Change Charter includes employment support as well as outreach work.

Our employment programme continues to develop and we have hosted a number of individuals as they transition out of the Forces.

Our Internal veterans network is 60 strong and meets every couple of months for breakfast and banter.

In Southampton we continue to support the Veterans Drop in Centre in Woolston.

In Portsmouth we are creating a Centre of Mental Health Excellence in Portsmouth City with an ambition to spread the model and learning across the region to support a new trauma service.
The Alliance includes a number of veterans groups and community sector partners.

Partner Organisations		
Solent Mind	Prince of Wales Royal Regiment	Naval Families Federation
Society of St James	Cygnet	
Veterans Outreach Support	Royal Navy and Marines Charity	
ExForcesNet	All Call Signs	

The Alliance has focussed on the delivery of 3 new services in Portsmouth to support veterans, their families and carers. These are funded by a grant of £697,000 from the Armed Forces Covenant Fund under their Tackling Serious Stress Programme.

Quick Reaction Force (QRF)

Veterans in crisis will be supported by the Quick Reaction Force (QRF), a group of volunteers working with first responders to place an arm around the veteran, and help to deescalate and facilitate access into Positive Minds. The development of the QRF was initially led by Princess of Wales Royal Regiment (the 'Tigers') and ExForcesNet and more recently other groups, such as All Call Signs and VOS have contributed to the ongoing development and refinement of the role as well as supporting recruitment through raising and maintaining awareness in the veteran community.

Positive Minds

Positive Minds will work with individuals to identify the cause of their distress and put together a bundle of support e.g. 1:1 peer support, community groups, life skills and coping classes, receiving psychological therapy or being supported into secondary care mental health. Positive Minds will include military veterans with lived experience as part of the team of wellbeing advisors who can "talk the same language".

Solent Recovery College

Veterans can access the veterans tailored curriculum of Solent Recovery College to help them sustain their recovery. The new curriculum modules were co-produced and piloted with the veteran's community and the new role of Veterans Coordinator within Solent Recovery College has been taken up by an experienced naval veterans.

Overall we are developing a deep engagement with our Armed Forces Community- attending many events and working on service design with those with lived experience.

7. **Community engagement – the Solent Ambition**

Two key events have been held to support our ambition to further develop our community engagement.

On 18 September 2019, Lord Kamlesh Patel visited the Trust and shared his vision of how effective community engagement enables the delivery of equitable services with improved access, experience and outcomes. The event enabled people from service line and corporate teams to explore with Lord Patel the challenges and opportunities of engagement and to establish how positive sustainable changes can be made using this approach.

In addition, a workshop was held with the Trust Management Team on 25 September 2019 to:

- Explore how teams feel about the concept of community engagement, the practical implications for service lines and opportunities.
- Examine how individuals experienced involvement and engagement when they or a close family member used NHS services
- Identify key areas of support required, which were:
    1. Help leaders identify specific areas which would benefit from more effective community engagement.
    2. Support the development and production of accessible documents, from Board papers to policies.

3. Challenge ourselves to move towards providing opportunities to every person who uses our service to provide feedback about their experience.
4. Increase engagement but avoid "the loud voices" and focus on the seldom heard groups.
5. Develop meaningful measurements to demonstrate progress
6. Provide opportunities for people to learn more about community engagement

A detailed plan will follow from the Community Engagement Committee by the end March 2020.

8. **Summary**

The Trust's strategies for community engagement, diversity and inclusion and subsequent establishment of the Community Engagement Committee and Delivery Plan has been important in raising the profile of this work across the Trust. The Committee will now be responsible for both the strategy on community engagement and the revised strategy for diversity and inclusion and will provide an effective governance structure that enables the Trust to strengthen and align various functions and systems in support of the important aims and objectives that these strategies set out. Mainstreaming this across the Trust is not something that can be done overnight, but the time is now right to scale up the level of work, increase the pace of delivery and increase the contribution and ownership of this agenda across the Trusts' senior leadership team.

Authors:

Sarah Balchin – Associate Director, Community Engagement and Experience
John Bashford – Framework Lead
Pamela Permalloo-Bass – Strategic Lead, Diversity and Inclusion
Sarah Williams – Associate Director, Research and Improvement

September 2019

Item 12.1

Presentation to	**Public Board**		
Title of Paper	**Emergency Planning, Resilience and Response**		
Author(s)	Elaine Peachey	**Executive Sponsor**	David Noyes
Date of Paper	7th October 2019	**Committees presented**	
Link to CQC Key Lines of Enquiry (KLoE)	☐ Safe ☐ Effective ☐ Caring ☐ Responsive ☒ Well Led		

Well Led KLoEs								
W1 Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	
W5 Risks and Performance		**W6** Information		**W7** Engagement		**W8** Learning, Improvt & innovation	

Action requested of the Board	☒ **To receive**		☐ **For decision**				
Link to BAF risk	BAF # ---------- Concerning ---------- or ☒ N/A						
Level of assurance *(tick one)*	Sigificant		Sufficient	X	Limited		None	

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

A formal review and assessment of Solent Trust was undertaken by the commissioning Emergency Planning Leads, who supported the assessment of evidence provided to NHS England that Solent NHS Trust was fully compliant with the standards. The CCG will present the evidence at the NHS England 'Confirm and Challenge' meeting where the final decision will be made and Solent NHS Trust notified in November 2019.

Solent NHS Trust has provided evidence in 54 of the 54 core standards and all 20 of the 'deep dive' standards.

The expectation is that full compliance will be notified to Solent NHS Trust at the end of November 2019.

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

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

Board Recommendation

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

Assurance Level
The Board is asked to consider whether this paper provides sufficient assurance.

Item 12.2

ANNUAL REPORT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

OCTOBER 2019

1. Introduction

As all NHS-funded organisations are expected to meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS Standard Contracts, and the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR), this report identifies work undertaken to ensure that the Trust is compliant with these statutory requirements. The report therefore outlines the current position of emergency preparedness, resilience and response through the key activities that have taken place during the last year 2018-2019.

2. Requirements and Principles of EPRR

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

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

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

3. Civil Contingencies Act

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

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

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

4. Assessment of Risk

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

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

Local potential business continuity risks are also included in the trust risk register and reviewed regularly and as part of the normal business continuity management process.

5. Emergency Preparedness Plans

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

- Incident Response plans
- Psychosocial care following a mass casualty event (as part of the system wide planning group LHRP)
- Mass Casualty (as part of the system wide planning group LHRP)
- Lockdown in partnership with the ASMS
- Evacuation planning
- Winter preparedness and contingency plans
- Adverse weather and travel disruption planning

6. Business Continuity Management

Business Continuity Plans are in place across the organisation. A full review and audit of BCPs was carried out in 2019 and all plans were tested as part of the review. A number of table top exercises have also taken place and will continue throughout 2019/20.
The Business Continuity Policy continues to be aligned to ISO 22301 (Societal Security – Business Continuity Management Systems – Requirements).

Solent NHS Trust continued to work in partnership with the acute Trusts and CCG's in the winter of 2018-2019 as part of the acute trusts surge management response. Although the winter of 2018/19 went well lessons were learnt and resulting actions were taken in readiness and preparation for the winter 2019/20. This will be particularly important as we are due to leave the European Union on 31/10/19 which could have a significant impact on services depending on the Brexit result.

7. Brexit preparations

Following the original preparations for a 'no deal' Brexit in spring 2019 the work for further assurance will commence again in August 2019 building upon the work already completed to assure NHS England that we are prepared for the sudden impact that a no deal Brexit impact on services and staff.

The national co-ordination will commence early October 2019 with daily reporting responsibilities for trusts from 1st October although this may be delayed slightly. The focus will be on more breadth across the system with procurement and the original planning preparations that have already taken place. NHS England will be holding various planning exercises prior to October 31 although details of these are not yet available. Solent NHS trust planning will continue through the Brexit working group that currently meets monthly although the frequency will change as required.

8. Put in Place Arrangements to Warn and Inform the Public.

Solent NHS Trust has continued to work in partnership with other health providers and commissioners to provide information to both staff and the public. Throughout the year, severe weather warnings, flood warnings and Brexit planning information have been placed on the staff web site when required, and an information leaflet on Brexit was available to download for staff.

Flood warnings and severe weather warnings are received by email and are then circulated widely to all managers, in order to allow us to pro- actively warn and inform and prepare our services.
In preparation for winter and potential adverse weather the 'emergency zone' on solnet will contain weather warnings, alerts and responses to winter capacity issues.

9. Co-operate with Other Providers

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

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

In 2019 Solent NHS Trust participated in the planning and response to the D-Day celebrations held in Portsmouth in June and attended by a number of high profile personnel and the public. They incident co-ordination room was opened and Solent prepared information to be shared with the wider community regarding any adverse impact upon services and the ability to respond if an incident occurred.

10. Training and Exercising

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

The plan for 2019-20 is included in the annual training plan:

EPRR Training and exercise programme 2

11. Core Standards

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

- Enable agencies across the country to share a common purpose and to co-ordinate EPRR

activities in proportion to the organisation's size and scope; and
- Provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

The Trust has now carried out a detailed self-assessment against the applicable 2019/20 Core Standards which has been supported by NHS England and the CCG, with the following results:

Overall assessment:	Fully compliant

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

Tota

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	5	0	0
Total	20	20	0	0

COMPLIANT STANDARDS

A comprehensive self-assessment of the 2019-2020 standards has been carried out and Solent NHS Trust considers that they have sufficient evidence to comply with all the standards and therefore have concluded that we should be considered as fully compliant. This assessment is also supported by the CCG Associate Director for Emergency Planning.

In 2019/20 Solent NHS Trust also submitted evidence that were seen as innovative of best practice to NHS England.

- Best practice - mass countermeasures for community/metal health trusts.
- Innovation - the standardised estates improvements booklets to ensure sustainability and environmental good practice applications for estates improvements.

The final confirm and challenge meeting with NHS England will take place in October 2019 and a final decision will be published in November 2019.

12. Work plan

- Continue to work on the Brexit preparation programme
- Continue with annual review and testing of Business Continuity plans.
- Work with Contracts team to help identify specific essential supplies and third party services and ensure that we are sufficiently assured that they have processed in place through their business continuity management plans to be resilient. It should be noted that this work is has progressed well however will continue into 2019/20.
- Continue to offer further training particularly in incident management skills and knowledge, including familiarity with the Incident Coordination Centre (ICC) related procedures and offer training to teams who do not normally participate in on call.
- Further develop the current training programme at all command and control levels.
- Work with IT to establish a more robust communication system and look at the use of new technologies in emergency planning and business continuity.

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

13. Summary

In summary the Trust has over the last year, demonstrated that it has the ability to respond to Major, Critical and Business Continuity Incidents. When an event occurs the incident would be formally reviewed at the 'debrief' to identify lessons and continue to improve and refine responses in the future. Solent NHS Trust has demonstrated assurance to NHS England and the CCG, through compliance with the EPRR Core Standards. The trust plans are reviewed annually and work will continue to take place to demonstrate full compliance for 2019/20 until final submission at the start of October 2019.

Item 13.1

Solent NHS Trust

Presentation to	x	In Public Board Meeting		Confidential Board Meeting								
Title of Paper	Brexit 'no deal' preparedness											
Author(s)	Elaine Peachey EPRR Lead			**Executive Sponsor**	David Noyes							
Date of Paper	September 2019			**Committees presented**								
Link to CQC Key Lines of Enquiry (KLoE)	x	Safe		Effective		Caring		x	Responsive	x	Well Led	
Well Led KLoEs	**W1** Leadership Capacity & Capability	X	**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities	X				
	W5 Risks and Performance	X	**W6** Information	X	**W7** Engagement	X	**W8** Learning, Improvt & innovation					
Justification for inclusion in the Confidential Meeting	As the possibility of a 'no deal' Brexit is not yet confirmed and the risk to the organisation at this stage is theoretical it would not be in the public interest.											
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	x	Sufficient		Limited		None					

The Trust has been planning and preparing against a dynamic and frequently changing range of scenarios regarding Brexit, including appointing an executive lead to oversee our preparedness. The Department of Health and Social Care have now issued an 'EU Exit Operational Readiness Guidance' which outlines key areas of concern and the actions we should be taking as a Trust, which replicate those that we had already been focussed on. This report is to update the board on the assessment of readiness, and builds on an initial report provided to the Audit and Risk Committee.

A Solent NHS Trust Brexit Working Group (BWG) was formed in October 2018 of key staff headed up by the executive lead. The BWG continues to monitor the situation and ensure compliance with the operational readiness guidance and any updates in the guidance. The overall assessment is that Solent is prepared and ready and is clear of what needs to be done if a 'No deal' situation occurs.

Business continuity plans in place at Solent NHS Trust have been reviewed along with a risk assessment of the plans using the current seven key areas. The Emergency planning lead is also attending a number of service meetings to increase awareness and has carried out a number of appropriate scenario exercises which will continue throughout 2019. The trust also participates in multi-agency exercises and national events related to Brexit.

Communications have been distributed to staff electronically and verbally with updates around the current position of Solent with regards to Brexit and a communications plan is in place.

It was identified in January that the risk from Brexit should be added to the Risk Register for the Trust to monitor and this risk remains on the register (1336).

Board Recommendation

The Board is asked to note and accept the assurance in the report that necessary actions are effective to prepare for the potential outcome.

Assurance Level

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

- Significant, assurance

Item 13.2

Solent NHS Trust

Brexit 'no deal' preparedness

Update September 2019

1.0 Summary

This paper provides an update of the actions and planning for a 'no deal' Brexit by Solent NHS Trust, drawing on the central planning guidance updated in August 2019. The Board will recall that they received a paper in January 2019 outlining Trust preparedness for EU exit when it was anticipated that the UK would leave the EU on 31 March and have also been kept appraised by the SRO for Brexit**.**

Introduction

Naturally, with the very fluid and dynamic political situation regarding Brexit, it is important that Solent NHS Trust remain fully aware of the possible implications of a "no-deal" Brexit. From the outset, it was envisaged within the Trust that exit under "no deal" was the scenario which was likely to generate more challenges and issues than leaving under a deal, and hence our planning has always anticipated this outcome. Throughout the planning process the Trust has been updating actions and re-assessing our level of risk exposure.

2.0 Key Actions to date

- Solent NHS Trust have had an Exec Director (David Noyes) leading on Brexit planning since the autumn 2018;
- There is a monthly working group looking at the issues outlines in the NHS guidance attended by key leaders across the Trust, and have developed contingency plans for a range of scenarios. The group has included representatives from HR, finance procurement and communication team. This group was placed in temporary abeyance following the decisions taken by central government in March 2019 to extend the deadline for leaving the EU, but re-convened in August 2019;
- The Brexit Working Group (BWG) continues to has a live action tracker to identify and resolve issues as they arise, and also an appropriately associated risk register;
- Brexit issues are identified and reported as a corporate risk to Trust Board;
- Trust Board is sighted on issues and developments via position paper provided to Audit and Risk Committee earlier in the year;
- NHS England and the Department of Health and Social Care have issued comprehensive regular stream of guidance, which the BWG regularly analyse and act upon as required;
- NHS England and Improvement will re-introduce daily sitrep reporting of the trust position and preparedness in October 2019;

Key areas of work considered:

- **Workforce analysis** – Solent employs more than 4000 people, however the risk to the organisation is surprisingly low. At the moment we have 142 staff listed as EU Nationals of which 47 have already applied for the EU Settlement Scheme. Solent NHS Trust has actively written to all EU nationals in the Trust providing information about applying for the EU Settlement Scheme since the launch of the Pilot Scheme in December 2018. Communication has also been sent to all new starters who have joined the Trust since April 2019 and we will continue this process each month as new staff join the Trust The staff yet to apply for the EU settlement scheme have until December 2020 therefore further contact will be made with staff in preparation for the cut-off date.
- **Contracts/Third party suppliers** – in Spring 2019 a risk assessment was carried out across all our third party suppliers and contracts, except for those large national suppliers that were on a central list which the Department of Health and Social assessed centrally. A further risk assessment has been carried out on any purchaser contracts that we have signed since we did the main risk assessment. Of these, we have assessed all as low risk (low value, non-clinical, UK-based e.g. childcare vouchers, training providers) and not requiring any further mitigating action. Regarding the suppliers that DHSC were risk assessing centrally, following an extended period of lobbying, we have received assurance that the Department has completed their assurance process. DHSC advise that these suppliers will continue to communicate regarding continuity of supply via national communications and guidance.
- **Supply chain -** We have conducted a review of non-pharmaceutical supplies (including medical devices) and taken action where required to assure continuity of supply. This risk has been assessed as low and we have been assured that we should not stockpile as there is now an express delivery route for single use items and a number of actions by central government to ensure continuity of supplies. More warehouse capacity has also been provided for key suppliers to use to mitigate any disruption to supply. Solent NHS Trust normally accepts delivery during normal working hours but have taken the decision to plan to accept 24/7 deliveries if required.
- **Pharmacy -** there is clear and explicit direction not to stockpile pharmaceuticals from NHSE, therefore Solent continue to comply with this directive. The previous review of non-pharmaceutical supplies (including medical devices) is still relevant and no further actions are required at this time to assure continuity of supply. There are two main factors affecting the risk of shortages in medicine supply: (1) road transport difficulties resulting from a no-deal brexit could delay medicines deliveries into Solent and also deliveries out to our customers who we hold contracts with. (2) Solutions to any national shortages of medicines

are likely to be actioned by the pharmaceutical industry any such actions could in-turn lead to an increase in costs of essential medicines and therefore pose financial risk concerning medicines supply rather than actual availability of medicines – we are not able to forecast or predict the magnitude of this at the present time but the impact is likely to be low. DoH National schemes are in effect to ensure equity of access to all medicines across the UK in the event of a no-deal Brexit and Solent are fully engaged and compliant with these UK national schemes. We now have a new chief Pharmacist who has reviewed the planning arrangements and is assured by the content of the plans. The Brexit SRO has also requested that the Chief Pharmacist to ensure that we have six weeks supply of all our key pharmacy products available.

- **Fuel** – there is a Hampshire and IOW fuel sharing agreement which is managed by the local resilience forum, and requires that South Central Ambulance service, who have fuel bunkerage, to sustain the supply of fuel to our emergency generators (which support our services in event of power outage and essential/priority fuel users) This is therefore considered to be a low risk. We have been advised that the risk to fuel is very low. In preparation for any potential issues Enterprise Pool cars are linked into transport policy and are part of the NHS framework. Work has commenced to identify the appropriate expenses data to evidence the business case needed for the potential number of vehicles needed. In the meantime estates are working on a 'blocked booking' solution for the estimated number of vehicles which will be hired on a monthly basis. Some of these cars will be hybrid cars that can run on electricity therefore increasing the sustainability of transport to priority users if fuel is in short supply.
- **Food** - The new catering solution for Solent premises is now in place. St Marys has had additional freezer space added enabling more stock of food and has the ability to hire more chiller units for St Marys if required. Solent is also working in partnership with Portsmouth City Council and Portsmouth Hospital Trust to identify and mutually beneficial actions that could be procured. The main food supplier to the trust has also assured their customers that they have extra storage capacity for food available and will hold off any price increases until they need to do so.
- **Business Continuity plans** –a full review of business continuity has continued both at Trust level and for each area of Service in the context of Brexit and exercises are continuing to be carried out in teams and services.
- **Command and Control** – processes are still emerging for how NHS England will seek to exercise control over the period, but we will of course participate as required, as well as with

the Local Resilience Forum. We have reviewed our On Call arrangements for end October Apr to ensure we have very senior and experienced people on call.

- **Medical/Professional registration** – there are central arrangements in place which give us sufficient assurance on the enduring nature of medical/professional registrants.
- **Data sharing/protection** – we continue to review our position and establish if there is any reliance on EU in this area. This is currently low risk as no issues have been identified and we have already conducted a full audit of our data sets.
- **Communications** – we are regularly communicating with staff regarding developments and have a communication plan in place specifically concerning Brexit and the potential impacts.
- **Research and clinical trials**. The Associate Director of Research and Clinical Effectiveness has assessed the trials that Solent are participating in and assessed there is no risk.

4.0 Overall self- assessment

The overall assessment is that Solent NHS Trust is doing everything necessary to be ready for whatever comes including an awareness of emergent risks and issues that arise during the period which may not have been anticipated particularly as this is now likely to be in the winter pressure period. At this stage we are confident that we will be able to continue to deliver all our services without disruption.

Internally services continue to participate in table top exercises specifically around business continuity plans and Brexit which will continue for the rest of the year. Externally Solent NHS Trust participates in all national and regional exercises and workshops run by NHSE and NHSI.

Currently the biggest risk identified is the Portsea island potential travel disruption and the table-top exercise for the Southeast will concentrate on this issue. In the meantime estates and facilities are looking at alternatives such as using 'cargo bikes' for the final part of a supplies journey similar to the solution already used by Portsmouth city council.

Based on NHS England guidance our preparedness is deemed to be high as in the table below.

Preparedness	Preparedness	Guide

	High	We have made **significant progress** with our planning to mitigate/manage disruption in this sector (e.g. developed local risk assessment; reviewed plans and capabilities; undertaken training and exercising), we are **very confident** in our level of preparedness, and we are **nearing completion** of preparedness activity

Item 14

Presentation to	**Public Board**							
Title of Paper	**Information Governance Briefing Paper**							
Author(s)	Sadie Bell, Data Protection Officer		**Executive Sponsor**		David Noyes - SIRO			
Date of Paper	19th September 2019		**Committees presented**		N/A			
Link to CQC Key Lines of Enquiry (KLoE)	[ ] Safe	[ ] Effective	[ ] Caring	[ ] Responsive	[x] Well Led			
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy	x	**W3** Culture		**W4** Roles & Responsibilities	x
	W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement		**W8** Learning, Improvt & innovation	
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	

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

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

Board Recommendation

Compliance with regards to Data Protection and Freedom of Information Requests has reduced, since the last reporting period. This has been identified to be a result of the Trust's escalation process and compliance & monitoring process not being implemented during a period of significant staff disruption within the IG team, which resulted in a temporary lack of senior expertise oversight. Work is being undertaken to reinstate this and increase compliance.

The number of IG incidents has increased over the last two quarters. The same themes / types of incidents are still being reported and therefore further actions, assessments and reviews have been identified to address these issues.

Assurance Level

Sufficient level of assurance: The new Data Security and Protection Toolkit has been released nationally and the Trust's Head of Information Governance is focusing on assessing the Trust's compliance head of the October baseline assessment and this will be audited by the internal auditors in November 2019.

1.	**Purpose**	**3**
2.	**Data Protection and Security Toolkit 2019/20**	**3**
3.	**Summary of Information Governance's Legal Requirements Compliance**	**4**
4.	**Information Governance Incidents / Security**	**5**
5.	**Summary**	**7**

1. Purpose

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

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

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

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

- Data Protection and Security Toolkit
- Compliance with legal requests for information
- Information Governance Incidents

2. Data Protection and Security Toolkit 2019/20

Data Security and Protection Toolkit (DSPT) is an online self-assessment tool, mandated by NHS Digital, which enables Health and Social Care organisations to measure their performance against Data Security and Information Governance legislation. The DSPT was developed following the National Data Guardian's (NDG) review which was instated in July 2016.

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

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

In March 2019 the Trust submitted its annual response to this toolkit and identified itself as fully compliant.

The new Toolkit was released in July 2019, however during July and August the Trust's Data Protection Officer was on a period of extended absence and leave, so it was not possible for work on this start. The Trust's Data Protection Officer is now in a position to undertake this assessment, prior to the Trust's Baseline Assessment at the end of October 2019; this will also be internally audited in November. Compliance will be shared with the Trust's Senior Information Risk Owner, prior to submission and the Board will be updated in the next IG Compliance Report.

3. Summary of Information Governance's Legal Requirements Compliance

Subject Access Requests: General Data Protection Regulations 2016 requires requests for records to be processed within one calendar month (Approx. 30 days). Below is a breakdown of compliance. Please note that the Information Commissioner's Office require the Trust to be 95% compliant with this requirement.

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

	2018/19	**Q1* 2019/20**	**Q2* 2019/20 (July/Aug)**
Number of requests received	1115	308	232
Number of requests responded to within 21 days (best practice)	842 (75.5%)	231 (78.3%)	149 (77.2%)
Number of requests responded to within GDPR (30 days) Or DPA (40 days), for all requests prior to GDPR	157 (14.1%)	36 (12.2%)	29 (15%)
Total legal compliance	**999 (89.6%)**	**267 (90.5%)**	**178 (92.2%)**
Number of breaches	116 (10.4%)	28 (9.5%)	15 (7.7%)
Not Due	-	13	39

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

Freedom of Information Requests:

Freedom of Information Act 2000 requires requests for information to be processed within 20 working days. Below is a breakdown of compliance. Please note that the Information Commissioner's Office require the Trust to be 95% compliant with this requirement.

Quarters	**April**	**May**	**June**	**July**	**August**
No. Requests	27	33	27	28	30
No. Breaches	5	2	3	9	20
No. Not Due	-	-	-	-	5
% Compliance	84.5%	93.9%	88.9%	67.9%	80%

Summary and Actions:

- Subject Access Request compliance dropped to 88% compliant in June and July (requests would have been due for release in July and August)
- Freedom of Information Request compliance dropped in June, July and August (requests would have been due for release in June, July, August and September)
- Upon review of the breaches it has been identified that the escalation process in place to prevent breaches was not followed, nor was compliance monitored during this time period, as per policy, allowing the Trust to be alerted to such low compliance, noting that due to the absence of senior staff we were operating with reduced capability at this time.
- The Head of Information Governance and Security is working with the Senior Records Officer to reinstate compliance monitoring and escalation processes.

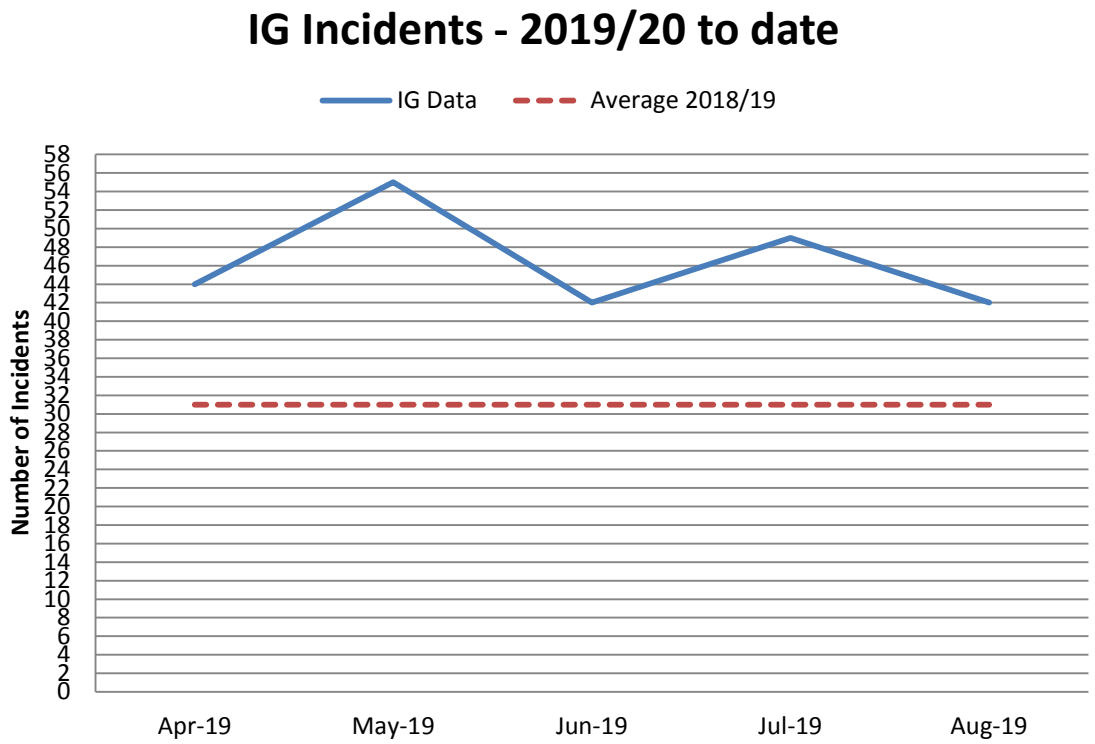
4. Information Governance Incidents / Security

4.1 *IG Incidents, Q2, 2019/20 (up to the 12/09/2019)*

IG Incidents – Main Issues		
	Q1	Q2 As of 12/09/19
Lost Notes/PID	6	4
PID sent to wrong address / person	36	26
PID in wrong record	39	36
Records Error	10	4
PID Saved / Stored Insecurely	9	20
Insecure Email Route	13	2
Post Issues (way in sent / received)	2	0
PID found in public place	3	4
Breach by staff - Deliberate	3	0
Breach by staff - Unintentional	8	6
Printing Issues (left on printer / wrong printer)	3	2
Other	9	1
Sub Total	**141**	**105**

* Please note that data is subject to further data validation and may change in the next reporting period. A piece of work is being undertaking jointly between the Information Governance and Quality Services to ensure accurate reporting.

Total Service - IG Incidents									
	AMH	Adults, Ports	Adults, Soton	Childrens, Portsmouth	Childrens, Southampton	Dental	Primary Care	Sexual Health	Corporate
Q1	10	14	22	19	8	13	32	18	5
Q2	10	14	10	13	13	3	12	16	14
Total	**20**	**28**	**32**	**32**	**21**	**16**	**44**	**34**	**19**



There has been a significant increase in the number of IG incidents reported, compared to the previous financial year, although the number of incidents being reported do seem to be reducing month on month, however this is still about the average number of incidents.

From reviewing the data reported, a few themes emerged;

- Primary Care reported a significant increase in the number of IG incidents, but upon further review it was found that a service within the service line was undertaking a validation review on their patient records and reported a large number of PID in wrong record. The service identified that further training was needed for staff, on the use of the electronic patient system and this training was undertaken.
- A higher number than usual incidents around Insecure Email Route was reported. This was partly due to the Local Authorities changing their secure email system. However there is a risk with Solent NHS Trust still using two email systems, one for sending emails securely for internal purposes (@solent to @solent) and one for sending emails for securely external purposes (PID only @nhs.net to @nhs.net), as the remaining incidents related to the using Solent emails (only secure internally) to send PID externally, instead of using @nhs.net (Secure external email). Solent NHS Trust is currently in the process of assessing its ICT provisions and part of this is identified a joint secure and encrypted email system, for both internal and external use; this will remove this risk altogether.
- An issue on SolNet was identified towards the end of Q1 and in to Q2, whereby templates for staff to use on the HR SolNet page were being saved over, accidently, with PID; rather than the user saving this on their own H.Drive. This led to a large increase in the number of incidents reported as PID Save/ Stored Insecurely. However it is important to note that there was also an increase of incidents reported under this category in reference to PID being left in offices; although the offices are secure they will be accessed by other staff such as security, cleaners and others in the building, making this a breach of PID and area that needs to be addressed.

The Trust has a very open reporting culture; however the Trust's top three reporting areas continue to remain the same;

- The highest reported type of incident is "PID in Wrong Record", this type of incident needs to be addressed by the Trust, but also needs to be looked at in context, compared to the activity levels within the Trust e.g. number of record entries, compared to the number of incidents. Additionally the error is contained within the Health & Social Care setting, with records being amended as soon as the error is reported (removing the risk of a breach); therefore the risk to the patients data and the Trust is low.
  - The Trust will undertake a wider review of this type of incident and review the following;
    - ✓ Number of entries that have been "marked in error" over the last 12 months, on SystmOne (similar assessments are to also be undertaken on Inform and R4) – the likelihood is that there are more incidents than that reported
    - ✓ Number of entries made within medical records during the same period, to identify the percentage of this issue
    - ✓ If there are any particular services areas, who identified entries as "PID in Wrong Record".
    - ✓ To work with the Information Systems Team and Governance Leads to assess the reasoning around why this type of incident are occurring and if there are any training needs that need to be address, or any cultural / environmental reasons for this occurring

- The second highest reporting category is PID sent to wrong address / person. This remains a highly reported category and is of a concern; however as per above this needs to be looked at in comparison with the number of letters sent each year, compared to the number of incidents (the occurrences are low). Actions taken within the Trust have also significantly reduced the impact of these incidents, e.g. removing patient's addresses from reports, using window envelopes to clearly see the address, only using minimal PID within documents, to reduce the likelihood of identification of an individual to a third party, should the letter be received incorrectly by a third party. This is reflected in the number of incidents reported as High Risk or Serious Incidents, within this reporting category only four have been identified as high or above breach.
  - The Trust will undertake a review of these type of incidents and assess if the end result of the incident was the disclosure of PID, or if it the measures put in place actually prevent the breach. If this was the case then the incident needs to be re-categorised as "No IG Breach".
  - We will also assess why such a high number of incidents are reported, and look at the nature of such incidents, reported this year to date and identify if there are any new themes and / or existing themes that still need to be addressed.

- The third highest reporting category is PID Saved / Stored Insecurely.
  - As stated above the majority of these incidents related to an issue on SolNet, where staff were able to save over a template. This issue is being addressed and lessons learnt from this will be cascaded throughout the Trust.
  - The other type of incident here relates to PID being left in secure offices, but can be accessed by staff, who should not see the PID. Regular spot-checks are to be undertaken and service leads will also be requested to undertake such assessments, so that we can ensure that PID is secure at all times and only accessible by those who have a need to see it.

- In addition to the above, the Information Governance Team are to undertake a retrospective review of all IG incidents to assess the following
  - Was the incident pure human error
  - Was the incident a result of failure to follow processes and / or safeguards
  - Was the incident a result of not being aware of processes and / or safeguards
  - Was the incident a result of lack of training
  - Was the incident a deliberate act

  The above will allow the Trust to identify the root cause of these incident and identify learning outcomes and training / awareness needs.

5. Summary

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

There have been some areas of reduced compliance, which is now being focused upon and the Trust's Head of Information Governance, after a period of absence is now focusing on Data Security and Protection Toolkit and reinstating are high level of compliance with GDPR requirements and FOI compliance.

A number of actions have been identified to reduce the number of IG incidents.

Solent NHS Trust

Item 15.1

Exception and recommendation report

Committee /Subgroup name	Assurance committee	Date of meeting	19th September 2019
Chair	Mick Tutt	Report to	Trust Board

Key issues to be escalated

We received an up-date on progress with regard to **statutory & regulatory compliance** particularly with regard to CQC expectation. The Head of Quality & Professions for Mental Health Services provided detailed assurance regarding the actions taken as a consequence of the one 'must do' action from the autumn 2018 inspection.

We noted that one service Child & Adolescent Mental Health (C&AMHs) continued to carry a 'requires improvement' rating from the autumn 2018 inspection, and asked for detailed up-date at the next meeting, of current potential for rating and the associated risk.
We agreed that future reports on this item would embrace wider statutory and regulatory compliance

We received the following **reports**:-

- the Learning from Deaths (LfD) quarterly report and focussed on the shared learning across service lines, and plans for further iteration for the next year
  - *The information from the LfD work, mandated nationally as a requirement for Boards to receive, is appended to this report*
- **Complaints Annual Report** – which indicated that there was a reduction in the numbers of formal complaints received and actioned; matched by a corresponding increase in local resolution activity. We were assured that learning was sought from the latter cohort, as well as the former. *Also appended to this report.*
- The **Community Engagement and Experience Report** of people who access services provided by the Trust and sometimes their carers quarterly report – and commented on the potential for enhancement of the assurances provided for future reports
- **Infection, Prevention & Control Quarterly Report** during which we were informed of the retirement of the IPC Lead.
- **Risk Analysis Quarterly Report** essentially focussed on safety
- **Safeguarding Quarterly Report**

these 5 reports are available, if required, for further scrutiny

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

- The current review of the model and delivery for our Speech & Language Therapy service was noted.
- Further review of security arrangements at RSH was noted.

Decisions made at the meeting
We endorsed the **current relevant BAF entries** and also received and endorsed the **Operational Risk Pyramid**, with relevant mitigations noted. We discussed the potential for **SPC** data to offer additional assurance but were unable to progress the debate, because timing had prevented many members from receiving the necessary information.
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

REPORT

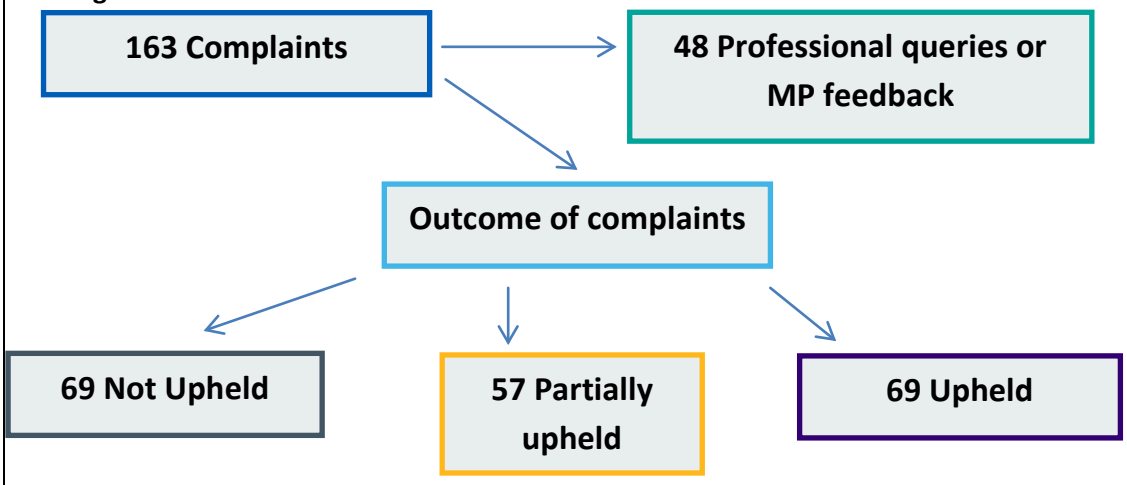
Report presented to:	QIR		
Title of Paper:	Annual Complaints Report 2018/19	**Author(s):**	Ellie Lindop and Emma Bundy
Executive Lead:	Jackie Ardley	**Date of Paper:**	02/09/2019
Committees presented:	N/A		
Link to 8 Key Lines of Enquiry (KLoE)			

W1 Leadership Capacity & Capability		**W2** Vision & Strategy	x	**W3** Culture		**W4** Roles & Responsibilities	x
W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement	x	**W8** Learning, Improvt & innovation	x

Executive Summary

The purpose of this report is to provide an annual overview of the complaints, service concerns and plaudits received during 2018-19. In addition, learning and improvement identified to improve future practice and to highlight plans for 2019/20. The Trust has an open and transparent approach to complaints management and provides a non- judgemental approach to support complainants in addition to supporting staff to review and make improvements to promote improved future outcomes.

Findings



Please note the outcome of 16 complaints, 3 are ongoing at time of report and 13 were de-escalated or withdrawn.

- Compared to national data, Solent NHS Trust have a high number of complaints per patient contact (in real terms this is still less than 1%). On further review there are several contributory factors including the type of services provided, inclusion of professional feedback and current categorisation of themes results in duplication.

- The complaint themes reported continue to be consistent with national reporting.

Future plans

In the following year the Trust will seek to further improve and develop upon the existing complaints process. Work will continue to ensure that patients, families and or carers who complain about our services and staff are supported. Improvements to develop and co-design the Trust policy and process with patient partners will be completed, to ensure that services provided are truly reflective of the community served.

Continued development of the Ulysses database will ensure that the Trust have a robust and auditable

approach to complaints management, this will also improve the reporting that is required to provide assurance internally and externally. There will also be an increased focus on how to manage learning to ensure that learning and improvements implemented as a result of complaints are shared and disseminated across the Trust to support Trust wide learning and improvement.

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

Nil Noted

Key Decisions/ Action(s) requested

To receive the following assurances :

- Reporting themes are consistent with nationally reported themes and work continues to identify improvements required to improve patient, family and carer experience of the services that Solent offer and provide.

- The Trust will continue to monitor reporting numbers and consideration of benchmarking data. The importance of ensuring accurate reporting and standardising inclusion criteria's, definitions of upheld etc. will continue to inform the process. The Trust will continue to maintain an open and honest approach to complaints and ensure that the process to complete these is accessible and clear to understand.

- The Complaints team continue to develop the service provided and to identify and implement improvements that will enhance the Trust process for the complainant and the services. It is recognised that the Trust continues to develop and improve the complaints process and will work closely with the AD for Community Engagement and Patient Experience. Patient, family and carer engagement is valued in this continued development work and improvement on the complaints policy and process.

ANNUAL COMPLAINTS REPORT 2018/2019 INCLUDING SERVICE CONCERNS AND COMPLIMENTS

The report covers the period 01/04/2018 – 31/03/2019

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Executive Summary

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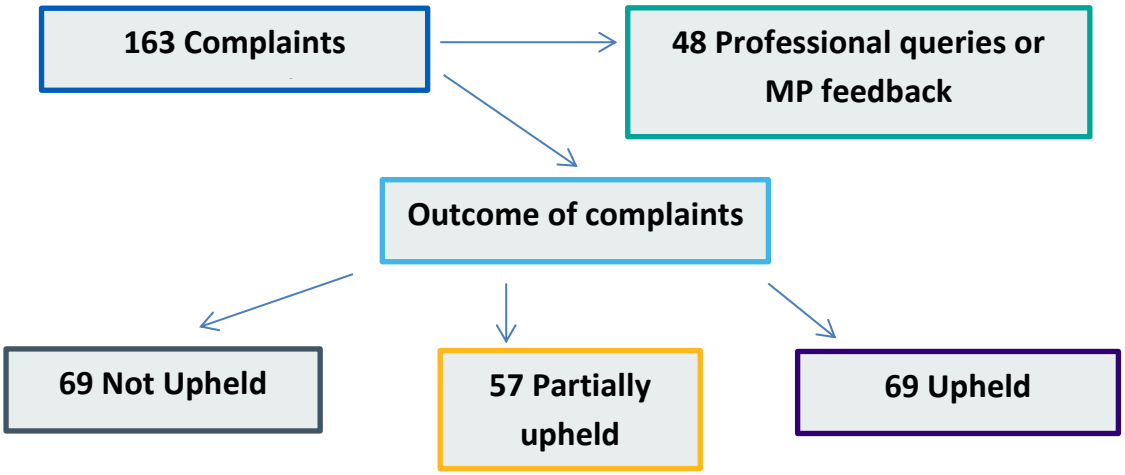

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Continued development of the Ulysses database will ensure that the Trust have a robust and auditable approach to complaints management, this will also improve the reporting that is required to provide assurance internally and externally. There will also be an increased focus on how to manage learning to ensure that learning and improvements implemented as a result of complaints are shared and disseminated across the Trust to support Trust wide learning and improvement.

1. Introduction

The following report provides a summary of complaints, service concerns and compliments as per the National Health Service Complaints (England) Regulations 2009. This report will be made public on the Trust website and sent to commissioners of the Trust services.

The data used to produce this report was extracted from the Trust's database (Ulysses) on the 2nd July 2019.

1.1 The Trust values the experience and feedback received from patients. When despite best efforts the patient/ family or carer have reason to be dissatisfied with the care received, it is important to support the complainant through the complaints process and ensure that they feel well supported in a non-judgemental manner.

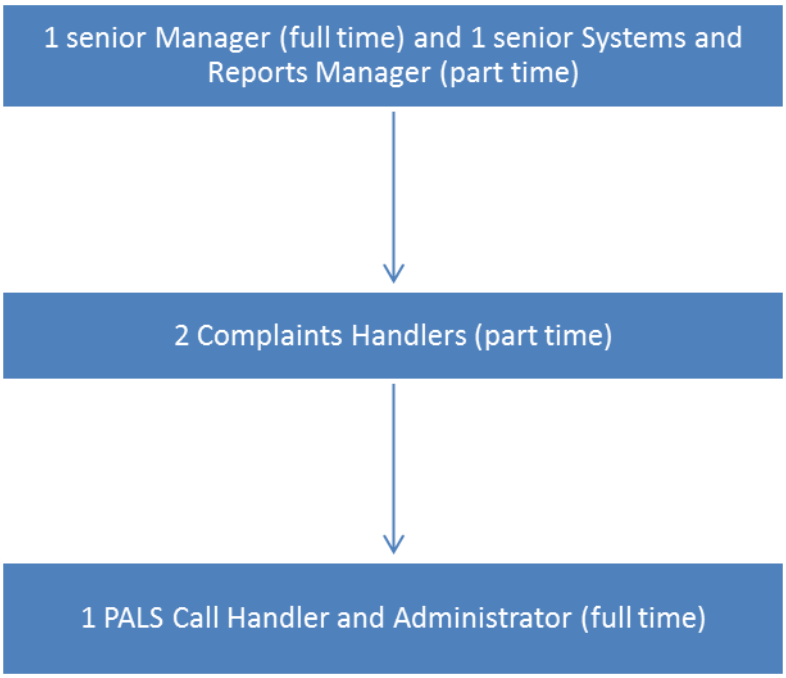
1.2 Terms referred to throughout this report are as follows:

Complaint: An expression of dissatisfaction made to the Trust about the standard of service, action, or lack of action, by the Trust or its staff.

Service Concern: An expression of dissatisfaction made to the Trust as above that can be resolved, with the agreement of the complainant, by the service or team directly, either verbally or in writing.

Compliment: An unsolicited expression of praise or thanks received in relation to the service, care, or treatment provided (also referred to as a plaudit).

1.3 In Solent, the complaints team currently consists of:



The PALS Call Handler and Administrator role is a fixed term pilot until the end of March 2020 as a result of increased demand on the team relating to signposting and liaison (the opportunity to do this is as a result of the Complaints Manager undertaking a secondment). The role of the Complaints team is to support the complainant in a non-judgemental manner and assist in navigating the Trust process. In addition to this, they are responsible for ensuring that the 3 day acknowledgment of a complaint is achieved, support the services to ensure that the Trust provide quality responses which answer the complaints raised and subsequently submitted to deadline. The team also use Ulysses for information management and are able to access this for auditable purposes as required.

1.4 The agreed complaints process detailed in the Trust complaints policy is as follows:

- Complaint received by telephone, email or other
- The Complaints team have 3 working days to acknowledge the complaint (NHS regulations)
- A complaints handler makes contact with the complainant and records the complaint on Ulysses (The Trust quality database).
- The complaints team notify the service and request an investigation

- The services investigate the complaint within an agreed time frame (until April 2019 this was set at 30 working days but is now agreed with the complainant).
- A meeting is offered on conclusion of the investigation (a pilot has been run in Adults Portsmouth and it is now in policy that a complainant should be offered to meet initially to discuss the complaint in more detail should they wish to do so).
- A final letter is sent to the complainant on conclusion of the investigation and signed by the Chief Executive or Deputy Chief Executive. Detailed in this letter any learning for the service or Trust will be included.
- Complaints are reviewed monthly in a quality review meeting with the Head of Quality and Professions (previously referred to as the Professional lead).
- A selection of complaints and process are scrutinised at the quarterly complaints panel chaired by a Non-Executive Director.
- Quarterly reports are prepared to detail and review the complaints received.

The service concerns process is less formal and therefore there is no requirement to receive sign off from the Chief Executive or Deputy Chief Executive. These are either reported to the complaints team or the services submit directly onto Ulysses.

The submission of compliments is service led and these are submitted directly onto Ulysses.

2. Overview of complaints

During the reporting period 1st April 2018 to 31 March 2019 a total of 211 complaints were received across the Trust. Of these 163 were formal complaints, 38 were professional feedback (a concern raised by a clinical professional about a Solent service) and 10 were MP queries. See table below.

Table 1

	Q1	**Q2**	**Q3**	**Q4**	**Totals**
New Complaints	49	35	38	41	**163**
MP Queries	3	4	2	1	**10**
Professional Feedback	10	9	14	5	**38**
Total	62	48	54	47	**211**
Acknowledged within 3 working days	59 (95%)	48 (100%)	51 (94%)	46 (98%)	**204 (97%)**
% of cases closed within agreed Timeframes	61%	77%	72%	68%	**Average across year 69.5%**
Cases referred to PHSO	2	3	1	2	**8**

The top 3 reported themes in the Trust are consistent with nationally reported themes See table 2):

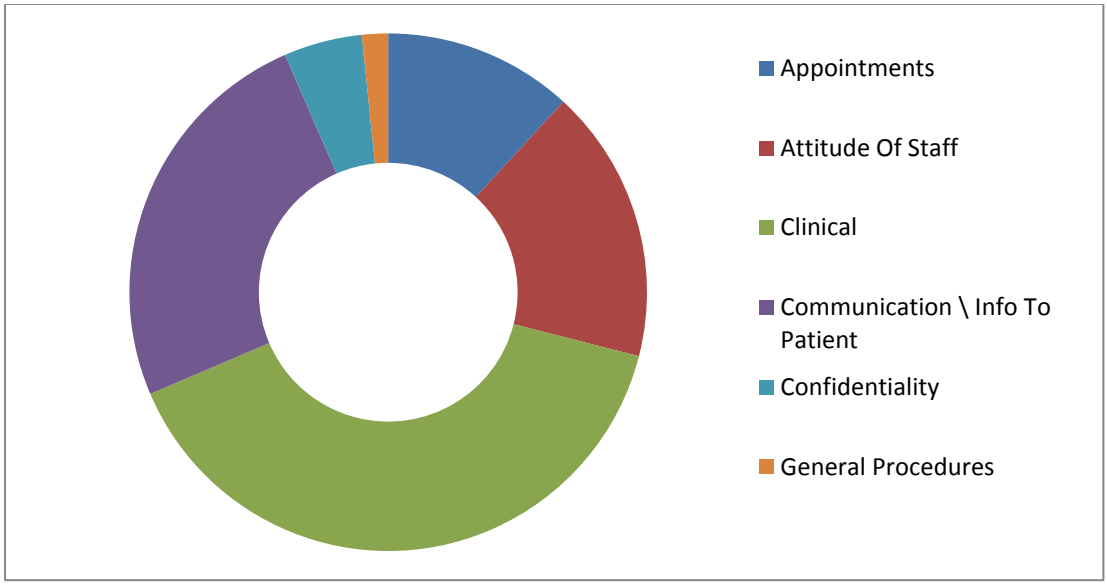
- Clinical concerns
- Communication
- Attitude of Staff

Clinical complaints are the highest reported theme and include the following concerns:

- nursing care
- medical errors
- operation delays
- diagnosis queries

Clinical complaints are frequently linked to other categories for reporting predominantly communication and staff attitude indicating that consideration of customer care training for all staff would be of benefit.

Table 2



Benchmarking data from comparable Trusts (using the Model Hospital)

The figures in Table 3 demonstrate a comparison of the 2017/18 and 2018/19 data against the National Median calculated in 2017/18. The National Median is the mid-point of all the submitted data from National Trusts. Please note the 2018/19 national median data is not yet available at the time of producing this report.

In comparison to the national median and data from other trusts Solent was ranked as the following in 2017/18:

- The % of upheld formal and informal complaints was within the 3rd Quartile within the national data (75% of Trusts sit below, 25% above) in 2017/18.
- The number of formal and informal complaints received per £100 million turnover placed Solent within the top (highest) quartile.
- Number of written complaints per 1000 WTE (work time equivalent) staff places Solent as the highest in comparison to 8 other comparable trusts.

It is important to acknowledge the following points when considering the data:

- There is no agreed definition of what results in a complaint being upheld therefore different Trusts will grade resolved complaints differently.
- Solent complaint data in this report includes professional feedback (this has now been removed for future reporting); it is likely that other Trusts already exclude this from their data.
- Service Concerns contribute over 60% of the data and escalation of these to formal complaints is low. Therefore services are resolving concerns effectively, and patients feel comfortable raising concerns to members of staff.

In order to identify best practice, the team will be to liaising with other Trusts that are ranked closer to the nation median to establish how complaints are managed and logged and consider what improvements we can consider to improve our processes and learning.

The following table provides a comparison of Solent's data compared to National data (2018/19 data is not yet available nationally).

Table 4

	National Median 2017/18	Solent 2017/18 data	Solent 2018/19 Data
% of Upheld formal and informal complaints per year*	24%	48%	46%
Number of formal and informal complaints per £100 million turnover*	150	319	332
Number of written complaints per 1000 WTE staff**	12	56	69

*Note: Figures include both service concerns and formal complaints (including MP Queries and Professional Feedback)

**Note: Figures submitted by Trust to Model Hospital are based on number of categories received for formal written complaints therefore will include duplicates.

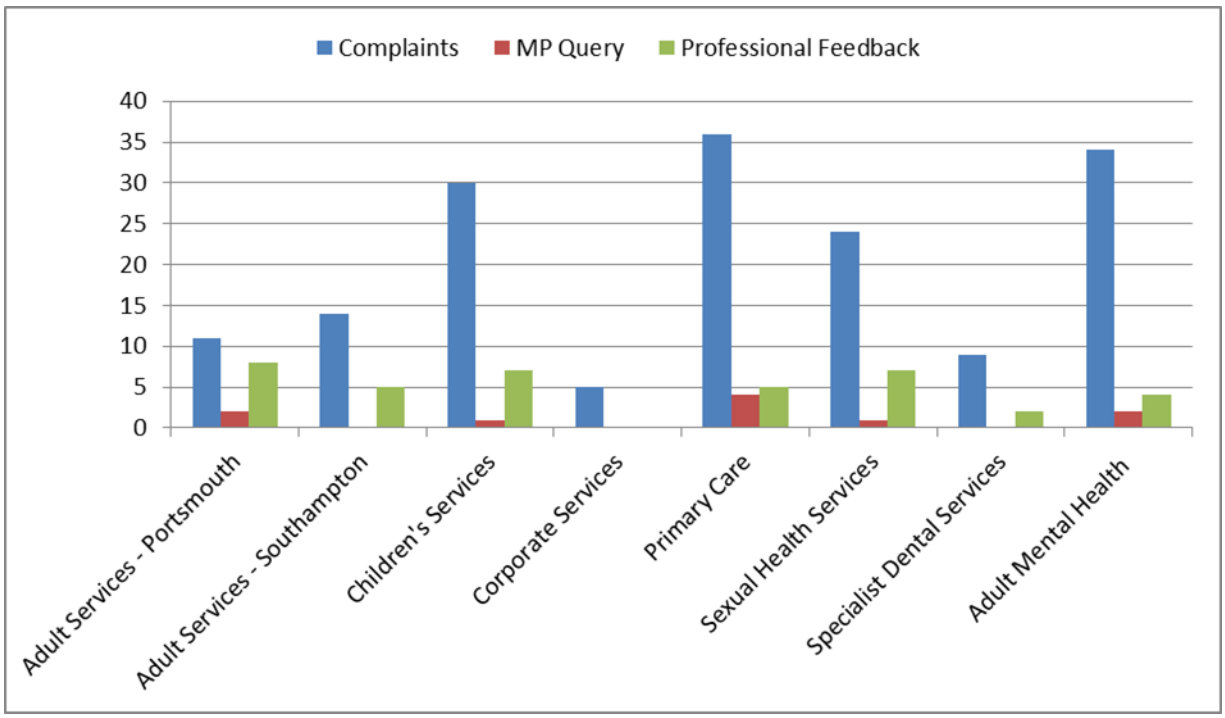
3. Review of complaints, service concerns and compliments by service line

Solent NHS Trust is organised into seven clinical Service Lines within two Care Groups in addition to the corporate teams who support the assurance processes for the Trust.

3.1 Complaints categories

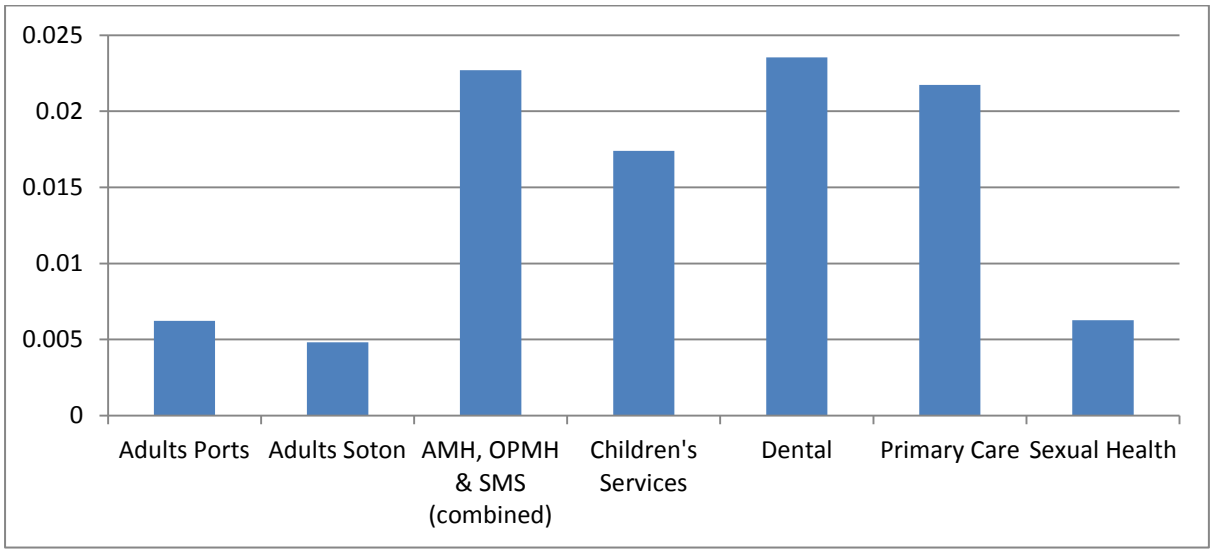
For 2018/19, 286 categories were logged for the 211 complaint cases received.

Table 5



The data in Table 6 highlights that AMH, Children's and Families, Special Care Dentistry and Primary Care received a higher number of complaints per number of contacts, this would not be unexpected considering the complexity and type of service offered across these specialities.

Table 6



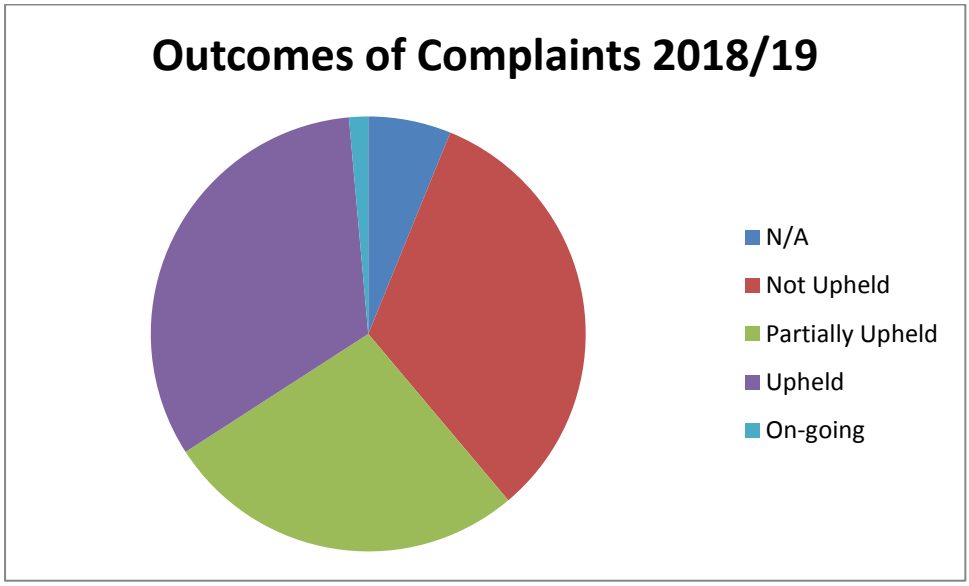
When a complaint is closed it is graded as to whether it has been upheld, partially upheld, or not upheld by the Trust. Definitions of these outcomes are as follows**:**

Upheld: The term used to identify where a failure in service delivery has been identified, and actions are required to rectify this problem

Partially Upheld: The term used when the above is confirmed in part

Not Upheld: The term used when there is no failure in service process or provision identified.

As summarised in Section 3, 69 complaints were noted as being upheld, 69 not upheld and a further 57 were partially upheld. The remaining 16 complaints were either on-going at the time the data was extracted or had been withdrawn (N/A)-see **Chart 7**



4. Learning and improvements as a result of complaints

The Trust values the feedback that complaints provide regarding patient and families/carers experience of the services provided which then enables services and teams to review what they provide and make improvements to improve future outcomes. Refer to Appendix 1 for a sample of improvements made as a direct result of complaints received.

5. Parliamentary and Health Service Ombudsman (PHSO)

The Parliamentary and Health Service Ombudsman is an independent and impartial service that makes final decisions on unresolved complaints regarding the NHS in England. It is free to use, and information is provided to all complainants within the final response letter. People contact the PHSO when they remain dissatisfied with the Trusts response to their complaint following exhaustion of the resolution process.

During the 2018/19 reporting period, the PHSO either investigated or commenced investigations into 8 complaints, an increase from last financial year when 5 were investigated.

5 of these cases were closed following the preliminary investigation by the PHSO, and no further actions were required by the Trust.

Of the remaining cases, one case was still in the preliminary investigation stage going into 2019/20, and the remaining two cases the PHSO decided to commence a full investigation.

The Trust received a final report for a complaint that had been referred to the PHSO in 2017/18 which related to a patients experience and treatment in a sexual health clinic. The case was upheld by the PHSO and the Trust was required to pay £5000 in compensation with a letter of apology for the patient.

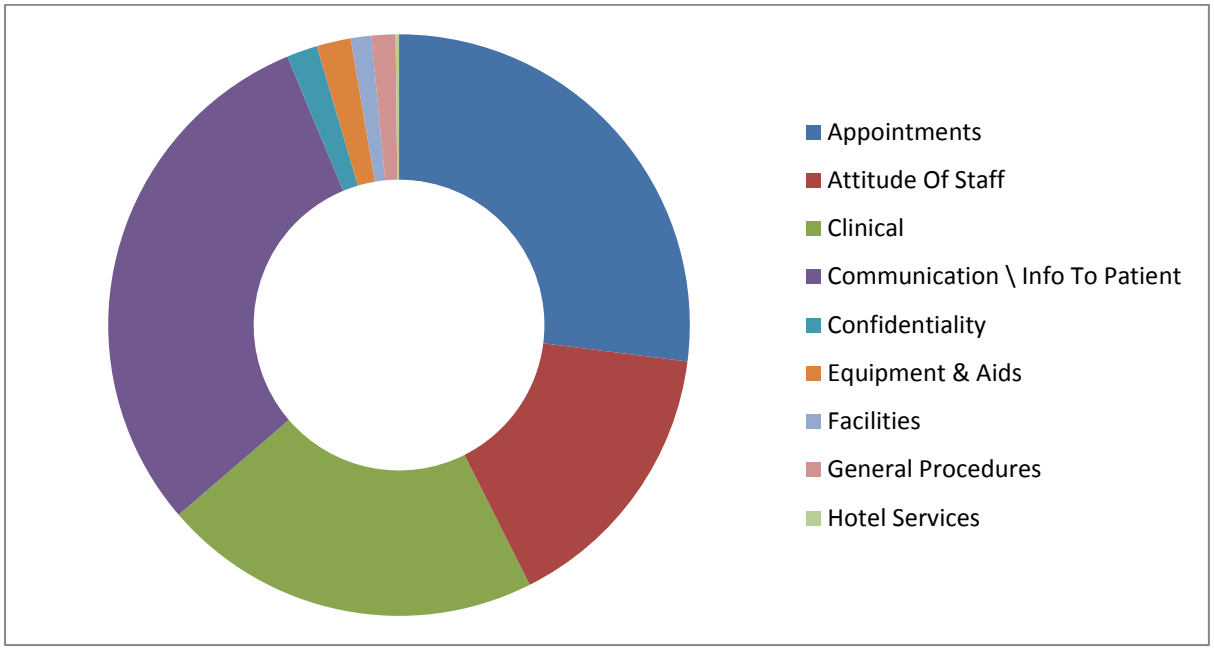
6. Service concerns

A total of 420 service concerns were received in 2018/19. The most common identified themes are communication and then appointments. Examples of these include; failure to receive a call back, delays in referrals by service, dissatisfaction with changes to telephony system, issues with booking system and information given by service.

It is important monitor the themes of concerns received to further identify issues the service may be experiencing and consider learning and possible improvements. For example, Sexual health identified a need to review how patients access the service following an increase in concerns.

Primary Care, Children's Services, and Sexual Health received the majority of concerns respectively, and the chart below highlights this. Common themes include appointment access and telephone communication.

Chart 2



Please note, hotel services relates to cleanliness of premises, condition of waiting rooms, treatment rooms, food and laundry services.

7. Compliments

The Trust measures the number of compliments received to celebrate good practice and inform learning to know what we do well and learn from excellence. Compliments are received in a number of ways including by letter, cards, emails and donations. These may be received from patients, their family, or members of public, to express their thanks and appreciation for the care provided. These are usually sent directly to the service where the person or team receiving the compliment is based.

During 2018/19 a total of 1,542 compliments were received. This is an increase of approximately 500 compared to the figures from the last five years, which previously remained at a similar level.

Table 8

	2018/19	**2017/18**	**2016/17**	**2015/16**	**2014/15**
Total Number	1,542	1,044	1,024	1,008	1,033

Refer to Appendix 2 for some examples of positive compliments receive**d.**

8. Future plans 2019/20

- Policy/Training – develop training for the complaints team and all Trust services to fully operationalise the updated policy.

- PALS Call Handler and Administrator– review of the role and consideration of permanent recruitment at the end of the pilot period.

- Liaising with other Trusts to identify good practice in complaints management.

- Complete the development of service concern management on Ulysses.
- Updating and continued improvement of the Ulysses system to ensure we are using it to its maximum potential to support the complaints processes.
- To work closely with the community engagement team to further improve and develop the Trust's approach and process relating to complaints management and to co-design future improvement's with patient partners.
- To increase patient feedback following completion to support future developments and improvements
- Customer care training for the Complaints team.

9. Summary

Reporting themes are consistent with nationally reported themes and work continues to identify improvements required to improve patient, family and carer experience of the services that Solent offer and provide.

The Trust will continue to monitor reporting numbers and consideration of benchmarking data. The importance of ensuring accurate reporting and standardising inclusion criteria's, definitions of upheld etc. will continue to inform the process. The Trust will continue to maintain an open and honest approach to complaints and ensure that the process to complete these is accessible and clear to understand.

The Complaints team continue to develop the service provided and to identify and implement improvements that will enhance the Trust process for the complainant and the services. It is recognised that the Trust continues to develop and improve the complaints process and will work closely with the AD for Community Engagement and Patient Experience. Patient, family and carer engagement is valued in this continued development work and improvement on the complaints policy and process.

Appendix 1

Service Line	Theme of complaint	Improvement in service
Mental Health Services	Personal information breach due to double sided handover sheets	Handover sheets are now printed single sided
	Communication issues when a patient finds it difficult to articulate needs and requirements	Communication methods and tools used have been reviewed and staff awareness raised
	Concerns regarding professional behaviour in therapeutic sessions	Supervision for counsellors now includes a review of random cases
Adult Services Southampton	Referral pathways	The referral pathway has been updated to ensure the correct team receive the referral.
	Information provided to patients relating to rehabilitation	A leaflet has been written which explains about service delivered which enables patients to make an informed choice about where they can receive their rehabilitation treatment following discharge.
	Inaccurate contact information	Contact information has been updated and shared externally
Adults Services Portsmouth	Inaccurate expectations of what service the community nursing team can offer	Additional information and training provided to GPs to ensure greater awareness
	Communication problems	The 'This is me' document introduced which is completed by staff with the patient and relatives to improve communication
	Communication-methods and materials available	Communication methods and materials updated including a leaflet which includes end of life care management
	Failure to escalate in an urgent situation	Process implemented which ensures the senior clinician on duty is informed verbally of all urgent messages requiring action.
Service Line - Primary Care	Delay of results and impact on treatment	Podiatry Service now has full access to swab results on the system
	Lack of privacy	Provision of new consultation room at one of the surgeries for greater access to private space for patients.

	Inaccurate information on the surgeries website	Updates and accuracy checked to ensure correct information available to patients
	Inappropriate referral	Further advice & support offered to referring GPs to ensure patients are referred appropriately to the Pain team
Service Line – Dental	Inappropriate referral	Review of communication to patients who do not meet criteria
Service Line - Sexual Health Service	Accessibility of test results	A patient specific portal will be introduced in 2019/20 to enable patients to directly access results.
	Waiting time in clinic and poor communication	Signage improved within clinics so patients are better informed
	Unclear communication	Appointment text messages now include clinic dates and time
	Accessibility to service	The service have introduced booking online for appointments and same day release
	Accessibility to service	Online booking system and web chat facility introduced for alternative advice & signposting.
	Accessibility to service	An SMS text cancellation service implemented
Service Line – Children Services	Inaccurate personal information	Introduction of new process to ensure the transfer of patient details is correct.
	Information sharing and delays	Team meetings held to discuss the impact letters/reports may have on young people especially if there is a delay in sending the report out.
	Unclear information/communication	Nasal flu spray consent form made clearer.

Appendix 2

A few examples of compliments received:

"Many, many thanks for all the care, help and advice you all gave me during my stay with you. I really do appreciate all that was done for me by you all. I am settling well into life at home."

'Thank you so much for all the help and therapy you have kindly given to xxx over the last 4 years. All your support has been amazing and thank you so much once again for pushing us towards the provision. You have given xxx a chance and we truly appreciate everything you have done for our family. Once again thank you for all your help, care & love'.

'Just like to thank you all for the help, love and support that you gave to my mum in the 7 months that you was with us. Unfortunately, her illness didn't come to a happy ending but all of you supported and cared for her in the best possible way and I thank you all for all your help. She went off really peacefully and I know that she would have really appreciated the help and support she got. Once again thanks a million for all your support'.

'To Doctors, Nurses, HCS, OTs, Physios, Housekeeper+ everyone!! Thank you so much for all your help, support, and encouragement at Snowdon which enabled me gain more skills and mobility. You are a great team working together to let us -patients always smiling+ happy, very caring and kind.'

'Thank you so much for all your help and support getting me back on my feet.'

'I can't thank you enough for being so great with J and getting us in so quickly to have his poorly teeth removed. You have gone above and beyond what any other dentist would have done, and I am truly grateful he has such a wonderful Dentist. Thank you so much! J is finally back to his cheeky self since the infected tooth has gone."

"My mother and I would like to say thank you for your help and rehabilitating my mother. Mum was in a sorry state when she arrived in Southampton weighting 4st, 10 lbs., and only able to walk a few steps. Thanks to your team's encouragement, mum can now walk independently; she now weights 6 stone 2 lbs. We really appreciate all your efforts and support."

Item 15.3

Learning from Deaths (LfD) Quarter 1 2019/20

Committee /Subgroup name	*Learning from Deaths(LfD)*				**Date of meeting**	*July 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 1 information. • A learning review into a death that occurred in one of our community mental health services is currently in progress led by the NED sponsor for LfD to identify any learning that the Trust can highlight internally (and externally where applicable). This is the first time the Trust has undertaken a review using this format. • The Family Liaison Manager has now been in post for 8 months and she continues to work closely and flexibly with families/carers in need of her support. Feedback to date from those she has supported (both families and staff) has been extremely positive and she has now been approached to present at a national event. • The new LfD policy was approved and has now been implemented Trust wide. The Head of Patient Safety is currently visiting services to discuss the policy. General feedback to date regarding the policy has been positive and all services have been encouraged to make contact if any problems are encountered. • The Structured Judgement tools (SJT) within the policy are currently validated for adults only. There will be continued work with the service to develop a specific paediatric tool, but until then the Children and Families service will base the reviews on the adult tool. Any national developments regarding this will also be considered. • The dashboard below has been updated to reflect the inclusion of final scoring relating to preventability of death and the quality of care provided; this element only is updated quarterly rather than monthly as it may not always be known at the time of monthly reporting. • Refer to page 4 for the quarterly mortality dashboard for an overview of reporting across the Trust.
Decisions made at the meeting
• For all SI's completed, the LfD panel now make the final decision regarding preventability of death and grade the quality of care given to the patient prior to their death. • Additional licenses to access Verto were identified as required by panel members to ensure that actions can be updated in a timely and efficient way-this was raised with the CPMO team and further licenses were acquired. • The Head of Quality and Professions for service lines* have been asked to highlight any SJT's to the Quality and Safety team which would benefit from an extended discussion at the panel meeting. (*The Specialist Dental team report by exception only as per the new LfD 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

Learning from coroner's inquests

In Q1 there were a total of 4 inquests and there were no prevention of future deaths reports for Solent.

What has changed as a result of Learning from Deaths during Quarter 1?

In this quarter, the following improvement and change have been noted from VERTO:

Service	Learning and Improvements
Adult Mental Health	Following the death of a patient who had been referred into and assessed by one of the service community teams, it was identified that there was a missed opportunity to review a letter which had been sent from the acute provider which noted an attempt to end his life by self-harm (the patient did not disclose any intents to self-harm when assessed). This has been reviewed as per the SJT process and whilst that information would not have changed the priority of care provision or offer, the service has updated their Risk SOP to state that all letters on Systm1 are to be reviewed for the previous 3 months. This action is being monitored via Verto.
Adult Mental Health	On review of a case of a community patient who self-harmed and ended her life, it was noted that no indications of her intention to self-harm were expressed and that all risk assessments were completed to a good standard. However, it was highlighted that there were some gaps in documentation. There is already a Trust wide steering group reviewing documentation and how to improve Trust wide and will be reported on once concluded.
Adult Mental Health	Following the death of an elderly patient on a Mental Health Service inpatient ward, it was highlighted that not all staff were aware of what is referred to as "restraint". The service planned workshop for staff to attend in July which included restraint and a further piece of work will be undertaken (format to be confirmed) which will clarify for all what is defined as restraint (noting that this can be applicable Trust wide).
Adult Mental Health	It was highlighted in the community team that there was a need to clarify the discharge process and update the final sign off process to reflect a Registrant sign off rather than a Medical sign off. This action is being monitored via Verto.
Children's and Families	Following investigations into infant deaths and concerns relating to safe sleeping messages, the service presented how training had been delivered to children centres, therapies etc. and updated on the standardisation of materials to support the safe sleeping messages that have been agreed and disseminated. It was also noted that it is available in different languages. Staff have been reminded of the importance of completing documentation and the need to maintain a professional curiosity to confirm where an infant is

	sleeping. This action is being monitored via Verto.
Children's and Families	Following the unexpected death of a child, it was identified by the service that there was a need to improve communication between Occupational Therapists and Physiotherapists. It was identified that a lead professional needs to be identified for children who are cared for by the community children's teams.
Adults Southampton	The service highlighted positive learning which confirmed that a high standard of palliative care had been provided and anticipatory plans had been in place ready for use when required and families were well supported.
Adult Southampton	On completion of a Structured Judgement Tool (SJT), the service identified the challenges when multiple providers are involved in the care of a patient with complex needs and different healthcare records systems which are used by other providers. It was identified that in this case the patient had not received a joined up approach to her care and that a MDT approach should be considered for cases such as this. It was not identified that this had any impact on her death.
Adult Southampton	After investigation it was identified that a patient on the community caseload, was not identified as a vulnerable adult requiring further discussion with the Trust safeguarding team. It was also noted that there was a lack of understanding regarding the management of a diabetic patient with complex need and concerns re the completion of documentation. The service are in the process of arranging mental capacity and substance misuse training for staff and reminded of the role that the Trust safeguarding team have in support of staff. A project management action has also been identified to improve the working relationship with the specialist diabetic team- this action is being monitored via Verto.

Trust-wide Mortality Report, Q1 2019

Number of deaths reported YTD

Number of Deaths Reported
400

Quarterly Count of Deaths Reported

monthname	Number of Deaths Reported
April	138
May	145
June	151

Quarterly Count of Deaths Reviewed via SJT* or MDT*

monthname	Reviewed via SJT or MDT
April	65
May	57
June	59

Quarterly Count of Deaths SI Rated

monthname	SI
April	2
May	0
June	1

Quarterly Count of Deaths of Learning Disability Patients

Counter
4

Quarterly Count of Deaths Reviewed by Another Provider

monthname	Reviewed by Another Provider
April	7
May	6
June	12

Supporting 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
*SJT = Structured Judgement Tool

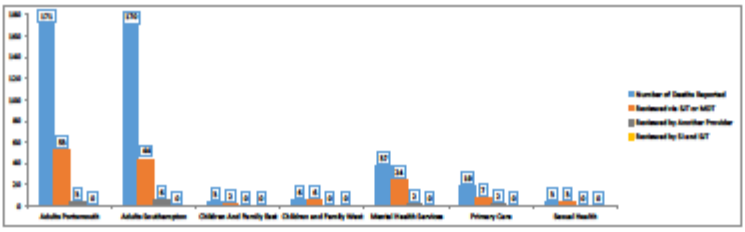
Data sources:
Dates of death and patients extracted from CareFlow (as per Service Line definitions), confirmed against Spine, confirmed by Service Lines
Q data provided by Quality Team (inclusion = date of death within reporting period)
Primary Care Services overlap with Solent GP
Sexual Health Data 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 SJT or MDT by Service Lines
Adults Portsmouth: 1. Specialist Palliative Care deaths in the community 2. Some deaths in QAH
Adults Southampton: 1. Palliative care & 1st. pathway deaths in the community 2. Some deaths in UHS
General Number Deaths in UHS are reviewed in UHS and the learning is shared with Solent

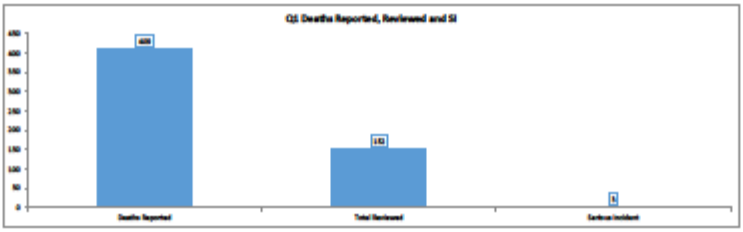
Q1 Deaths Reported and Reviewed by SJT* or MDT* or by Another Provider by ServiceLine

service line	Number of Deaths Reported	Reviewed via SJT or MDT	Reviewed by Another Provider	Reviewed by SI and SJT
Adults Portsmouth	171	65	5	0
Adults Southampton	170	46	4	0
Children And Family East	5	2	0	0
Children and Family West	8	4	0	0
Mental Health Services	57	24	3	0
Primary Care	38	7	3	0
Sexual Health	5	3	0	0



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

Category	Count
Deaths Reported	400
Total Reviewed	183
Serious Incident	1



Learning Disabilities

Considered for Review via SJT or MDT*
4

Trust-wide Mortality Report, Q1 2019

Number of deaths reported YTD

Number of Deaths Reported
409

Quarterly Count of Deaths Reported

monthname	Number of Deaths Reported
April	135
May	143
June	131

Quarterly Count of Deaths Reviewed via SJT* or MDT*

monthname	Reviewed via SJT or MDT
April	43
May	57
June	39

Quarterly Count of Deaths SI Raised

monthname	SI
April	2
May	0
June	1

Quarterly Count of Deaths of Learning Disability Patients

quarter
4

Quarterly Count of Deaths Reviewed by Another Provider

monthname	Reviewed by Another Provider
April	7
May	4
June	2

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
*SJT = Structured 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
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

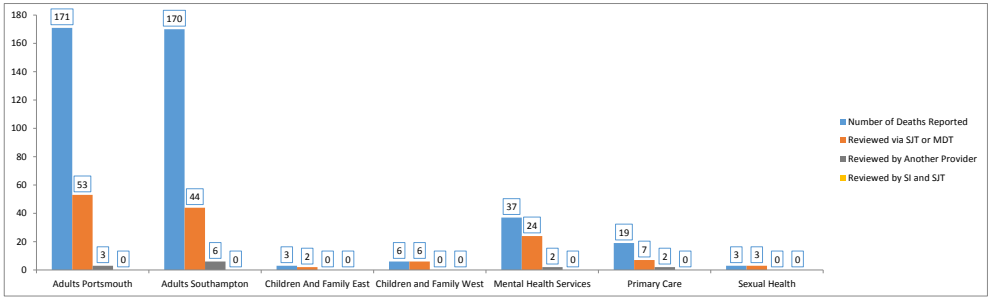
Main categories of deaths not reviewed via CJT or MDT by Service Lines:
Adults Portsmouth: 1. Specialist Pallliative Care deaths in the community 2. Some deaths in QAH
Adults Southampton: 1. Palliative care & EoL pathway deaths in the community 2. Some deaths in UHS
General Practice: Deaths in UHS are reviewed in UHS and the learning is shared with Solent

Q1 Deaths Reported and Reviewed by SJT* or MDT* or by Another Provider by ServiceLine

service line	Number of Deaths Reported	Reviewed via SJT or MDT	Reviewed by Another Provider	Reviewed by SI and SJT
Adults Portsmouth	171	53	3	0
Adults Southampton	170	44	6	0
Children And Family East	3	2	0	0
Children and Family West	6	6	0	0
Mental Health Services	37	24	2	0
Primary Care	19	7	2	0
Sexual Health	3	3	0	0

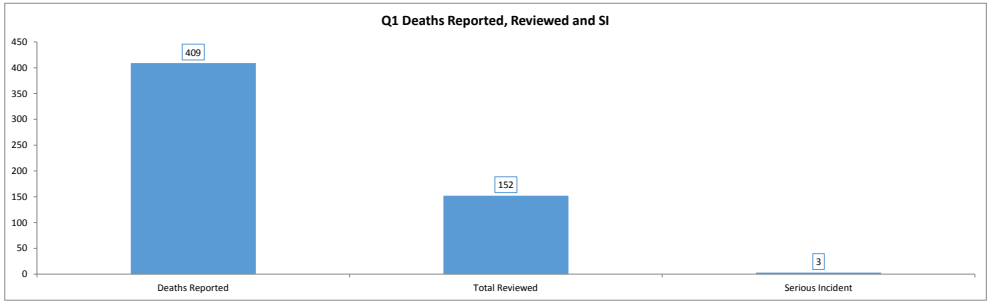
Learning Disabilities

Considered for Review via SJT or MDT*
4



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

Category	Count
Deaths Reported	409
Total Reviewed	152
Serious Incident	3



Item 16

Exception and recommendation report

Committee /Subgroup name	**Complaints Review Panel**	**Dates of meeting**	3 September 2019
Chair	**Stephanie Elsy**	**Report to**	Trust Board

Key issues to be escalated

1. Complaints Reviewed

The panel reviewed one formal complaint, and two Parliamentary and Health Service Ombudsman cases (PHSO).

1.1 Primary Care Service
Outcome: Not Upheld
Key Learning Points:

- Importance of continuity of care to build trusting relationships with patients, particularly those with complex needs.
- The need to provide articulate clear boundaries for people with addictions to support management plan.
- When patients exhibit behaviour that challenges, an incident should be recorded and consideration given to the use of the zero tolerance policy.

1.2 Sexual Health Service (PHSO Case)
Outcome: Upheld - £5000 recompense awarded
Key Learning Points:

- Investigators should be appointed that are external to the Trust when there are potential sensitivities including professional opinion.
- The patient did not feel listened to. There was little evident regard for this gentleman's emotional state after having received a potentially life limiting disease diagnosis. Consideration needs to be given to the context of conversations with patients, to ensure they can understand the information being shared with them.
- Confusion about the pathway out of hours for people requiring urgent antibiotic therapy was evident. This has now been clarified.
- The patient was required to attend SMH for meetings rather than consideration of home visits or alternative venues.

1.3 Adult Mental Health (PHSO Case)
Outcome: Not Upheld
Key Learning Points:

- PHSO investigation reported our involvement with the family was beyond what was expected of the service
- Service initially felt they were very and appropriately responsive to the needs of the family members. On reflection the constant change of medication and plans of care in response to requests from the family, could have led to a sense of them not being confident in the competence of the health care team. In future active involvement of families will continue, but extra consideration given to the need to maintain a plan until it has had a chance to take effect.

2. Complaints Panel next steps
   Panel terms of reference to be reviewed

3. Benchmarking and metrics
   Service user led development of local metrics planned plus use of national benchmarking data(e.g. Patient Experience Headlines Tools comparators)

Decisions made

As above

Recommendations to the Trust Board

The Board are asked to note:

1. The key learning points from the case reviews
2. The plan to introduce service user designed metrics as part of complaints process redesign work.

Other risks to highlight (not previously mentioned)

Nil to note

Item 17.1

Exception and recommendation report

Committee /Subgroup name	People and OD (POD) Exception Report	**Date of meeting**	12th September 2019
Chair	Mike Watts, Non-Executive Director	**Report to**	Board

Key issues to be escalated

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

An update on the implementation of the Learning & Development strategy was given, noting the business case that has been drafted for Directors to review on investment in learning infrastructure. A progress report was provided for the e-rostering improvement programme and the Committee expressed their concern about the lack of traction and also noted the critical issue of dedicated business support resource in service lines. The terms of reference for the rostering and sustainable workforce internal audit were approved and the Committee was given an update on the workforce optimisation programme, the PID for which will be signed off by Directors during September.

Key areas of concern from the workforce dashboard were discussed including vacancy rate, agency spend and rising sickness absence. An early presentation of SPC analysis highlighted a significant adverse trend in absence for mental health reasons trust-wide and significantly higher sickness in certain service lines. The relationship between these three elements as it pertains to workforce sustainability was discussed and it was noted that a deep dive on the sickness absence trends would be brought to TMT. In addition a summary paper to integrate the findings from the deep dive on the BAF workforce sustainability risk was presented. Findings from TMT, a follow-up questionnaire and the POD workshop were considered alongside the previous POD Committee paper and it is recommended that the residual risk score continue to remain a major/likely risk for the foreseeable future.

A paper was presented outlining hard to recruit roles alongside the forward recruitment plan. A discussion took place about our ability to reduce our vacancy rate and whether we could aspire to zero vacancies as part of going from good to great. It was acknowledged that we needed to build on our existing resourcing offer. The implications for finance and quality were discussed and the current business plans which include a vacancy rate as part of the financial plans. It was recommended that this be considered holistically in the context of risk appetite and workforce sustainability as an agenda item at the Workforce and OD Committee.

A summary of the STP workforce programme was given, highlighting where Solent is involved and leading. The committee reflected on the differences between collaboration and unification and the potential obstacles to doing things once across the system. It was agreed that our Non-Executive Directors could make an offer to get involved with the STP workforce programme.

A Diversity & Inclusion maturity model and accompanying action plan was provided to the Committee, highlighting the key areas of work for the next 6 to 18 months. The next step to present a draft Diversity & Inclusion strategy for consultation with key group of staff members and community groups was noted. Current governance arrangements are still being reviewed with the POD and Community Engagement Committee. The intention to continue operating within existing governance arrangements (which will include the refreshed name of the EDI sub-committee to the D&I Strategic Group) was noted. We will update terms of reference when governance arrangements are clarified. Our submission to the Workforce Disability Equality Standards (WDES) was shared for information and recommendations for this will be agreed at the Strategic Diversity & Inclusion Group. This will form part of the overall strategy and plan to be presented at Board. The Board will need to discuss and agree our Trust Equality objectives.

The Health & Wellbeing strategy and plans were shared and the Committee noted the specific

requirements around flu vaccination at 80% and the requirement for a separate mental wellbeing plan in response to the Stevenson/ Farmer Thriving at Work Review. The flu target is particularly challenging within a Community Trust but the Committee noted the excellent performance over the last two years.

A detailed review and recommendations against the 'Learning lessons to improve our people practices' (letter from Dido Harding) was shared with the Committee. A new HR Consultancy Assurance report was also presented. Immediate actions were highlighted such as the introduction of a People Management Advisory Forum (PMAF) to implement plurality in decision-making. A summary paper will be brought to the next Board with recommendations on oversight and reporting.

Decisions made at the meeting

The People and OD Committee Annual Report 2018-19 was approved and is appended for information (see Appendix 1, Item 17.2).

The Committee approval recommended changes to workforce targets for reporting purposes.

Recommendations

The Board are asked to formally **approve the Workforce and OD Committee Terms of Reference** (which has been approved virtually via the Governance and Nominations Committee). The full People and OD Governance and Assurance arrangements review paper (as presented to the POD Committee on 12th September) is appended incorporating the Terms of Reference (See Item 17.3 - Appendix 2).

Other risks to highlight (not previously mentioned)

- The implementation of changes to the Travel Policy/ parking was highlighted as a risk for retention and engagement. The challenge in effectively and consistently communicating across a multitude of sites was noted.
- Staff and patient safety at RSH was noted as a risk requiring further escalation
- Insufficient rostering resources within service lines is creating a risk to the Roster Improvement programme, which is in turn impacting assurance levels around safe and sustainable staffing.

NHS Solent NHS Trust

People and OD Committee Annual Report 2018-19

Introduction

The People and OD Committee oversee all matters relating to workforce planning, talent acquisition, learning & development, employee productivity and workforce performance. It is responsible for ensuring that effective People & OD programmes are developed, which align with organisational strategy and deliver continuous improvement in organisational effectiveness. All of this is done within the context of system transformation and organisational change.

Meetings

During 2018/19 the following meetings were held:

- 21st June 2018
- 21st September 2018
- 10th December 2018
- 14th March 2019

Membership & Attendance

Attendance by members is outlined as follows:

	Meeting				
NAME	21st June 2018	21st September 2019	10th December 2018	14th March 2019	**% attendance**
Mike Watts Non Executive Director	P	P	P	P	100%
***Stephanie Elsy** Non Executive Director	P	P	P	A	75%
***Francis Davis** Non-Executive Director	A	P	A	A	50%

P= Present A= Apologies

Terms of Reference

The TOR were not reviewed this year.

Status against the achievement of the Committee's Objectives

Objectives	Status
Embed the governance structure of the Committee within the Trust governance and assurance framework, ensuring key matters are considered, escalated and cascaded	Achieved – see objective for 19/20, which will further strengthen governance arrangements
Ensure representation from all service lines at service leadership level and build capacity and capability to deliver improvements in organisational effectiveness	Achieved – Committee very well attended
Further refine the assurance framework for the Committee, including: agenda cycle, papers and outcome reporting	Developing – the Committee is maturing and will benefit from a full review in the next year.

Summary of business conducted in year

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

- The Committee received regular exception reports from the Equality, Diversity & Inclusion, Employee Engagement, Health & Wellbeing Sub-Committees, Joint Consultative Committee and People and Operations Service Delivery meeting.
- The June 2018 meeting received an overview of medical education activity. IT system access issues for students and consequential negative feedback from the GMC was highlighted and the matter was escalated.
- The Committee received an update on the Mental Health Recruitment Campaign that improved advert visibility and encouraged more interest.
- A review of learning and development activity was received and key pieces of work undertaken during 2017/18 were highlighted. The committee acknowledged the need to consider key principals to produce a refreshed L&D strategy. The strategy's progress was presented at the March meeting and it was agreed to create a timetable with set milestones for the strategy's development.
- E-Learning compliance rates were regularly reviewed.
- The Committee received a presentation on 'Stress at Work' and a step by step guide to complete a stress risk assessment was shared.
- The risk register was reviewed and a Chief People Officer update received at each meeting.
- Exit interview pilot results were shared at the September 2018 meeting.
- The September Committee received a presentation on Digital Recruitment Campaign outcomes. The Recruitment and Retention strategy was discussed and it was agreed to review in 6 months' time.
- The December meeting received a deep dive on e-rostering, agency use and workforce development. It was agreed that e-rostering would be a standing item at each meeting going forward to address issues identified.
- The Committee received a presentation on Brexit plans and implications to EU nationals.

Objectives for 2019-20

Objectives
To commission a review of the Committee and sub-committee structure, membership and Terms of Reference to ensure their effectiveness and that the Board is receiving appropriate assurance from the People & OD areas of oversight and on the workforce sustainability risk within the Board Assurance Framework.
To approve recommended changes to the governance arrangements for the People & OD Committees and Groups resulting from the review, ensuring alignment with other committees and groups.
Receive an update on the progress and effectiveness of the actions detailed within the workforce sustainability risk of the Board Assurance Framework at each meeting.
Specifically to receive an update on the learning and development strategy implementation and e-rostering improvement programme at each meeting.

Conclusion

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

Report Author(s)	Mike Watts, Non-Executive Director and Committee chair Jayne Jenney, Corporate Support Manager, Assistant Company Secretary

Item 17.3

NHS Solent NHS Trust

Report presented to:	*People and OD Committee*		
Title of Paper:	People and Organisational Development Governance and Assurance arrangements review	**Author(s):**	Bal Johal and Helen Ives
Executive Lead:	Helen Ives, Chief People Officer	**Date of Paper:**	September 2019
Committees presented:	People and OD		

W1 Leadership Capacity & Capability	x	**W2** Vision & Strategy	x	**W3** Culture	x	**W4** Roles & Responsibilities	x
W5 Risks and Performance	x	**W6** Information	x	**W7** Engagement	x	**W8** Learning, Improvt & innovation	x

Executive Summary

This paper includes:

- The outcomes of a review of the current People and Organisational Development (POD) governance arrangements and proposed changes to POD governance
- Terms of Reference for a new Committee: Workforce & Organisational Development (WOD)
- Terms of Reference for a People & Organisational Development Group (POD)
- The content of the POD are largely the same but the governance arrangements have been amended
    - WOD: Non-Executive and Executive members
    - POD: Senior leadership team members
- The underpinning group/ sub-committee structure has also been amended. Some have been integrated into the POD and others have been designated as forums
- This review has taken place following the deep dive into sustainable workforce and alongside the development of the People & OD strategy (concluding in January 2019)

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

N/A

Key Decisions/ Action(s) requested

- The Committee is asked to endorse the proposed approach and agree the Terms of Reference for the WOD and POD.

People and Organisational Development Governance and Assurance arrangements review

1.Introduction

1.2 The purpose of this paper is to highlight the outcomes of a review of the current People and Organisational Development (POD) governance arrangements and present the proposed changes to POD governance.

1.3 The review was undertaken with an aim to clarify the expectations in outputs from supporting meetings, to ensure the avoidance of duplication, align assurance areas and justify and reconfirm the added value of each meeting within the POD governance structure.

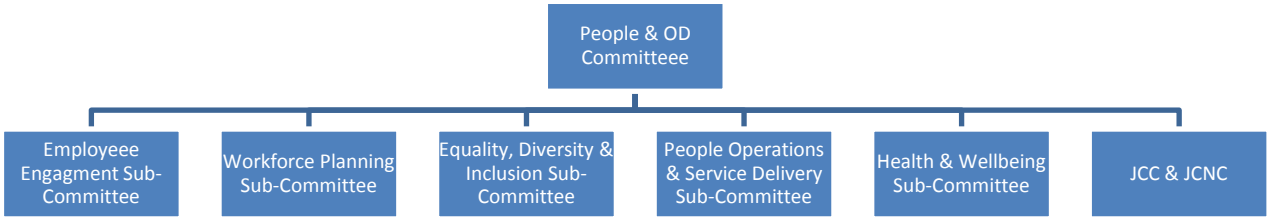
2. Approach to Review

2.1 The approach to review consisted of five task and finish meetings - 'Rewiring POD', chaired by the Chief People Officer with lead people services representatives having oversight of and informing expectations on key areas of assurance as follows:

- Equality Diversity and Inclusion
- Recruitment & Retention
- Compensation & Benefits
- Workforce Planning & Metrics
- Communications
- Culture and Leadership
- Employee Experience
- Health and Wellbeing
- Education, Learning and Development
- Workforce Sustainability

2.2 Governance arrangements from other Trusts were reviewed to incorporate wider learning.

2.3 The current POD governance arrangements:



2.4 The review considered the following key areas:

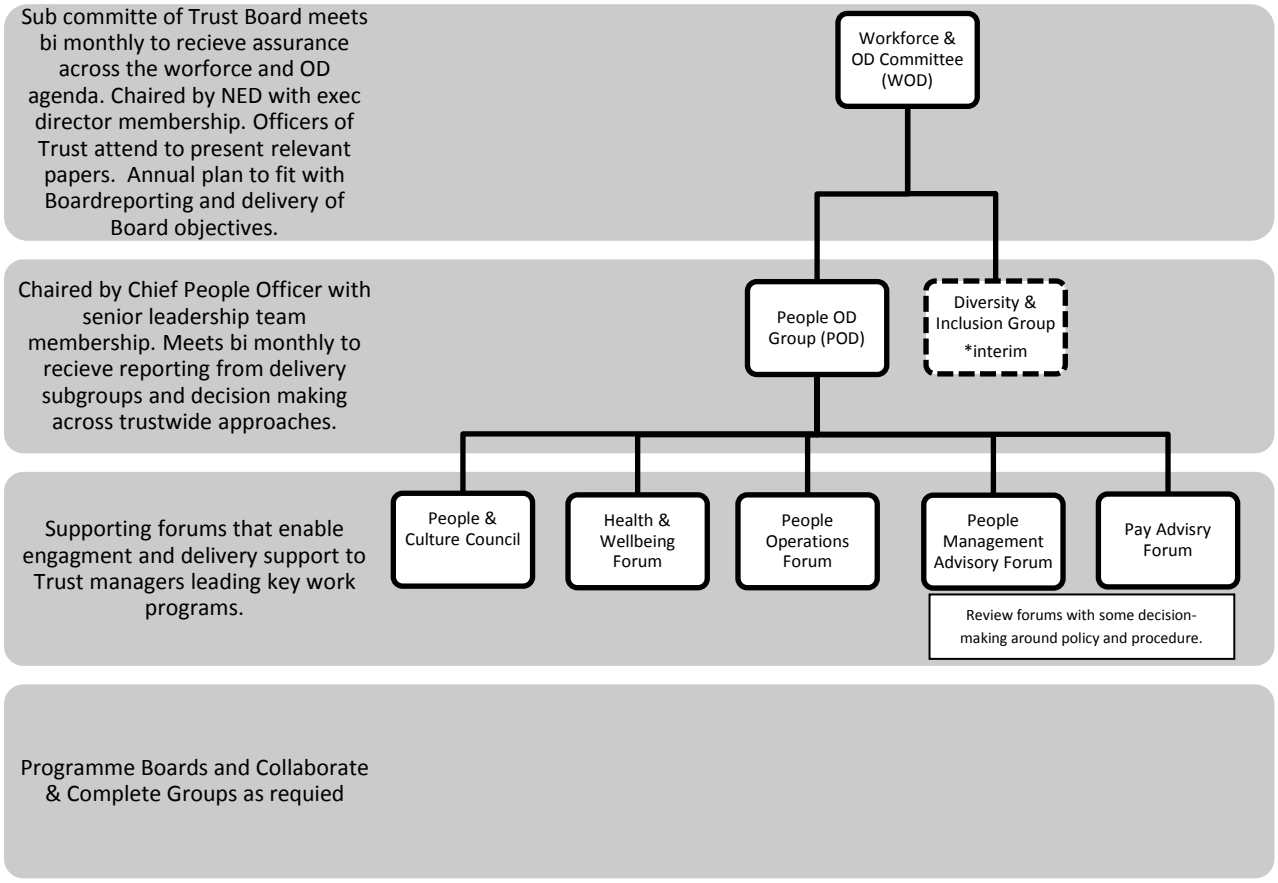
- Clarity of distinction between operational delivery issues and governance/ assurance of delivery
- Clear overview and facilitation of the development of the the Trust values-based culture,leadership and employee engagment
- The need for a staff network /engagment forum
- Diversity & Inclusion reporting and linkage into Community Engagement Committee
- Intergration of Health & Wellbeing into core business
- JCC/JCNC reporting to TMT and escalation of risk issues into governance
- The need for operational engagment, debate development and planning with service involvement and enagagement
- Continued embedding of people governance into service lines' performance and governance structures
- Ownership of the People & OD agenda at Executive and Senior Leadership levels
- Terms of reference and flow
- The need for forums rather than committees and management of the administrative burden
- The need for an annual plan and agenda framework for reporting
- Alignment with the STP/ ICS, long term plan and people plan

3 **Changes agreed for implementation**

3.1 The changes agreed for implementation are highlighted in the table below, alongside these all terms of refernce for the groups were reviewed. It was agreed to establish revised working forums to support People and OD Group delivery plans across the areas of Health & Wellbeing , Staff engagement, Operations and Management

4 Proposed People Management and OD Governance Arrangements

4.1 The revised structure following implementation of changes is highlighted below and encompasses establishment of forums to support delivery and monitoring of implementation of agreed strategies and workplans.



4.2 The establishment of a Workforce and OD Committee(WOD) as the main assurance Committee will be supported by a People and OD Group, which the forums will feed into. An annual agenda and plan has also been devised and this will be shared at the first WOD Committee meeting alongside the revised TOR.

4.3 The annual plan includes the following areas of reporting:

- Workforce sustainability
- Programme updates
- Workforce planning
- STP/ICS workforce programmes and plans
- Rostering metrics
- Education, learning and development, inc Apprenticeships
- HR Consultancy assurance
- WRES, WDES, SOM and other Diversity & Inclusion standards
- Health & Wellbeing including CQUIN, SDIP (inc flu and mental health wellbeing)
- Recruitment and retention
- Communications
- Annual staff survey

- Culture, values and leadership
- Succession planning and talent management
- Compensation & Benefits and Gender Pay Gap
- Staffside information updates (inc facilities time)
- People & OD strategy/ Chief People Officer's report
- Medical education and staffing **recommend review by Chief Medical Officer in Q4 19/20*

4.4 The revised Terms of Reference for the Workforce and OD Committee (WOD) and People & OD Group (POD) are attached in appendix 1 and 2.

4.5 The Terms of Reference for the revised Diversity & Inclusion Group are pending a decision on configuration of the WOD Committee and Community & Engagement Committee.

4.6 The Terms of Reference for the forums will be approved at the next meeting of the POD.

5 Timescales for Implementation

5.1 It is proposed that the new Terms of Reference are agreed at the meeting on 12th September 2019. The WOD will then be approved at the next Governance and Nominations Committee.

Recommendation

5.2 The existing arrangements have been effective in establishing governance for People & OD across the Trust, particularly in garnering senior leadership involvement and ownership. The new arrangements reflect the maturing of the agenda.

5.3 The Committee is asked to endorse the proposed approach and agree the Terms of Reference for the WOD and POD.

APPENDIX 1

Solent NHS Trust Workforce and Organisational Development Committee

TERMS OF REFERENCE

1 Constitution

1.1 The Workforce and Organisational Development (WOD) Committee is a formal committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. The Workforce Committee is accountable to the Trust Board.

2 Purpose

2.1 The Committee is responsible for providing assurances to the Trust Board on all aspects of workforce and organisational development supporting the provision of patient care and the NHS people plan. In particular, ensuring the strategic objectives and trust ambitions are being delivered.

3 Duties

3.1 The Committee is the primary Board committee for providing assurance and raising any concerns to the Trust Board about delivery of the People & Organisational Development strategy, Communications Strategy ,Workforce Plans and the recruitment, retention, deployment and development of the Trust's workforce.

It is chaired by a Non-Executive Director of the Board.

3.2 The duties of the Committee will be to provide the Trust Board with an independent and objective review of, and assurances in relation to:

- Workforce & OD risks recorded on the Board Assurance Framework
- The development and delivery of a people and organisational development strategy that supports the Trust plans and ensures an appropriate culture is in place.
- The creation and delivery of workforce plans aligned to Trust strategies and financial envelope to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users. We have the right people, in the right job, with the right skills, at the right place, in the right time and for the right cost (the 6Rs).
- The effectiveness of the Trust Communication strategy and workplans.
- The Trust's workforce performance indicators including sickness absence, training, appraisal, bank and agency usage and expenditure and monitor any necessary corrective plans and actions.
- Effectiveness of recruitment and retention processes to ensure that the Trust has the people to deliver its strategy.
- Meeting legal and regulatory requirements in relation to the workforce (to include Diversity & Inclusion).
- Effectiveness of arrangements to understand and improve health and wellbeing.

- The effective identification and mitigation of workforce and organisational development risks within the supporting infrastructure of the Board Assurance Framework and Risk Register.
- Employee engagement and experience, reviewing staff surveys (national & local) and delivery plans to achieve a highly motivated and engaged workforce.
- The effectiveness of training and education of the workforce in all professions and oversight of the arrangements for medical education.
- National reports and best practice relating to workforce and organisational development.
- Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.
- Safe working in relation to the overall safety of doctors working hours.
- Development of effective and compassionate people practices and just culture.

The Committee will be supported in executing its responsibilities through the People and OD Group which will be supported by delivery forums.

4 Membership

4.1 The membership of the committee shall comprise the following:

Members	**In attendance**
Non-Executive Director (Chair)	Associate Directors/Heads of
Non-Executive Director (Vice Chair)	People & OD
Chief People Officer (Lead Executive)	Service/Corporate reps as
Medical Director	required
Chief Nurse	
Chief Operating Officers	
Chief Executive	
Chief Financial Officer	

4.2 If any member is unable to attend a meeting, they are to designate another suitable officer to attend as an alternate in their place. Members are expected to attend at least 75% of meetings annually. An annual register of attendance of members will be published by the Committee.

4.3 Other organisational managers and colleagues invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5 Chair

5.1 The Committee will be chaired by a Non-Executive Director. In the absence of the Chair, the Vice Chair will cover.

6 Secretary

6.1 The administration of the meeting shall be supported by the PA to the Chief People Officer or alternative member of Business Support who will arrange to take minutes of the meeting and provide appropriate support to the Chair and committee members.

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

7 Quorum

7.1 A quorum shall be two of the voting non exec members and two other members.

8 Frequency

8.1 The Committee will meet bi monthly.

9 Notice of meetings

9.1 Meetings shall be summoned by the secretary of the Committee at the request of the Chair.

10 Minutes of meetings

10.1 The minutes of Committee meetings shall be formally recorded and will be shared with the members following agreement by the Chair.

11 Authority

11.1 The Committee shall be accountable to the Trust Board. The committee is authorised to:

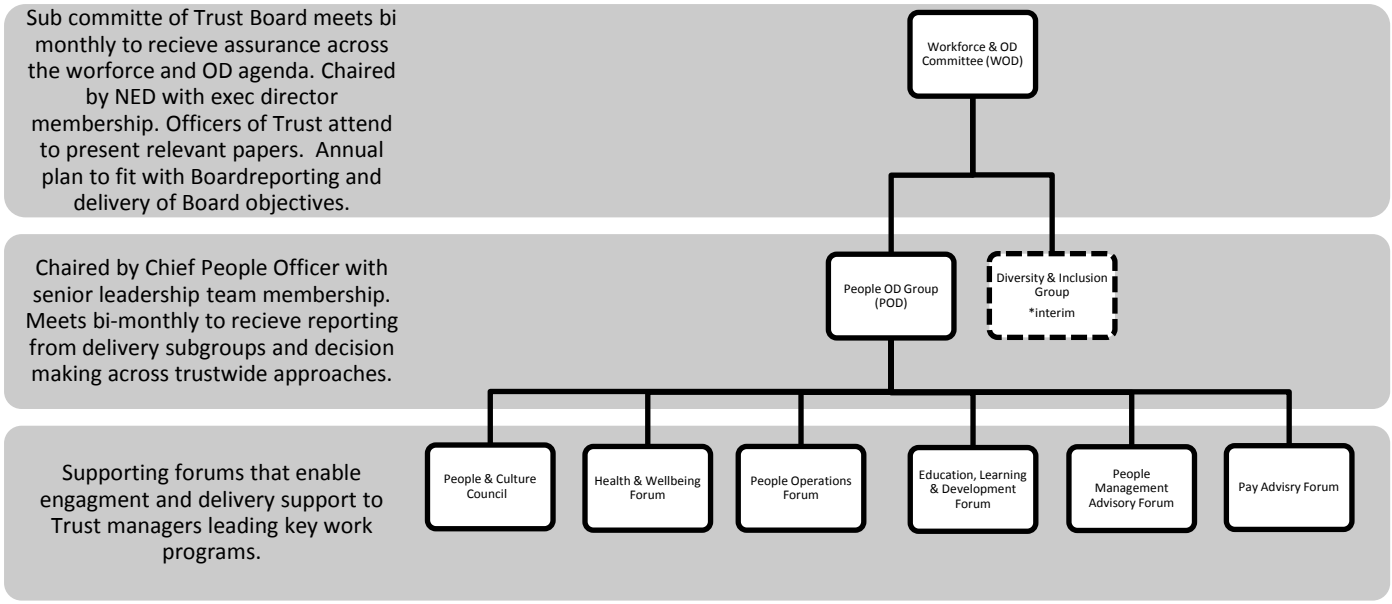
- To seek any information it requires from any employee of the Trust in order to perform its duties
- To call any employee to attend a meeting as and when required
- Seek external expertise where required

12 Reporting

12.1 The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

12.2 The Committee will prepare an annual work plan for the Board that will demonstrate the Committee's discharge of its duties. This report should be produced as required according to the Board's Annual Work Plan.

Appendix 1 – Committee Structure



APPENDIX 2

People & OD Group

TERMS OF REFERENCE

1 Constitution

1.1 The People and OD Group oversee all matters relating to workforce planning, talent acquisition, learning & development, employee productivity and workforce performance. It is responsible for ensuring that effective People & OD programmes are developed, which align with organisational strategy and deliver continuous improvement in organisational effectiveness. This is done within the context of system transformation and organisational change.

1.2 The People & OD Group has established a number of forums to execute its responsibilities as follows :
People & Culture Council
Health & Wellbeing forum
People Operations forum
Education, Learning & Development forum
People Management Advisory forum
Pay Advisory forum

1.3 Workshops will be led as and when they add value by the Non-Executive Director chairing the Workforce and OD Committee (WOD) and Chief People Officer to ensure connectivity, learning and integration.

2 Purpose

2.1 The People and OD Group's core purpose is to:

- provide a vehicle for strategic planning and continual improvement of Organisational Effectiveness (see Figure 1)
- oversee execution of the People & OD Strategy by monitoring delivery of the in-year workforce priorities and People & OD business plans (Service Line and Corporate)
- ensure there is a consistent focus on People and OD at senior leadership level and appropriate challenge in support of our strategy and vision of being a Great Place to work
- assess organisational effectiveness against a People & OD scorecard

2.2 The groups of the People & OD Group will:

People & Culture Council

- Oversee the ongoing development of our values-based culture, leadership and employee engagement

People Operations Forum

- Ensure continuing development of People practices and services by discussing key workforce issues, recommending solutions and prioritising resources

Health & Wellbeing Forum

- Facilitate the effective implementation of health & wellbeing initiatives and support the delivery of the Workforce Health & Wellbeing Strategy (including the OWLES group)

Education, Learning & Development Forum

- Oversee the ongoing implementation of our Learning & Development strategy and ensure alignment across service lines, Medical Education, Learning & Development and Quality functions

Pay Advisory Forum

- Review pay cases and ensure decision-making is aligned to Agenda for Change terms and conditions and the Pay Policy

People Management Advisory Forum

- Review employee relations cases and ensure decision-making is aligned to policies and procedures, upholding the recommendations from 'Improving People Practices'

2.3 The purpose of the workshops are to:

- develop the value proposition that underpins the Trust People & OD Strategy and feeds into system transformation
- discuss key workforce risks for the system as a whole in order to build an agile & resilient organisation (ambidextrous leadership)
- govern & embed a culture in which high-quality care and quality improvement is intrinsic to everyone (organisational citizenship behaviours)
- determine key priorities for the People & OD Group in the year ahead
- ensure the correct investment level in People and that long-term ROI is validated
- prepare the workforce of the future

3 Duties

3.1 The People & OD Group will:

- collectively ensure that the meetings add value (see Appendix 2)
- ask the right questions to ensure: we have the right people, in the right job, with the right skills, at the right place, in the right time and for the right cost (the 6Rs[1]). See Appendix 1 for the Quality of Conversation framework
- embed Trust-wide ownership for the People & OD agenda, working across organisational boundaries and unblocking issues when they arise
- advocate for and uphold our values, working to develop our engaging leadership, culture and capacity for transformational change
- identify workforce risks to organisational performance and recommend mitigation strategies, taking input from performance committees
- act as the escalation point for People & OD service delivery issues when normal operational processes cannot resolve
- ensure fit for purpose workforce plans are in place, which enable us to live within our budget and achieve sustainable staffing models. This to include oversight and quality of Medical and Clinical Education, role and service redesign and the safe and sustainable staffing agenda (Education, Learning & Development forum)
- maintain oversight and responsibility for People & OD practices across the whole employee lifecycle, ensuring we are continually improving outcome measures (People Operations forum)
- provide a forum for employee voice to be heard through involvement and advocacy (People & Culture council)
- ensure the health & wellbeing of our team members continues to be supported as an organisational priority (Health & Wellbeing forum)
- ensure continual improvement of people practices and policies and maintain a just culture (Pay Advisory forum and People Management Advisory forum)
- oversee the continual development of an inclusive culture in which equality & diversity is

[1] Jim Collins, Good to Great

embedded into all of our people practices

4 Membership

4.1 The People & OD Group comprises:

- Chair: Chief People Officer
- Associate People Director
- Associate Director of Professional Standards
- Clinical Director (on behalf of CD Group)
- Operations Directors/ Heads of Service or delegated Service Lead / Head of Professions & Quality
- Associate Directors of People & OD
- Heads of People & OD
- Head of Occupational Health & Wellbeing
- Head of Communications
- Director of Finance
- Director of Medical Education

4.2 Members are required to send an appropriate deputy where they themselves cannot attend. Members are expected to have devolved accountability for their lead areas and be aware of the key issues to raise at People & OD Group and to endorse/support People & OD Group decision making. All members are expected to represent the views and requirements of their staff group, Care Group or in the case of the Corporate management rep, the entirety of the Corporate service.

5 Attendees

5.1 The following attendees will be invited when required:

- Other organisational managers and colleagues invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed
- The Chair of the Group will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the function of the Group the Chair will discuss the matter with the members and if necessary seek a substitute or replacement

5.2 The People & OD Group may call upon any employee to attend the meeting

5.3 Executive Directors and members of the senior leadership team have a standing invitation.

6 Chair

6.1 The Chief People Officer will chair the Group. In the absence of the Chair, a nominated deputy will be cover. The Chair of the Group will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the function of the Group the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

7 Secretary

7.1 The administration of the meeting shall be supported by the PA to the Associate People Director or alternative member of Business Support who will arrange to take minutes of the meeting and provide appropriate support to the Chairman and Group members.

7.2 The agenda and any working papers shall be circulated to members five working days before the

date of the meeting.

8 Quorum

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

- The Chair or nominated deputy
- Two members of the Group

9 Frequency

9.1 The People & OD Group will meet on a bi-monthly basis unless the Chair of the Group decides it necessary to alter the frequency of the meeting based on the volume or complexity of business that the Group is asked to consider.

10 Notice of meetings

10.1 Meetings shall be summoned by the secretary of the Group at the request of the Chair.

11 Minutes of meetings

11.1 Minutes of the meeting will be shared with the members following agreement by the Chair.

12 Authority

11.1 The People & OD Group has no powers, other than those specifically delegated in these Terms of Reference.

12.2 The People & OD Group is authorised to:

- To seek any information it requires from any employee of the Trust in order to perform its duties
- To call any employee to be questioned at a meeting of the People & OD Group as and when required
- Seek external expertise where required

13 Reporting

13.1 The Chair will report by exception to the Workforce & OD Committee on a bi-monthly basis via a formal written report.

13.2 The People & OD Group shall make whatever recommendations to the Board/ Trust Management Team it deems appropriate via the report from the Chair (items requiring immediate decision to go direct to the weekly directors meeting).

13.4 The identified forums of the People & OD Group will escalate any matters which require further consideration.

Version	1.0
Approved at Board meeting	
Date of Next Review	

People & OD Group Structure

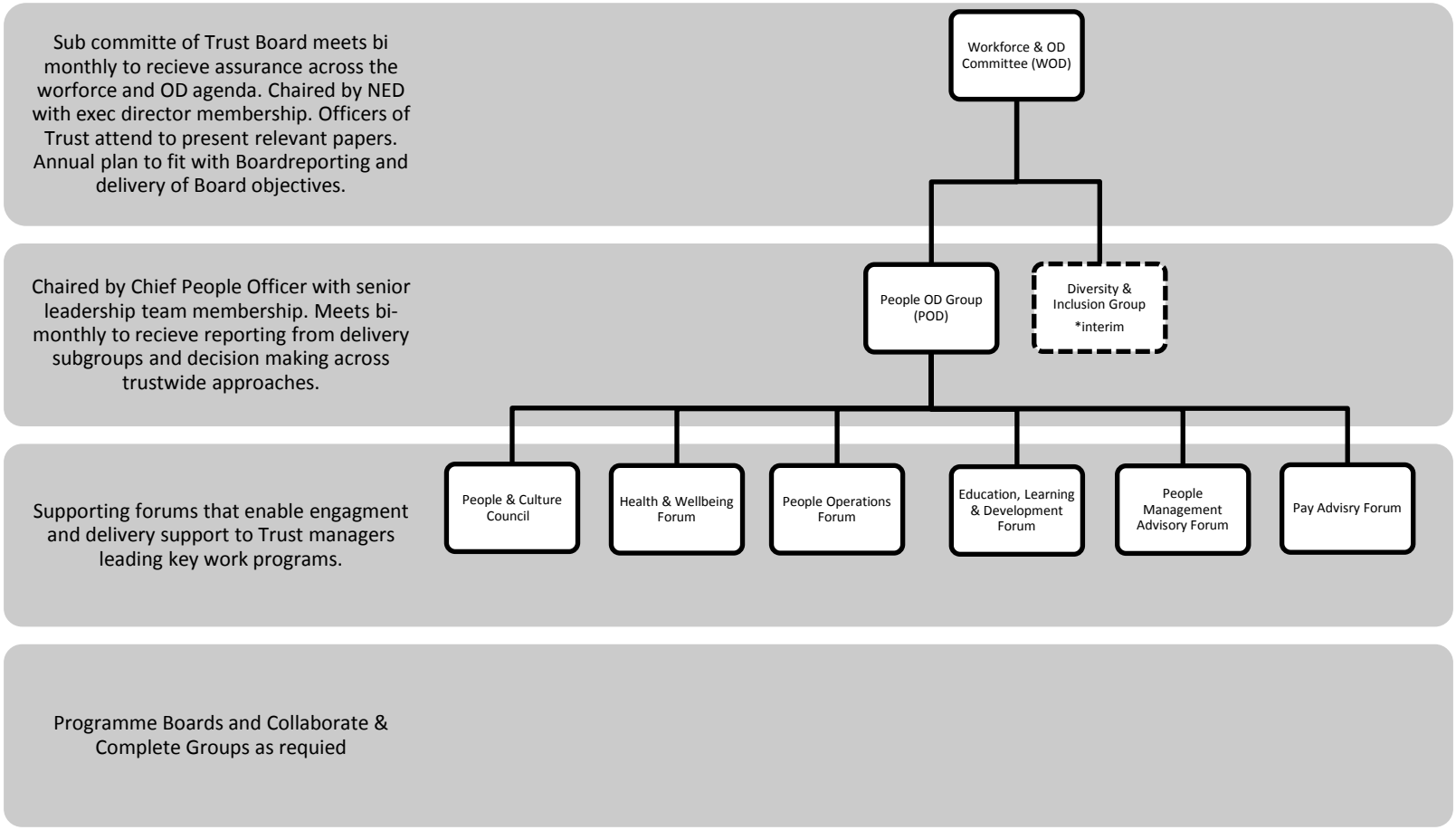


Figure 1 Model of Organisational Effectiveness

Appendix 1 Quality of Conversation framework (Standing Agenda)

The following questions get to the heart of the organisational effectiveness model (see Figure 1) and will form the standing agenda. There will be greater emphasis on some elements depending where we are in the annual business cycle. Assurance will be sought from Care Groups and Corporate Services in the form of a written paper and key issues will be discussed during the meeting. Workforce performance metrics will be tracked in a dashboard.

Workforce Planning
Do we have well founded establishment requirements?
Do we have an informed view of changing workforce requirements?
Is our staffing model sustainable?

Workforce Acquisition
Do we have the required sourcing capability?
Are our Recruitment & Retention plans delivering value?

Workforce Deployment
Do we optimise productivity of the established workforce?
Do we understand the cost of our workforce and are we deriving best value?

Workforce Development
Do we have a clear L&D offer/curriculum and is it appropriately costed/funded/owned?
Are planned learning outcomes being delivered?
Do we have accurate records of learning?

Strategy, Culture & Leadership
Are we creating the right culture and environment to support people to be the best they can?
Do we have the leadership needed at each level of required leadership contribution?
Do we have robust leadership succession plans?
Are our values embedded in our decision-making and behaviours?
Are internal communications effective and engaging?
What scenarios (STP) do we need to strategically plan for and how do we flex our workforce?

Appendix 2 People & OD Group Charter

The People & OD Group members agree to uphold the following charter in order to uphold our values and take action that makes a difference.

- Put the most important items on the agenda
- Check at the beginning of the meeting that the agenda items are the right ones
- Be fully present in the room
- Sense check priority items and support time management
- Work in partnership and don't throw stones
- Call it if we aren't having the courageous conversation
- Speak up if we aren't deriving value from the meeting
- Actively encourage divergent perspectives and opinions
- Commit to having a 15 minute break
- Rate the usefulness of the meeting and agree how to improve next time
- Follow through on agreed actions

18.1

Exception and recommendation report

Committee /Subgroup name	**Community Engagement Committee**	**Dates of meeting**	26 September 2019
Chair	**Stephanie Elsy**	**Report to**	Trust Board

Key issues to be escalated
Community Engagement Strategy Update Progress report submitted (full report to Trust Board) outlining: • Integrated approach to community engagement and diversity and inclusion • Update on priority projects: AMH Portsmouth and Nicholstown Surgery • Draft Diversity and Inclusion Strategy • Research and improvement developments Membership expansion • Community partners (Healthwatch and community reps) have been invited to join the committee. TMT Session Feedback • Additional open space event suggested for leaders in the organisation
Decisions made
As above
Recommendations to the Trust Board
The Board are asked to note: 1. The progress in delivery of the strategy **2.** The request for open space event for leaders
Other risks to highlight (not previously mentioned)
Nil to note

Solent NHS Trust

Item 19

Exception and recommendation report

Committee /Subgroup name	**Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee**	**Date of meeting**	22nd August 2019
Chair	**Mick Tutt**	**Report to**	Trust Board

Key issues to be escalated

We considered, at some length, the **experience for people within the Orchards** and risks posed as a consequence of someone awaiting transfer elsewhere, where the to be receiving service was not as responsive as we aspire to be. Further detail could provide personable identifiable data but can be provided during the confidential part of the Board meeting.

We received a first iteration of **a revised Mental Health Act activity report**, addressing many of the recommendations of the Internal Audit, from PwC regarding the review of the effectiveness of assurance provided for the Board from the committee's scrutiny of Mental Capacity & Mental Health Acts application. We noted that these appeared to generate an additional degree of scrutiny, across committee members, and commended the recently-appointed MC&MHA Lead for these improvements.

Of particular note within the report was the increase in breaches of the Trust internal target for ensuring people detained under the Act understood their rights (**s132**). It must be emphasised that the internal target sets a more exacting threshold for both 'reading people their rights' and documenting this. We explored, in some detail, the challenges posed by this expectation and the current management plans to address the increase. We will continue to monitor compliance.

On a more positive note, the report also demonstrated that there had been a clear and demonstrable reduction in the number of incidents related to exceptions to consent to treatment certificate requirements (**s62**), over the past year. This followed, directly, from the actions of the clinical director; introducing a Quality Improvement programme and providing individual support to specific practitioners

We undertook our standard scrutiny of the **use of restraint and seclusion** where we were provided with assurances that management review confirmed that all incidents were lawful and used approved taught techniques. Additionally, we were assured that all incidents of seclusion were appropriate to the situation and that the policy had been followed. Consequently, the principles of least restrictive interventions were used.

We were briefed on the **emerging implications of the Liberty Protection Safeguards** arising from a recent amendment to the Mental Capacity Act 2005. It was noted that both the MC&MHA Lead and the chair of MHASc were involved at a national level, in discussions regarding the implementation of this significant alteration in which people deemed to lack capacity to consent are managed. Undoubtedly the Board will need to take a view on these implications once greater clarification is available

We noted the recent changes to the panel of **Associate Hospital Managers.**

Decisions made at the meeting
None of note
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 21.1

Exception and recommendation report

Committee /Subgroup name	Audit & Risk Committee	Date of meeting	1st August 2019
Chair	Jon Pittam, Non-Executive Director	**Report to**	Board

Key issues to be escalated

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

- Four large cases of alleged clinical negligence were noted as potential liabilities in the 2018/19 accounts and further clarification and review of governance was requested.
- On behalf of the Director of Finance and Performance, the Financial Controller presented a report outlining **Single Tender Waivers** processed and **Losses and Special Payments** since the last meeting. The rationale for one payment and STWs were provided – these were noted by the Committee. However as there were a large number and value of STWs further consideration would be given to the procurement issues around partnership working and contracting with the voluntary sector
- The Trusts' internal auditors, PwC presented the **Internal Audit 2019/20 Progress Report** – a summary of progress against the 2018/19 Internal Audit Programme is as follows:

Review to be undertaken	Executive Sponsor	Target AC date	Audit Sponsor identified	Scoping meeting(s) held	Terms of reference approved	Fieldwork dates confirmed	Fieldwork completed	Report issued to Solent	Review complete
Key Financial System - Management of activity based income and expenditure	Director of Finance and Performance	January 2020	Completed	Completed	In Progress				
IT Asset management and GDPR follow up	Chief Operating Officer – Southampton and County Services	May 2020	Completed	Completed	In Progress				
Risk Management - Adults (Southampton/Portsmouth	Chief Nurse	May 2020	Completed	In Progress*					
Data Security Protection Toolkit	Chief Operating Officer – Southampton and County Services	January 2020	Completed	Completed	In Progress				
Medicine and pharmacy management	Chief Medical Officer and Chief Operating Officer – Portsmouth and Commercial	October 2019	Completed	In Progress*					
E-Rostering	Chief People Officer and Chief Nurse	October 2019	Completed	In Progress*					
Follow Up of internal audit actions	Director of Finance and Performance	May 2020	Completed						

The Committee noted progress and received the report.
The oversight of the internal audit action tracker was discussed at the meeting, and since the meeting together with the executive team, it has been suggested that Board Committees have oversight of progress of internal audit actions in the same way as Committees oversee relevant Board Assurance Framework risks.

- Ernst & Young presented the **Annual Audit Letter for 2018/19** and the formal unqualified opinion was noted. It was acknowledged that the consultation on the National Audit Office Code of Audit Practice continues, which is likely to result in an increase scope of auditor requirements in respect to Value for Money; consideration to therefore be given to the 2019/20 auditor fees. The EY **Health Audit Committee Briefing** (Q2, June 2019) publication was also received.
- The Committee received the **Fraud, Bribery and Corruption Progress Report** (16th May – 22nd July 2019). The Committee were briefed on work being undertaken to support the National Procurement Exercise – results to be presented to the next Audit & Risk Committee. A forthcoming Cyber Crime awareness event was promoted – which has since been circulated more broadly across the Trust.
  The Committee were informed that nationally 'working whilst sick' remains the top fraud area of investigation – it was agreed that further communication be shared via Managers Matters and Staff News to highlight this matter.
- The Chief Nurse briefed the Committee on the **recent external reviews –** including the CQC

Mental Health Act visit and positive outcome.

- The Committee were informed that the Trust has been asked by Dr Henrietta Hughes, the National Guardian for the NHS, to take part in a case study to share learning on the back of our **Freedom to Speak Up Index Score**, following analysis of our staff survey results. Solent scored 86%, the highest index score for 2018 for combined Mental Health/Learning Disability/ Community Trusts. The highest recorded score across all Trusts was 87%. Dr. Hughes, in her letter, stated that she believes a healthy Freedom to Speak Up culture is a reliable indicator of a high performing organisation. An updated **Freedom to Speak Up self-review tool for Jan –July 2019** was presented and areas of further work were highlighted. The **FTSU Annual Report for 2018-19 and vision and strategy for 2019/20** were shared and supported ahead of presentation to the August Board meeting.
- The Committee reviewed and approved the updated **Audit & Risk Committee Terms of Reference** (Item 21.2 - Appendix 1)
- The Committee considered the anonymised outcome of the recent **committee effectiveness review**

Decisions made at the meeting

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

Recommendations

The Board are asked to formally approve the Audit & Risk Committee Terms of Reference
(The FTSU Annual Report and Vision and Strategy were presented at the August Board meeting).

Other risks to highlight (not previously mentioned)

There are no risks to highlight.

AUDIT & RISK COMMITTEE
TERMS OF REFERENCE

Reference to "the Committee" shall mean the Audit & Risk Committee.
Reference to "the Board" shall mean the Trust Board

1. Constitution

1.1 Solent NHS Trust Board hereby resolves to establish a committee of the Board to be known as the Audit & Risk Committee ('the Committee'). The Committee is a non executive Committee of the Board and has no executive powers, other than those specifically delegated by the Board in these Terms of Reference which are incorporated within the Trust's Standing Orders.

1.2 The Terms of Reference reflect the particular nature of Audit Committees in the NHS and the role of the Committee in developing integrated governance arrangements and providing assurance that NHS bodies are well managed across the whole range of their activities.

2. Purpose

2.1 The Committee is responsible for assuring the Board on matters concerning: governance (including financial governance, corporate governance and clinical audit): risk management; and internal control, seeking assurance from internal and external audit and counter fraud.

3 Duties

3.1 The duties of the Committee can be categorised as follows:

3.2 <u>Governance, Risk Management and Internal Control</u>

3.2.1 The Committee will seek assurance that the Trust's activities are efficient, effective and represent value for money

3.2.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

3.2.3 In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and will review processes to ensure continued compliance with the Care Quality Commission), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including ensuring effective use of the Board Assurance Framework) and the appropriateness of the above disclosure statements.
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud (NHS Protect) and Security Management Service
- the Trust's Quality Accounts

3.2.4 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.2.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.2.6 To formally review, on a quarterly basis, contentious issues as escalated by the Executive Team.

3.3 Internal Audit

3.3.1 The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework.
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise the use of audit resources.
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- monitoring the effectiveness of internal audit and carrying out an annual review
- ensuring the periodic re-tendering of the internal audit function

3.4 External Audit

3.4.1 The Committee shall review and monitor the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment, cost and performance of the External Auditor, as far as the rules governing the appointment process permit
- discussion with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.4.2 In accordance with the Local Audit and Accountability Act 2014, the Committee shall establish an 'Auditor Panel' to advise on the appointment of external auditors (membership of the panel will be approved by the Board). The Panel shall recommend the appointment of external auditors to the Board.

3.4.3 To ensure objectivity and independence, the Committee will agree acceptable thresholds and safeguards for non-audit services conducted by the external auditors. Any such work will be disclosed within the Annual Report. Auditors are expected to identify to the Committee principal conflicts of interest that may be reasonably considered to affect objectivity and independence.

3.5 Other Assurance Functions

3.5.1 The Audit & Risk Committee shall review the findings of other significant assurance reviews, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g NHS Improvement/England, CQC, NHS Resolution etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

3.5.3 In reviewing the work of the below listed committees, and issues around clinical risk management, the Audit & Risk Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

3.5.4 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. The Committee may request that the Chairs of the following Board committees attend to provide exception reports;

Committees include:

- Governance & Nominations Committee
- Remuneration Committee
- Assurance Committee
- Finance Committee
- Mental Health Act Scrutiny Committee
- Charitable Funds Committee
- People and OD Committee

3.5.5 The Audit & Risk Committee will also scrutinise the annual governance review of the Board Committees conducted by the Governance & Nominations Committee, satisfying itself that committees are appropriately constituted and functioning in accordance with their Terms of Reference.

2.5.6 The Committee will also annually review the accounting policies of the Trust and make appropriate recommendations to the Board.

3.6 Counter Fraud

3.6.1 The Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.7 Management

3.7.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.7.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit) as may be appropriate to the overall arrangements.

3.8 Financial Reporting

3.8.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

3.8.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.8.3 The Committee shall review the annual report/accounts and financial statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted miss-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- qualitative aspects of financial reporting
- reported losses and compensation

3.8.5 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.9 Whistleblowing /Freedom to Speak Up

3.9.1 The committee shall review the effectiveness of the Trust's arrangements for its employees to raise concerns, in confidence, about possible improprieties in financial, clinical or safety matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

4 Membership

4.1 The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members at least one of whom shall have recent and relevant financial experience. One of the members will be appointed Chair of the Committee by the Trust Board

4.2 The Chairman of the Trust Board shall not be a member of the committee.

4.3 In the absence of the Committee Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5 Quorum

5.1 The quorum necessary for the transaction of business shall be 2 members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

6. Attendance

6.1 The following officers will have an open invitation to each meeting, unless otherwise informed by the Committee Chair (or when the Committee meets privately):

- The Director of Finance
- The Chief Executive
- The Chief Nurse
- Representatives from Internal Audit, External Audit and Counter Fraud
- The Associate Director of Corporate Affairs and Company Secretary
- The Independent Freedom to Speak Up Guardian

7 Access

7.1 The Head of Internal Audit, representative of external audit, counter fraud specialist and FTSU Guardian have a right of direct access to the Chair of the Committee.

8. Frequency

8.1 The Committee shall meet at least on a quarterly basis at appropriate times in the reporting and audit cycle and otherwise as required.

8.2 The Committee will meet in private with External and Internal Audit representatives without any member of the Executive present on at least one occasion each year.

8.3 The Accountable Officer, external auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

9. Authority

9.1 The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information it requires from any employee of the Trust in order to perform its duties and all employees are directed to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

10. Secretary

10.1 The Corporate Support Manager & Assistant Company Secretary or their nominee shall act as the secretary of the committee and will provide administrative support and advice**.** The duties of the secretary in this regard include but are not limited to:

- agreement of the agenda with the Chair of the Committee and attendees together with the collation of connected papers
- taking the minutes and keeping a record of matters arising and issues to be carried forward
- advising the Committee as appropriate

10.2 The agenda and any working papers shall be circulated to members five working days before the date of the meeting. No papers will be accepted after the original documentation is circulated – except with the express consent of the Chair.

11. Minutes of meetings

11.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

11.2 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly**.**

11.3 Minutes of Committee meetings shall be circulated promptly to all members of the Committee once agreed.

12. Reporting responsibilities

12.1 The Committee Chair shall submit an escalation report to the Board, together with recommendations where appropriate. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the Board, or require executive action.

12.2 The Committee will recommend to the Board the approval of the Accounts and Quality Accounts.

12.3 The Audit & Risk Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to:

- providing an objective opinion to the Board on the performance of all of the Board Committees (and as included within the Annual Report)
- functions undertaken in connection with the statement of internal control
- the assurance framework
- the effectiveness of risk management within the Trust
- the holistic nature of governance arrangements and
- any pertinent matters in respect of which the Audit & Risk Committee has been engaged

12.4 The Committee shall make necessary recommendations to the Board on areas relating to the appointment, re-appointment and removal of auditors, the level of remuneration and terms of engagement as it deems appropriate.

12.5 The Trust's Annual Report shall include a section describing the work of the Audit & Risk Committee in discharging its responsibilities and the Committee's Terms of Reference will be made publicly available. The Annual Report should explain to members:

- how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded
- details of the full external auditor appointment process
- where the Board decides not to accept the recommendations of the Committee with regard to the appointment of an auditor, a statement of the reasons
- where the auditor's contract is terminated in disputed circumstances, the removal process and the underlying reasons for that action.

12.6 Members attendance at Committee meetings will be disclosed in the Trust's Annual Report.

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Agreed at Audit & Risk Committee	Date: 1st August 2019
Date of Next Review	Date: August 2020