Item 18.1

Board Report – In Public Meeting

Title of Paper	**Information Governance Annual Report inc. Caldicott Guardian Annual Activity/Assurance Reports**				
Author(s)	Sadie Bell, Head of Information Governance		**Executive Sponsor**	Mandy Rayani, Chief Nurse Dr Daniel Meron, Chief Medical Officer	
Link to strategic Objective(s)	X	Improving outcomes		Working in partnership	X Ensuring sustainability
Date of Paper	12TH May 2017		**Committees presented**	N/A	
Action requested of the Board	X	To receive		For decision	
References	Information Governance Annual Report has also been presented at the May 2017 Assurance Committee				

Information Governance Annual Report: The purpose of this paper is to provide the Board with assurance that the Trust submitted a compliant IG Toolkit Submission for 2016/17 and identify current compliance with legal Requirements outlined in the Freedom of Information Act 2000 and data Protection Act 1998 (Subject Access Requests). The other purpose of this report is to identify the Trusts current level of IG incidents and the impact of this, within the Trust.

The report outlines a number of recommendations, under each section of the report

Caldicott Guardian Annual Report: Activity and plan to be noted and assurance provided that standards re being meet.

Board Recommendation

The Board is asked to review all reports and consider assurance the recommendations made, to assess if it feels that these are adequate enough to improve compliance.

In addition to this though there are three key considers for the Board, within the Information Governance Annual Report.

Subject Access Requests; consider the three options available with regards to the governance and processing of requests and the administrative burden this would have on clinical service lines. Identify a supported option

IG Toolkit; As Solent NHS Trust is now an established organisation it should be aiming to achieve Level 3 in the majority of, if not all, requirements of the IG Toolkit. This will ensure that the Trust is compliant with Caldicott 2 and prepared for the higher standards of compliance which come with the General Data Protection Regulations (2018). The Trust needs to make a decision if this is something they feel should be undertaken in 2017/18. A resource review will need to be undertaken to see what Solent NHS Trust can achieve with current IG resources and where not possible to achieve with current resources what is needed to achieve this. This will directly link with the General Data Protection Regulations (GDPR) IG Resource review

GDPR; The Data Protection Officer will need to undertake an IG Resource Review, to assess if adequate resources are available to successfully implement the Regulations and other requirements outlined in this report (IG Toolkit & Subject Access Requests). This report will be presented to Board at a later date.

Summary information and key points for the IG Annual Report

Please note Pg 3 – 10 of this report is content and pg 11 – 19 is the supporting data

IG Toolkit

- Solent NHS Trust declared at the end of the financial year that it was at least level 2 compliant with **all** requirements
- The Trust's compliance with regards to the 12 requirements linked to the Caldicott 2 Report, identify that the Trust is **working towards** the implantation of the Caldicott 2 Report, as the Trust has only reached the minimum requirement of Level 2 compliance.

IG Incidents

- In 2016/17, 310 IG Incidents were reported; of which 41 were HRIs and 12 SIRIs
- The top three reported Information Governance Breaches in 2016/17 were;
  - PID sent to wrong address / person
  - PID in wrong record
  - PID saved / sent insecurely
- The number of incidents reported has decreased each quarter and the impact of the incidents has reduced, due to measures put in place.
- Due to the success of bespoke training, monthly communications through the IG Newsletter and fortnightly IG scenarios sent to all staff, has had in reducing the number of Information Governance incidents reported each quarter and heightened awareness of Information Governance in working practices, Solent NHS Trust will continue with this type of awareness and have designed a new refreshed Information Governance Training programme.

Subject Access Requests

- Current compliance over the last four quarters currently ranges between 80%-90%.
- The IG Team hope to achieve an overall year compliance level of at least 85% once the remaining requests have been closed.
- The Trust has undertaken one SIRI investigation relating to the processing of a subject access request, which has also highlighted complaints that have been received by the IG Team, with regards to requests being sent incomplete by service lines.

FOI Requests

- The ICO have stated that compliance on FOI's should not fall below 85%.
- Solent NHS Trust's overall compliance to date is 87.3% (to date)

GDPR

- The Trust is currently working towards appointing a Data Protection Officer, who will undertake the implementation of the GDPR Action Plan and once implemented enforce the Regulations within the Trust.
- The Data Protection Officer will need to undertake an IG Resource Review, to assess if adequate resources are available to successfully implement the Regulations and other requirements outlined in this report (IG Toolkit & Subject Access Requests).

All embedded documents within the Caldicott Guardian Annual Report and Plan 2016/2017 are available via the Supplementary Papers pack.

Solent NHS Trust

Item 18.2

Information Governance

Information Governance Assurance Report Quarter 4 – End of Year Submission Report 2016/17

Author: **Sadie Bell**
Head of Information Governance

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1. Purpose

1.1 The purpose of this report is to provide the Trust with a detailed report of the Trust's current Information Governance compliance, with both Law and National 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 or 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; ,
- Information Governance Toolkit Submission, V14, 2016/17
- Incidents
- Subject Access Requests (Requests for personal information / records) compliance
- FOI compliance
- Implementation of the new General Data Protection Regulations (to be fully implemented by May 2018)

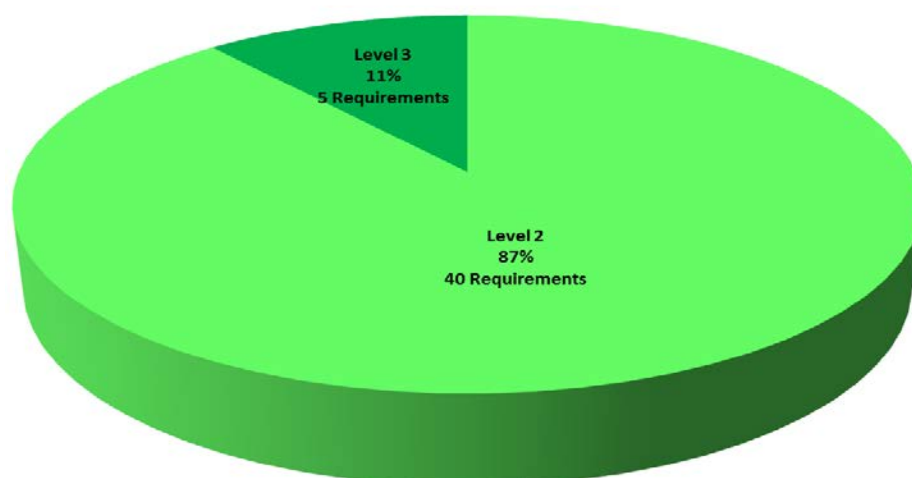
2. Information Governance Toolkit Submission 2016/17

In order to be compliant within the Information Governance Toolkit, Solent NHS Trust must achieve Level 2 or above in all 45 requirements. Solent NHS Trust declared at the end of the financial year that it was at least level 2 compliant with **all** requirements.

A full breakdown of the Trust's compliance can be found in Appendix A.

2.1 Summary of Results:

Requirement Section	Total No. Requirements	No. Requirements Level 2	No. Requirements Level 3
Information Governance Management (100's)	5	3	2
Confidentiality & Data Protection (200's)	9	9	0
Information Security Assurance (300's)	15	14	1
Clinical Information assurance (400's)	5	4	1
Secondary user Assurance (500's)	8	7	1
Corporate Information Assurance (600's)	3	3	0
Totals	**45**	**40**	**5**



2.2 IG Toolkit and the Caldicott 2 Report

The Caldicott 2 Report has been incorporated into the IG Toolkit.

Caldicott 2 is requirements are covered within 12 key requirements of the IG Toolkit. In order to be fully compliant with Caldicott 2, the Trust must achieve Level 3 in **all 12** of these requirements.

The achievement levels are;

- Has **fully implemented** a Caldicott 2 recommendation - **level 3**.
- Is **working towards** implementation of a Caldicott 2 recommendation - **level 1 or 2**
- Has **not started** implementing a Caldicott 2recommendation - **level 0**.

Compliance with Caldicott 2 IG Toolkit Requirements – V14, 2016/17

Req	Current Compliance Level
101	**2**
200	**2**
201	**2**
202	**2**
203	**2**
205	**2**

Req	Current Compliance Level
206	**2**
207	**2**
300	**2**
302	**2**
307	**1**
400	**2**

2.3 Overall Compliance Statement

Solent NHS Trust's overall Information Governance IG Toolkit compliancy score for 2016/17 was 70% and was graded as Green – Satisfactory. This is a slight decrease compared to 2015/16's compliance score of 73%.

The Trust's compliance with regards to the 12 requirements linked to the Caldicott 2 Report, identify that the Trust is **working towards** the implantation of the Caldicott 2 Report, as the Trust has only reached the minimum requirement of Level 2 compliance.

2.4 Next Steps

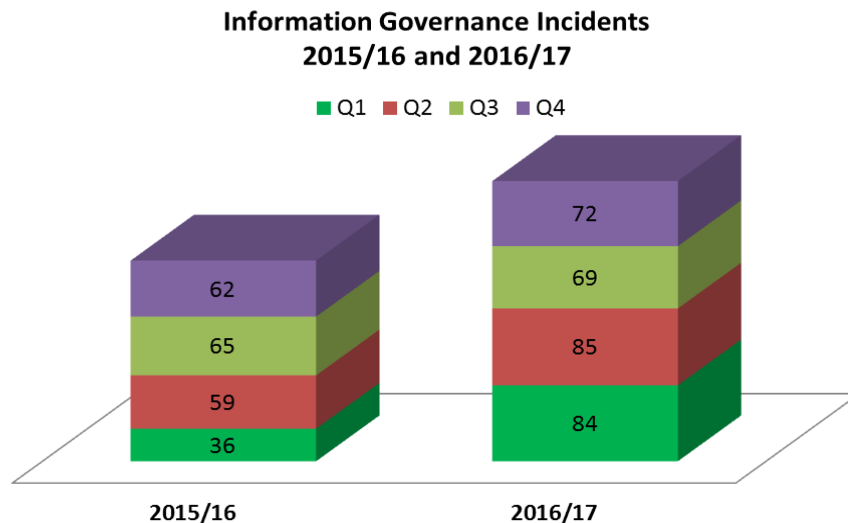
As Solent NHS Trust is now an established organisation it should be aiming to achieve Level 3 in the majority of, if not all, requirements of the IG Toolkit. This will ensure that the Trust is compliant with Caldicott 2 and prepared for the higher standards of compliance which come with the General Data Protection Regulations (2018). In addition to this, being Level 3 compliant will ensure that the Trust is able to demonstrate a higher level of compliance, which will provide patients with greater trust that Solent NHS Trust ensure that their information is kept secure and appropriately used. This will also provide the Trust with a competitive advantage, as a fully compliant Trust, with regards to Law and National Requirements.

Level 2 = Implementation of standards
Level 3 = Assessment, Review and Testing of implementation, to provide assurance that standards are not only implemented, but abided by.

A resource review will need to be undertaken to see what Solent NHS Trust can achieve with current IG resources and where not possible to achieve with current resources what is needed to achieve this. This will directly link with the General Data Protection Regulations (GDPR) IG Resource review, which has been identified as part of the Trust's GDPR action plan.

3. Information Governance Incidents

3.1 IG Incident Trends



Comparing the number of incidents reported in 2015/16 (222, average of 56 per quarter) to the number of incidents reported in 2016/17 (310, average of 78 incidents per quarter), it identifies that the Trust has increased the number of incidents reported by 40%. However the number of incidents reported each quarter is decreasing.

Trends:

IG Incidents – Main Issues					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Stolen Notes/PID	1	1	0	0	2
Lost Notes/PID	9	9	5	6	29
PID sent to wrong address / person	24	22	22	16	84
PID in wrong record	12	12	9	5	38
Records Error	5	9	7	5	26
PID Saved / Stored Insecurely	11	7	8	9	35
NHSMail not used for PID	1	0	0	5	6
Post Issues (way in sent/received)	3	1	0	4	8
PID found in public place	1	0	1	0	2
Breach by staff - Deliberate	0	0	0	1	1
Breach by staff - Unintentional	2	7	3	6	18
Printing Issues (left on printer / wrong printer)	3	7	4	2	16
Cyber Security	0	0	0	0	0
Other	12	10	10	13	45
Total	**84**	**85**	**69**	**72**	**310**

An additional 197 incidents with a minimal impact or out of Solent NHS Trust's control were also reported in 2016/17. Although these incidents are considered to be out of Solent NHS Trust's control they are still reported and monitored, as they could impact upon our data, patients and care provided.

IG Incident – Low Risk Incidents					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Lost Smart Card / ID Badge	6	6	6	8	26
System Error	42	17	20	27	106
Out of our control	14	23	16	12	65
Total	**62**	**46**	**42**	**47**	**197**

Appendix B: Service Line Breakdown

3.2 High Risk Incidents and Serious Incidents Requiring Investigation

High Risk Incidents (HRI): There were forty-one HRI's this financial year. This a double the number of incidents reported in 2015/16;

- Adult Mental Health – 2
- Adults Portsmouth – 3
- Adults Southampton – 6
- Child & Family – 17
- Corporate – 3
- Dental – 1
- Primary Care – 8
- Sexual Health – 1

Serious Incidents Requiring Investigation (SIRI): There were twelve SIRI's this financial year, which is a slight increase of one, when compared to 2015/16;

- Adult Mental Health – 3
- Adult Services Portsmouth – 1
- Child & Family – 6
- Corporate – 1
- Primary Care – 1

3.3 Summary

Information Governance incidents is a topic that Solent NHS Trust monitors closely and respond to in accordance to trends; As a result of this the Information Governance Team introduced bespoke tailored Information Governance Training in 2016/17, delivered through a mixture of online training and face-to-face training. This training heightened staff's awareness of how Information Governance effects staff's work at a service level, what to do to prevent incidents and also what type of incidents to report, this lead to spikes in reporting.

Information Governance Breaches have declined quarter on quarter, with the exception of Q4, which saw a slight spike, associated with an increase in incidents reported by Primary Care Services, where the majority of staff were trained in IG within Q4; therefore we would expect to see a spike in reporting.

The top three reported Information Governance Breaches in 2016/17 were;
- PID sent to wrong address / person
- PID in wrong record
- PID saved / sent insecurely

Although with all three of these categories, the number of incidents reported decreased each quarter and the impact of the incidents have reduced due to measures put in place.

The main areas of concern for both HRI's and SIRI's are;
- The secure transferring, sending and storage of Personally Identifiable Data (PID)
- Staff Breaches, both intentional and unintentional
- Records Management

Due to the success of bespoke training, monthly communications through the IG Newsletter and fortnightly IG scenarios sent to all staff, has had in reducing the number of Information Governance incidents reported each quarter and heightened awareness of Information Governance in working practices, Solent NHS Trust will continue with this type of awareness and have designed a new refreshed Information Governance Training programme.

3.4 Recommendations

- IG Team to continue to undertake
    - quarterly IG incident trending and assess the best way to prevent reoccurrence
    - provide bespoke IG Training & Awareness, as this has proved to be successful in raising staff awareness.
    - with lesson learnt based IG scenarios in Staff News and IG Newsletter
- IG Team to assess different ways of ensuring shared learning from incidents is cascaded to staff.

4. Summary of Information Governance's Legal Requirements Compliance

4.1 Subject Access Requests / Request for Personal Information Compliance Overview: Performance:

	Q1, 2016/17	Q2, 2016/17 *TBC	Q3, 2016/17 *TBC	Q4, 2016/17 *TBC	Year Total to date 2016/17
Number of requests received	191	160	170	187	708
Number of requests responded to within 21 days (best practice)	101 (53%)	94 (59%)	105 (61%)	94 (50%)	394 (55.7%)
Number of requests responded to within 40 days	51 (27%)	39 (24%)	40 (24%)	17 (9%)	147 (20.8%)
Number of breaches (in excess of 40 days)	39 (20%)	25 (16%)	22 (13%)	6 (3%)	92 (12.9%)
Number of breaches (RECORDS LOST)	0 (0%)	0 (0%)	0 (0%)	1 (1%)	1 (0.1%)
Not Due	0 (0%)	2 (1%)	3 (2%)	69 (37%)	74 (10.5%)

* final figures are subject to change, as some requests are currently not due to date.

	2016/17**	2015/16
Total	**634**	**881**
Total Compliance	541 (85%)	731 (83%)
No. breaches (in excess of 40 days)	94 (15%)	150 (17%)

**figures are total number of requests, minus those requests who are currently not due, to show current level of compliance. Final figures are subject to change once outstanding requests are closed.

Service Line Management	No. Request	Breaches	2016-2017 % Compliance***	2015-2016 % Compliance
Adult Services – Portsmouth	16	4	75%	80%
Adult Services – Southampton	27	5	81%	84%
Adult Mental Health	91	11	88%	84%
Children Services	107	16	85%	78%
Dental	14	0	100%	90%
Primary Care	222	45	80%	82%
Sexual Health	42	1	98%	80%
Coporate	21	3	86%	86%
Redirected Requests	94	7	90%	94%
Total	**634**	**94**	**85%**	**83%**

***figures are total number of requests, minus those requests who are currently not due, to show current level of compliance. Final figures are subject to change once outstanding requests are closed.

Summary:

The number of SAR Requests received within in a financial year has decreased slightly, however this will be due to Solent NHS Trust no longer receiving requests (or at least very rarely) for Walk-in Centre and Minor Injury Unit requests, which previously contributed to a large number of requests.

Current compliance over the last four quarters currently ranges between 80%-90%. The IG Team hope to achieve an overall year compliance level of at least 85%% once the remaining requests have been closed. Q4's compliance currently sits at the highest it has been in the last year, at 94% and overall compliance to date has increased, when compared to 2015/16; this is evidence that the Subject Access Request monitoring process is working.

In terms of Service Line Management (SLM) compliance, in most service lines, compliance levels are increasing. When compared to 2015/16. However some Service Lines compliance has decreased slightly;

- Adult Services Portsmouth
- Adult Services Southampton
- Primary Care
- Corporate

It is important to note that the Trust has undertaken one SIRI investigation relating to the processing of a subject access request, which has also highlighted complaints that have been received by the IG Team, with regards to requests being sent incomplete by service lines.

The Trust needs to consider if the current process for governing and responding to requests, is adequate or if the process needs to be changed, to increase compliance and reduce the administrative burdening on clinical services. It is also important to note that from May 2018 the Trust will have less time to respond to requests (currently 40days and will reduce down to 30days) and will become free (the Trust should expect an increase in requests), it is therefore expected that without changes to process, compliance levels will decrease.

There are three options available;

1. No change required; compliance is currently 85% and therefore this is not an adequate position or option
2. Service Lines who are not fully compliant are to identify adequate resources within the service line to process requests. Staff responsible for processing and / or signing off requests are provided additional training. Escalation of breaches are to be escalated to Operational and Clinical Directors. This option is still an administrative burden on clinical services and will require extra resources within Service Lines, to ensure compliance levels increase.
3. Centralise the Subject Access Request process within the IG Team. The IG Team currently provide the governance and monitoring aspects of this process and offer expert advice. By centralising the process within the IG Team the Trust will benefit further from this expert advice, control the time taken to respond to the request, ensure all information releasable under the law is collated, redacted and prepped ready for sign-off by a clinician. The IG Team will also be able to triage the request and advise the clinician of how much time needs to be set aside to sign off a case e.g. a direct patient request with no redaction – small amount of time; a complex case with multiple redactions and parent responsibility issues – additional amount of time required. This option will reduce the administrative burden with the clinical services. However for this option to be viable and absorbed within the IG Team, resources and allocation of work will need to be reviewed within the IG Team and included as part of the GDPR IG Resource Review, as indicated in the GDPR Action Plan.

4.2 Freedom of Information Compliance Overview:

In 2016/17 the Trust received a total of three hundred and three, with thirty-eight requests breaching (to date – four are currently not due); processes are continuously monitored and amended to reduce the risk of further breaches.

The number of FOI Requests received within in a financial year has increased by 41%, when comparing 2016/17 to 2015/16.

Month	April	May	June	July	August	Sept
No. Requests	26	24	26	30	32	24
No. Breaches	3	3	3	2	4	2
No. Not Due	0	0	0	0	0	0
% Compliance	88%	88%	85%	93%	87.5%	91.6%

Month	Oct	Nov	Dec	Jan	Feb*	Mar*
No. Requests	26	16	19	24	27	29
No. Breaches	7	3	4	2	1	4
No. Not Due	0	0	0	0	1	3
% Compliance	73%	81.3%	79%	91.6%	96.2%	84.6%

*March's figures have are subject to change, due to requests currently not being due

The ICO have stated that compliance on FOI's should not fall below 85%. Solent NHS Trust's overall compliance to date is 87.3%. Last year's compliance 2015/16 was 92.5%, therefore the Trust's compliance has decreased.

The Information Governance Team continues to work on reducing the burden of FOI's requests on services and reduce breaches by;

- the IG Team will also be requesting confirmation from services within two working days, that information is held and identifying if clarity on the request is required
- identifying the Frequently Asked Questions/Requests
- working with the services to see if we can annually publish data
- refer requestors to already published data

However as a result of the number of requests received continuing to increase; this has made little impact on improving compliance; although there are other factors that continue to impact the Trusts ability to improve compliance, e.g.

- Service sending incomplete responses back to the IG Team
- IAO's not approving responses prior to them being sent to the IG Team, so requests are being sent back
- Delays in the sign-off process

Recommendations:

The IG Team have will undertake the following actions to increase compliance to 100%;

- Request handlers to ensure that FOI disclosure being submitted to the IG Team is the full disclosure and not part disclosure
- Request handlers to ensure IAO has approved FOI disclosure prior to disclosure being submitted to the IG Team
- Ensuring that reminder emails and communications are sent
- Publication scheme and public facing website to be updated to allow similar requests to be populated by the IG team or redirected to the website, relieving pressure off services where applicable.
- Continued work with service lines to ensure that appropriate IAO's and request handlers are identified to receive requests within two working days.
- IG Team to review sign off process, to ensure it is sufficient and deadlines are met.

5. General Data Protection Implementation

In May 2018 the new General Data Protection Regulations will come into force.

What has changed?

1. **Data Subjects will notice more empowerment:**
- Wider rights of subject access and information about processing
- Greater transparency about processing, and,
- Stricter conditions for consent and right to object

2. Organisations will notice the **focus on increased accountability and pro-active, evidence-based compliance**
- Thorough risk assessments, and the principles of 'privacy by design' and 'data protection by default'
- Requirement to maintain accurate records of all data processing activities,
- Increased regulatory enforcement powers and penalties
- Stricter breach notification to regulators and to individuals affected

What actions have been undertaken and next steps?

The Trust has placed the implementation of these new Regulations on the Trust's Risk Register and identified an action plan to mitigate this risk.

See Appendix C – GDPR Action Plan & Updates

The Trust is currently working towards appointing a Data Protection Officer, who will undertake the implementation of the GDPR Action Plan and once implemented enforce the Regulations within the Trust.

Once this step has been completed, the Data Protection Officer will need to undertake an IG Resource Review, to assess if adequate resources are available to successfully implement the Regulations and other requirements outlined in this report (IG Toolkit & Subject Access Requests). The paper will identify the standard of compliance that can be achieved with current resources e.g. satisfactory / adequate, excellent, outstanding, etc…; the Trust would need to make a decision on the standard of compliance it is happy to accept. Although the standard of compliance is optional, the implementation of the Regulations is not and additional resources to implement the GDPR may be required.

Appendix A: IG Toolkit Compliance Breakdown

Req No	Description	Attainment Level
Information Governance Management		
101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Level 2
105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Level 2
110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Level 2
111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Level 3
112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Level 3
Confidentiality and Data Protection Assurance		
200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Level 2
201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Level 2
202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Level 2
203	Individuals are informed about the proposed uses of their personal information	Level 2
205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Level 2
206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Level 2
207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Level 2
209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Level 2
210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Level 2
Information Security Assurance		
300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Level 2
301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Level 2
302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Level 3
303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Level 2
304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Level 2
305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Level 2
307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Level 2

308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Level 2
309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Level 2
310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Level 2
311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Level 2
313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Level 2
314	Policy and procedures ensure that mobile computing and teleworking are secure	Level 2
323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Level 2
324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Level 2
Clinical Information Assurance		
400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Level 2
401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Level 2
402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Level 2
404	A multi-professional audit of clinical records across all specialties has been undertaken	Level 2
406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Level 3
Secondary Use Assurance		
501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Level 2
502	External data quality reports are used for monitoring and improving data quality	Level 2
504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Level 2
506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Level 2
507	The Completeness and Validity check for data has been completed and passed	Level 2
508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Level 2
514	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	Level 3
516	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	Level 2
Corporate Information Assurance		
601	Documented and implemented procedures are in place for the effective management of corporate records	Level 2
603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Level 2
604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Level 2

Appendix B: Incidents broken down by Service Line Management

	Adult Mental Health	Adults, Portsmouth	Adults, Southampton	Children Services	Dental	Primary Care	Sexual Health	Corporate
Q1	7	6	12	29	3	9	9	9
Q2	8	9	9	33	2	14	4	6
Q3	5	8	5	24	3	8	7	9
Q4	1	7	6	19	2	18	11	8
Total	**21**	**30**	**32**	**105**	**10**	**49**	**31**	**32**

* Minus minor IG issues

In 2016/17 the main service line who reported the most Information Governance incidents was Children Services (105 incidents). The remaining service lines averaged approx. 30 incidents, with Dental and AMH being below average.

Children Services: The main Information Governance Breaches are PID sent to the wrong address / person. The service line have introduced processes and procedures, to reduce the number of these incidents reported, but further documentation, communication and awareness of these processes are required.

	Q1	Q2	Q3	Q4	Total
Lost Notes/PID	1	3	1		**5**
PID sent to wrong address / person	14	13	11	5	**43**
PID in wrong record	5	7	1	3	**16**
Records Error	1	1	3	2	**7**
PID Saved/ Stored insecurely	3	2	4	2	**11**
NHS Mail not used for PID				2	**2**
Post Issues (way in sent/received)		1		3	**4**
PID found in public place			1		**1**
Breach by Staff - Unintentional	2	2	1	1	**6**
Printing Issues (left on printer / wrong printer)	1				**1**
Other	2	4	2	1	**9**
Total	**29**	**33**	**24**	**19**	**105**

Appendix C: GDPR Action Plan

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Status
Assurance Committee & Board to be made aware of the new Regulations, what has changed, what the impact is, any resource implications.	**Awareness**	This paper will act as awareness to Assurance Committee and Board	January 17	Head of Information Governance	**Completed**
The GDPR should be placed on the Trust's Risk Register, until actions are completed and updates on progress reported to Assurance Committee & Board on a monthly basis	**Awareness**		Jan 17 – Apr 18	Head of Information Governance	**Completed**
Appointment of the Data Protection Officer Role, with the appropriate accountability and responsibility. The role will have professional accountability to the CEO and Board and will need to advise Board on all decisions that may directly or indirectly impact upon personally identifiable or special category data.	**Data Protection Officer**	This role needs to be reported to ahead of May 2018, as they will be mandated to undertake all the preparation work for the organisation, to ensure that they are fully compliant with this action plan and the GDPR no later than May 2018	Jan 17 – Apr 17	Chief Executive	**In Progress** – Job Description is currently awaiting banding and sign-off
Review of Corporate Record Inventory and a documented list of all information held on our Network Drives to be undertaken. Ensuring retention dates are associated with all documents. **Review of resources required for this piece of work will need to be undertaken in advance to this**	**Information You Hold** **Data Protection by Design**	Existing Corporate Record Inventory in place, but these are not necessarily comprehensive Work on Network Drives being undertaken in preparation for SharePoint, but	Apr 17 – Dec 17	Data Protection Officer (once appointed)	In Progress – Collection of information has commenced. The IG Team / SharePoint Project Manager are currently requesting Bank Staff to undertake the Network Drive

		retention dates have not been assigned to archived data			work
Tighter monitoring of IG incidents required and reporting to Board Review of the IG Risk Policy All SIRI Breaches to be reported to ICO within 72hrs	**Data Breaches**	IG Risk Policy in place	Apr 17 – May 17	Data Protection Officer (once appointed)	**To Commence** – A review of the IG Risk Policy and SIRI process has not yet commenced. **In Progress** - IG Incidents and key summary information on IG incidents will form part of the IG update on the CEO report that goes to Trust Board. **Completed** - A detailed annual report will be submitted to Board
Review of all Existing Information Sharing Agreements, to ensure that information sharing arrangements comply with the new requirements and restrictions of the GDPR. Ensuring that all legal basis(s) are documented. In particular assess any data sharing that is currently undertaken without consent and under “best interest” to	**Legal Basis for Processing Personal Data**	Information Sharing Agreement and Privacy Notices already in place	June 17 – Aug 17	Data Protection Officer (once appointed)	

ensure it meets the new requirement of “vital interest”. Revised agreements to be put in place and signed off by all parties					
PIA Procedure needs to be tightened and this made Policy. Need to embed a culture that these are undertaken as routine and presented to the Data Protection Officer for Implementation. Early involvement and sign off by the Data Protection Officer is key Data Protection Officer to attend Service Line Governance Meetings and Board to advice on all decisions that may directly or indirectly impact upon personally identifiable or special category data. Review of PIA Template required	**Data Protection by Design and Data Protection Impact Assessments**	Privacy Impact Assessment Procedure in place	Apr 17 – Dec 17	Data Protection Officer (once appointed)	**To commence**
All Contracts for data processing are to be reviewed, to ensure that the legal basis is documented and Information Sharing Agreements are included, outlining every step of data processing and the returning / destruction of data, when contract is terminated	**Legal Basis for Processing Personal Data**		Jul 17 – Sept 17	Data Protection Officer (once appointed)	
All Contractors, contracted for data processing are to have their Data Protection Compliance and evidence reviewed in line with the new GDPR compliance	**Legal Basis for Processing Personal Data**	Some evidence is currently collected, but this needs to be strengthened and where not available, the organisation	Jul 17 – Sept 17	Data Protection Officer (once appointed)	

		needs to consider terminating the contracts			
Preventative work needs to be planned and implemented. Resources need to be reviewed to ensure that the Trust has adequate resources to prevent Data Breaches	**Data Breaches**		May 17 – May 18	Data Protection Officer (once appointed)	
Review of all consent processes, to ensure that consent is freely given, specific, informed and unambiguous. Implied consent is no longer acceptable. The GDPR is also clear that controllers must be able to demonstrate that consent was given – review processes in terms of verbal consent New consent processes need to be fully embedded within organisational culture by May 18	**Consent**		May 17 – May 18	Data Protection Officer (once appointed) Head of Information Systems	
Review Data Flow Mapping and Information Sharing Review, to ensure that all data held, transferred and shared are documented and appropriate legal arrangements, processes and agreements are in place. Where not in place these need to be implemented	**Information You Hold** **Legal Basis for Processing Personal Data**	Existing reviews in place, but these are not necessarily comprehensive	Aug 17 – Oct 17	Data Protection Officer (once appointed)	
Assess Subject Access Request processes, and the suspected increase in demand, to ensure the Trust can comply and has adequate	**Individuals Rights** **Subject Access**	Subject Access Request processes already in place, but need to be amended	Jul 17 – Aug 17	Data Protection Officer (once appointed)	

resources Ensure that all our patients and staff are aware they can access their records for free from May 18	**Requests**	to reflect changes, such as demand, time to process requests reduced, cost removed, etc…			
Expand upon Privacy Notice, to ensure that it meets the new legal requirements Ensure that the Privacy Notice is written in a language that children will understand (Children aged 13+ can give consent, where deemed capable) Must document all data held, for what purpose, whom it is shared with, how it is stored, who has access to it and how long it is held for. This is to be made public Create an Internet Page "Your Information, Your Rights"	**Legal Basis for Processing Personal Data** **Children** **Communicating Privacy Information**	Privacy Notices already in place	January 18	Data Protection Officer (once appointed)	
Assess processes in place regards perceived "inaccuracies of data" and how these can be "corrected"	**Individuals Rights**		Jan 18 – Mar 18	Data Protection Officer (once appointed)	
Implement processes to comply with the "Right to be forgotten – erased"	**Individuals Rights**		Jan 18 – Mar 18	Data Protection Officer (once appointed)	
Review all IG policies in line with the GDPR	**Data Protection by Design**		Jan 18 – Apr 18	Data Protection Officer (once appointed)	
Implement new Subject Access Request Processes and Resources required to ensure compliance	**Individuals Rights** **Subject Access Requests**		Mar 18 – May 18	Data Protection Officer (once appointed)	

Ensure that data is portable and available in an electronic format and easily transferable to new providers on request of a data subject	**Individuals Rights** **Subject Access Requests**		Mar 18 – May 18	Data Protection Officer (once appointed) Head of Information Systems	
Embed a culture within the Trust where the Data Protection Officer is seen as central to the working practices of the Trust, with regards to any change or addition, which directly or indirectly affects personally identifiable and/or special category data. E.g. • Contract Review • Information Sharing Agreements • Privacy Impact Assessments • IG Audits • IG Training	**Data Protection by Design**		Mar 18 – May 18	Data Protection Officer (once appointed)	

NHS Solent NHS Trust

Caldicott Guardian Annual Report and Plan 2016/2017

Item 18.3

1. Introduction

Within Solent NHS Trust Daniel Meron, Chief Medical Officer is the Caldicott Guardian and is responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing. Ensuring that Solent NHS Trust in liaison with local Councils, Social Services and partner organisations satisfy the highest practicable standards for handling patient identifiable data.

2. Scope

This report covers several aspects of the Caldicott Guardian's role, identifying the activities that have been undertaken throughout the financial year. The Caldicott Guardian Issue Log provides evidence of the requests and additional considerations a Caldicott Guardian is required to provide.

The Caldicott Guardian is also key in ensuring that all confidential and personally identifiable data shared, is done so in the best interest of the patient and in line with the Caldicott Principles, therefore the Caldicott Guardian must sign off on all Information Sharing Agreements, Transfer of Service Agreements and Privacy Impact Assessments.

The Caldicott Guardian Annual Work Plan sets out the key objectives for the Caldicott Guardian for the forthcoming financial year, which includes the implementation of recommendations made in the Caldicott 2 Review.

3. Caldicott 3 Report

In July 2016, Dame Fiona Caldicott, the National Data Guardian for Health and Care, published her findings on a review of Data Security and Consent. The report proposes new measures to strengthen security of health and care information and help people make informed choices about how their data is used.

The report made twenty recommendations and an additional ten Security Standards. Nine of these recommendations are linked to Data Security, nine are linked to Consent and two are linked to the next steps.

The findings of the report then went out to public consultation from July 2016 – September 2017. The final Government response is still awaited. However the Head of IG did review the Caldicott 3 Report and assessed Solent's compliance against these, in preparation to the final report. This review identified that the Trust has mechanisms in place to ensure compliance with the recommendations that directly effect it, some of these however may need strengthening.

4. Caldicott Guardian Issue Log

Throughout the year various issues and concerns are raised with the Caldicott Guardian with regards to patient confidentiality and security of information. These issues are logged centrally by the IG Team and reviewed and approved by the Caldicott Guardian.

In 2016/17, forty-three items added to the Caldicott Guardian Issue Log, all of which have been considered by the Caldicott. Items logged for Caldicott Guardian consideration are in relation to the following subjects:

Subject	Total
Access Controls	16
Information Governance Breach / Incidents	1
Logical Deletion and/or Reversal	7
Other	2
Process Change	4
Records Management	2
Removal of Sensitive Information	3
Research / Audits / Surveys	3
Subject Access Request	4
SystmOne issues / controls	1
Total	**43**

The Caldicott Guardian Issue Log is to be authorised and by the Caldicott Guardian. This report will act as official sign-off from the Caldicott Guardian on all issues and concerns raised in 2016/17.

April16-March17_
Caldicott Issue Log

5. **Information Sharing Agreements and Privacy Impact Assessment Tables:**
The Caldicott Guardian must counter-sign all Information Sharing Protocols/Agreements, Transfer of Service Agreements and Privacy Impact Assessments with the SIRO and draw awareness to the Chief Executive outlining rules relating to the sharing of information with other organisations and provides guidance to staff in relation to sharing confidential information (Requirement 207).

Below is a list of all Information Sharing Protocols/Agreements that are currently in place, which includes who approved the agreement, when it was approved and when it is due for renewal.

Information Sharing
Protocol - Agreement

Below is a list of all Privacy Impact Assessments that have been approved, which includes who approved the agreement and when it was approved.

PIA Log.pdf

6. **Caldicott Guardian Annual Work Plan:**
At Solent NHS Trust, the Caldicott Work Plan is incorporated into the Trust's Information Governance Improvement Plan. The IG improvement programme will be managed by the Head of Information Governance and overseen by the Caldicott and the Quality Improvement and Risk Committee. The Head of Information Governance provides a quarterly report of assurance directly to the Assurance Committee.

20170512_Caldicott WorkPlan_2017-18_V

This report will act as official sign-off from the Caldicott Guardian for the 2017/18 Caldicott Guardian Work Plan.

7. **General Data Protection Regulations (GDPR)**
In May 2018 the new General Data Protection Regulations will come into force.

What has changed?
Data Subjects will notice more empowerment:
- Wider rights of subject access and information about processing
- Greater transparency about processing, and,
- Stricter conditions for consent and right to object

Organisations will notice the focus on increased accountability and pro-active, evidence-based compliance
- Thorough risk assessments, and the principles of 'privacy by design' and 'data protection by default'
- Requirement to maintain accurate records of all data processing activities,
- Increased regulatory enforcement powers and penalties
- Stricter breach notification to regulators and to individuals affected

The Trust has placed the implementation of these new Regulations on the Trust's Risk Register and identified an action plan to mitigate this risk.

Detailed report on the implementation of these regulations and the actions required are identified in the report below.

20170420_IntroGDPR_V1.1_SBe.docx

8. **Conclusion**
It is felt that continual awareness of Information Governance and the Caldicott Guardian's role means that staff are aware of maintaining confidentiality and the implementation of the Caldicott Principles and where necessary will raise issues with the Caldicott Guardian, questioning practice to ensure it meets Information Governance standards.

Further work on IG compliance needs to be undertaken, as identified in the Caldicott Guardian's work plan; mainly around ensuring adequate Information Sharing Agreements and Consent Processes are in place and continual staff

awareness on patient confidentiality. This work will be undertaken throughout 2017/18 and closely links to the implementation of the new General Data Protection Regulations, with the aim to provide greater accountability, openness and transparency. Regular updates will be provided to the Caldicott Guardian, as well as the SIRO, Assurance Committee and Board.

9. **Approval:**

Name: Daniel Meron

Signed:

Designation: Chief Medical Officer / Caldicott Guardian

Date:

Report by: Sadie Bell – Head of Information Governance
Danielle Reddy – Information Governance Officer

Report date: 24th April 2017

Item 20

Board Report – In Public Meeting

NHS
Solent
NHS Trust

Title of Paper	Chairman's report on Members Council		
Author(s)	Jayne Edwards, Corporate Support Manager/Assistant Company Secretary	**Executive Sponsor**	Dr. Alistair Stokes, Chairman
Date of Paper	15th May 2017	**Committees presented**	n/a
Action requested of the Board	[x] To receive	[ ] For decision	
Link to CQC Key Lines of Enquiry (KLoE)	[ ] Safe [ ] Effective [ ] Caring	[ ] Responsive	[x] Well Led

Since the report to the March 2017 Board, the following governor activities have taken place:

Following the Members Council meeting on 10th March where it was agreed that a working group be established to consider the role of the Council, the following representatives met on 5th May 2017;

- Michael North – Lead Governor, Public Governor Portsmouth
- Sharon Collins – Public Governor Hampshire
- Harry Hellier – Public Governor Hampshire
- Bob Blackman – Public Governor Hampshire
- Mandy Rayani – Chief Nurse
- Lesley Munro – Interim Chief Operating Officer Southampton and County
- Lauren Riddle – Membership Manager
- Jayne Edwards – Corporate Services Manager & Ass. Company Secretary
- Rachel Cheal - Ass. Director Corporate Affairs & Company Secretary

- The Group discussed and suggested proposals concerning the following;
  - Key roles
  - What 'good' would look like
  - Changes to the 'name'
  - Composition, tenure and vacancies
- An indicative phased plan, associated with any changes, is also proposed and consideration is to be given concerning the Trust's current public membership.
- The output of the working group is to be refined before being presented for discussion with the Board and wider current Members' Council.

Forthcoming meetings

- Following the Members' Council in June, the Communications Team will be holding a Membership Recruitment and Engagement Group (name to be revised). The meeting will focus on the renewed direction for membership.

There are no other matters concerning the Members Council to be brought to the attention of the Board.

Recommendation

- The Board is asked to receive the update above in relation to Members Council activities.

Solent NHS Trust

Item 22.1

Exception and recommendation report

Committee /Subgroup name	**Assurance committee**	**Date of meetings**	18th April & 16th May 2017
Chair	**Mick tutt**	**Report to**	Trust Board

Key issues to be escalated
We received a verbal up-date on the **Trust's Mortality Review process** at the April meeting, noting the requirements set out in the 'Learning from Deaths…new responsibilities for board members' report launched on 21st March 2017. Four key actions were reported as 'in hand':- i) identification of an existing Executive Director as Patient Safety Director ii) identification of an existing Non-Executive Director to take oversight of the arrangements iii) a process for – formally – reporting on action taken for all deaths occurring for people accessing Solent services iv) a revised Mortality Review policy We noted that the first, substantive quarterly 'deep dive' was scheduled for the June meeting The requirement for iii) is that a process is in place by June 2017 and should include quarterly reporting to the Board. Given the Board and Assurance meeting frequency and current escalation arrangements, it was agreed that the quarterly reports should be received by the Assurance committee (June & September '17, January & March '18) and be escalated to the Board via this Exception & Recommendation route. **The Board's agreement to this 'work around' is sought** The requirement for iv) is for a revised policy to be ratified by September 2017 and we were assured the arrangements were in hand to comply with this Having been informed of **short-notice re-Inspections of our Substance Misuse (SMS) and Children & Adolescent Mental Health (CAMHS) services, by the CQC**; to take place week commencing 22nd May, we used our May meeting to seek assurance that the action taken, in response to the concerns raised by the CQC in their Comprehensive Inspection last June, would be sufficient to provide evidence of progress The Clinical Directors (CDs) for both services and the interim Governance Lead for CAMHS joined our Chief Operating Officers (COOs) in providing that assurance; where we looked, in detail, at both the actions the CQC had asked for and the rational underlying the concerns that were prompting these actions. Whilst we received assurance that the majority of actions had, or were, being addressed it was noted that prescribing reviews in SMS had still not met national or local expectation and the CD outlined the further steps he had requested to address this. The CD for CAMHS confirmed that the service yet to implement a way of establishing how to manage waiting times, after an initial options assessment had been conducted. He outlined the reasons why this remained an issue and identified the further steps the service were planning to take to address this We concluded the discussion by noting that the CQC re-Inspection would be before the Board and, therefore, **initial feedback from the CQC should be available**, verbally, **to the Board** at the meeting

Consideration of the assurances regarding action taken to address the concerns raised by the CQC had been preceded by receipt of a first draft of a proposed **Quality Assurance Monitoring & Reporting** process. It was clear that the proposal would enable more robust assurance of the issues discussed with SMS and CAMHS and the committee approved the direction of travel, but asked for further management action to be taken to ensure operational effectiveness

In addition to the introduction of mandatory reporting and monitoring for the Mortality Review process, two further areas of activity are also associated with that requirement and we received reports on both of these in this reporting period:-

The first is now that associated with the introduction of the **Freedom to Speak Up Guardian** and we received a first quarterly 'deep dive' from the designated Guardian at the April meeting. We were briefed about the arrangements for ensuring access to the function, within Care Groups; current activity and linkages to the designated Non Executive Director and Chief Executive Officer
We were briefed, at our May meeting, about concerns raised by a group of practitioners (through their trade association); which had been addressed and were within the remit of the Freedom to Speak Up arrangements

The second related to **Information Governance** (IG) and we received an Annual Report on the Trust compliance with IG expectations at our May meeting. This demonstrated that the Trust met the requirements for compliance during 2016/7 and outlined a number of measures to be taken for this current year, to both continue with that compliance and address newly-introduced further requirements. The full Report is available, if required

The April meeting received the **Annual Report from the Wessex Speciality Doctors & Associate Specialists** (SAS), working with Solent. The committee agreed that this cohort of practitioners make a significant and valued contribution to the Trust's activity and we were, therefore, disappointed that:-

a) the Tutor (author of the Report) had noted that, nationally, this group of practitioners felt undervalued by senior managers
b) engagement, in formal educational activity, appeared to have diminished considerably since the previous year – although feedback from those attending appeared to suggest satisfaction with the content

The committee discussed various ways these concerns might be mitigated (through engagement with future Quality Improvement projects and a potential Conference) and the full Report is available, if required

The May meeting received a **Thematic Review**, conducted by the Governance Lead for Mental Health, **into the provision of care and treatment for people admitted to Brooker ward**, at the Limes, Portsmouth. The Review was acknowledged to be comprehensive, with a number of action points identified from the issues raised and conclusions reached. It was noted that these would be monitored by the relevant Governance group and reported through to QIR, for escalation to the committee if felt necessary
Comment was made regarding the absence of external peer review to the work, and the CD

explained the reasons why this planned activity had not taken place. In discussion it was confirmed that external peers would be asked to contribute to the audits to be undertaken to assess the effectiveness and embeddedness of the actions identified
The, wider, principle of external peer review was however highlighted and services were to be encouraged to ensure this occurred, whenever possible

The May meeting also received the quarterly up-date on the activity associated with **Serious Incidents Requiring Investigation**. Whilst the total number of Incidents had risen, slightly, compared to the previous year this was not felt to be significant – but we requested some alternative mechanisms for tracking trends, over time; to provide assurance that this assumption was accurate. The report contained a synopsis of the learning from Incidents investigated and the Chief Nurse outlined the various mechanisms available for dissemination of this learning across the Trust

An Annual Report regarding achievements associated with the **Making Every Contact Count** initiative was received at the May meeting. This was commissioned by Public Health Southampton and we were reminded that the initiative was part of all NHS contracts and was mandated. We sought to understand why the initiative was not commissioned in Portsmouth and the COO undertook to explore this with relevant colleagues, with a view to up-dating the committee when we receive a further up-date, in the Autumn

We looked to our COOs to identify the **major risks to high quality services and continued compliance with regulatory requirement, in the two Care Groups** and for the **Quality Improvement & Risk group** (QIR) to both underpin and enhance the assurance received from the COOs, and we received reports which continued to both:-

- collaborate some of the issues raised by COOs, particularly of an operational nature
- raised other issues, largely of a strategic or 'cross-cutting' nature

Significant issues included:-

- continued challenges associated with recruitment of practitioners, across the Trust – with particular 'hot-spots' in Community Nursing and Speech & Language Therapists, Southampton and Adult Mental Health wards (mitigated by the 'block-booking' of agency staff), Portsmouth
- a first outline, at the April meeting, of the quality and governance issues associated with the Trust's wider engagement in the Urgent Care system across Portsmouth & South East Hampshire – which led to a discussion regarding the most appropriate forum for this to be considered. **Further consideration by the Board was advocated**, with continued focus at the Assurance committee as an interim (as least) measure
- continued concerns that workforce issues – including the ability to attract, recruit and retain appropriately qualified and experienced people, and the provision of suitable and effective learning & development for all staff (including essential recording of training received) – were not, currently, being overseen by a Non Executive Director-led committee. It was **agreed**, at the April meeting, **that the Board would be asked to review this**

  the May meeting developed this theme, further; in that we received a status report on the 'fitness-for-purpose' of the electronic system which should identify the learning & development required for individual practitioners – in order that we can

be assured that they have the skills and experience required to undertake their role, and record the receipt of this learning, in an accurate and timely manner. We heard that the electronic system, currently, does not always enable managers to be confident that all necessary and relevant opportunities are identified for all practitioners and that managers cannot be confident that all learning & development activity is recorded accurately. We were given assurances regarding the measures being taken, at an operational level, to mitigate the risks these shortfalls pose and an outline of the programme to ensure the electronic system was 'fit-for-purpose'. Again, oversight of the implementation and achievements of this programme should be within the remit of the Non Executive Director-led committee, noted above

the May meeting also received an up-date, with regard to a specific aspect of this shortfall in confidence with the electronic recording system; that of Level 3 Safeguarding training. This was the issue, first raised at our January meeting, which alerted us to the potential shortfalls and risks. The up-date provided us with assurance of the process, through the provision of supervision, which would enable confidence to be achieved, that relevant practitioners received – and had been able to put into practice – the appropriate learning, in this instance

- we received up-dates on the action taken to address the concerns raised by the CQC with regard to the provision (by a 3rd party) of wheelchairs for people in receipt of our services, and of efforts to obtain the formal findings from a joint CQC/OFSTED Inspection, last autumn; which involved some of our services. Both these issues had been on-going for some time and we requested some focussed management attention, in order to attempt to reach resolution

We have received drafts of both the **Annual Governance Statement** (AGS) and **Quality Account**, in preparation for their inclusion with the Trust Annual Accounts, over several months and members were asked for final comments on the drafts at the April meeting, ahead of formal receipt by the Board

The May meeting received a draft of the Annual Report for the committee's activity during 2016/7, again ahead of formal receipt by the Board. In consideration of this item we reviewed the – perceived – effectiveness of the committee, particularly the changed arrangements for exception reporting from the COOs and QIR, since the revised Terms of Reference were adopted in January. We concluded that the arrangements did offer confidence that we could provide adequate assurance – or escalate issues of concern to us – to the Board; but that we would ask for an Internal Audit assessment, later this year; to offer a more independent judgement

We noted a recent Supreme Court Judgment, detailing that a hospital smoking ban had infringed the Appellant's Human Rights; because there had been reliance (by the Scottish Health Board involved) on the blanket restrictions invoked under the powers of the Mental Health Act 1983, at our May meeting. We were informed of the action taken to seek legal advice; which confirmed that this Judgement did not affect Solent policies. We did, however, ask for further consideration to be given to the detail of implementation within our Mental Health services, and asked for further clarification

We recorded out formal thanks to the Chief Nurse at our May meeting, for her contributions to quality and regulatory compliance within the Trust

Decisions made at the meeting

The April meeting received a report from our Contracts team, which outlined **the risk management process now applied to all known sub-contracts**. This had arisen as a consequence of historic requests for assurance of the quality and regulatory compliance of those who provided sub-contracted services for us, and we agreed that this report provided a useful first step – which would now be followed, on a quarterly basis, by more focussed exception reporting on those 10/12 sub-contracts assessed as posing the highest risks. We also noted that both Finance (re operational risks) and Audit & Risk (for governance) committees would be involved which monitoring this activity

At the April meeting we ratified the following policies:-

- IPC09 TSE CID Policy
- IG09 Registration Authority Smart Card
- RK08 Fire Safety Policy
- MMT03 Medicine Policy

We also noted the CLS11 Seclusion Policy following minor amendments made to the appendix, which was approved by Chairs' action on 18th March

Ratified by Chair's Action
- IG08 Policy for Surveillance Camera System (CCTV)
- RK05 Physical Security Management Policy

At the May meeting we ratified the following policies:-

- GO10 Managing Conflict of Interest Policy
- HR05 Bank, Agency and Locum Workers Policy

And following minor amendments, we ratified changes to the following
- RK01 Serious incidents requiring investigation (SI) policy
- RK04 Investigation Policy
- DA01 Waiting Times and Patients Access Policy

Ratified by Chair's Action:
- HS05 Slips Trips and Falls Policy (Patients)
- GO09 Anti-Fraud, Corruption & Bribery Policy
- RK08 Fire Safety Policy

Recommendations to the Trust Board

The Board are asked to:-

- agree that the quarterly Mortality Review reports should be received by the Assurance committee (June & September '17, January & March '18) and be escalated to the Board via this Exception & Recommendation route

- consider how the quality and governance issues associated with the Trust's wider engagement in the Urgent Care system across Portsmouth & South East Hampshire might most appropriately be monitored

- consider whether workforce issues should be overseen by a seperate Non Executive Director-led committee

➢ note the other issues set out above
Other risks to highlight (not previously mentioned)
none of note

NHS Solent NHS Trust

Item 22.2

Assurance Committee Annual Report 2016-17

Introduction

The Assurance Committee is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2017.

Meetings

During 2016-17 the following meetings were held:

- 19th April 2016
- 17th May 2016
- 21st June 2016
- 19th July 2016
- 20th September 2016
- 25th October 2016
- 22nd November 2016
- 17th January 2017
- 14th February 2017
- 14th March 2017

Membership & Attendance

Attendance by members is outlined as follows:

NAME	Meeting: 19th April	17th May	21st June	19th July	20th September	25th October	22nd November	17th January	14th February	14th March	% attendance
Mick Tutt – Chair Non Executive Director	P	P	P	P	P	P	P	P	P	P	100%
***Mike Watts** Non Executive Director	n/a	n/a	n/a	n/a	n/a	A	P	P	A	P	60%
***Francis Davis** Non Executive Director	n/a	n/a	n/a	n/a	n/a	P	A	P	P	P	80%
Jon Pittam Non Executive Director	n/a	P	P	P	P	n/a	P	P	P	P	89%
Sue Harriman Chief Executive Officer	P	A	P	P	A	P	P	P	A	P	70%
Mandy Rayani Chief Nurse	P	A	P	P	P	P	P	A	P	A	70%
Sarah Austin Chief Operating Officer	P	P	P	P	P	P	A	P	A	P	80%
***Alex Whitfield** Chief Operating Officer	P	P	P	P	P	A	P	P	P	n/a	89%
Dan Meron Chief Medical Officer	P	P	P	A	P	P	P	P	A	P	80%
Lesley Munro Interim Chief Operating Officer	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	P	P	100%
Rachel Cheal Associate Director of Corporate Affairs and Company Secretary	n/a	n/a	n/a	n/a	n/a	n/a	n/a	P	P	P	100%

P= Present A= Apologies

*Alex Whitfield left the Trust and Lesley Munro took the role of Interim Chief Operating Officer in March 2017.
*Mike Watts and Francis Davis joined the Trust in October 2016.

NHS Solent NHS Trust

Terms of Reference ToR
The ToR were amended in June 2016 to reflect that the Audit & Risk Committee Chair could be a member of the Assurance Committee. Revised ToR were presented to the November 2016 meeting, following reflection on governance reviews undertaken by Internal Auditors KPMG, External Consultant Julie Jones and the CQC. It was agreed to commence the revised arrangements in January 2017.

Status against the achievement of the Committee's Objectives

Objectives	Year end
Any urgent matters of safety will be reported to the Committee, at the commencement of each meeting.	*Agenda planned accordingly for every meeting*
A review of the frequency of meetings, duration and remit (including membership) will take place during August 2016 – following consideration of recent external reviews, including the CQC Comprehensive Inspection at the end of June 2016	*Review delayed – because of delay in receiving CQC draft report. Draft report received late October and discussion regarding frequency of meetings, duration and remit took place at November meeting… with agreed changes taking place from January 2017.*
Clinical ownership of quality governance and regulatory compliance will continue to be re-enforced and monitored through the focus on exception and 'deep dive' reporting from each service line, with a positive encouragement for candidness from CDs and others attending.	*The process of 'deep dives' and exception reporting enabled extremely detailed discussion of governance issues experienced by service lines to be discussed. Clinical Directors (CDs) and Governance Leads(GLs) made candidness a virtue – a situation much appreciated by the Chair, as this enabled full feedback to be provided for the full Board.* *The process for 'deep dives' changed from January 2017 – when CDs and GLs no longer, routinely, attended the Committee – but attended the Quality Improvement & Risk (QIR) group, as part of the revised ToR* *Chief Operating Officers (COOs) and the chair of QIR provide exception reports, reflecting the content previously provided by CDs and GLs and a revised series of 'deep dives' into specific areas of Governance and Regulatory Compliance has been established*
Safe Staffing will be monitored through the receipt of the monthly service line updates and quarterly corporate reporting.	*On-going and noted to remain a significant risk in almost all service lines.*
The Committee will continue to receive, review and comment upon the Corporate Risk Register	*On-going*

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(CRR) to accurately reflect the service lines' perceptions of risks and mitigations. The parallel process of Trust Management Team review will continue to be considered to ensure there are no duplications or omissions.	
The use of dashboards, reflecting performance will be received once deemed 'fit for purpose' and used by Committee members to interrogate assurance provided from service lines.	*Dashboards received for meetings from September 2016 onwards. The September meeting agreed to receive dashboards through to November 2016 and then consider future use.* *The COO and QIR exception reports have replaced the function partly envisaged of dashboards*
The Committee will receive a report at each meeting of the Quality Improvement and Risk Group and from other groups by exception which will assist in the achievement of objective 2.	*Verbal reports received, together with minutes from 'historic' QIR meetings were received at most Committee meetings, prior to January 2017. Subsequently, written reports were received for 2 of the 3 meetings held.*
Serious Incidents Requiring Investigations (SIRI) including mortality will continue to be monitored through receipt of an exception report from the Panel Chair and minutes available on request.	*SIRI Panel including monthly mortality review information received at each meeting, until January 2017, and scrutinised as necessary.* *Since January 2017 SIR and Mortality Reviews have been developed as 'deep dives'*
Other reports will be received, following agreement by the Chair, CMO and CN	*Other reports were received as requested and required.*

Summary of business conducted in year

Highlights of the main business conducted by the Committee for the period April 2016 to and including November 2016 are summarised as follows;

Quality

- The Committee were alerted to any Urgent Matters of Safety at each meeting.
- Quality matters were reported as part of individual service line updates.
- The Committee noted the Wessex Trust SAS Development Annual Report at the April 2016 meeting.
- The draft Quality Accounts were presented for comment at the April 2016 meeting and final version was agreed for Board endorsement in May.
- Mortality review updates were presented at each meeting including position updates on work to review policies and practices. The June 2016 meeting was informed of a revised interim process in place as part of the overall implementation plan.
- The Chief Medical Officer provided a verbal update on the Homicide Review at the April 2016 Committee. A copy of the report and action plan was circulated with the minutes of the meeting.
- The Recruitment and Retention Strategy was presented to the September 2016 meeting and it was noted that a Workforce and Performance sub-committee were to monitor the position going forward and the Assurance Committee would reflect on issues not being effectively addressed.

Regulatory Compliance

- 2014 CQC inspection 'Must', 'Should...' and 'Could do' action positions were presented, prior to the June 2016 Inspection; to ensure the original recommendations were effectively closed off.
- Initial feedback from the 2016 CQC Inspection, and arrangements for the Quality Summit were shared at the July 2016 meeting.
- CQC Inspection outcomes and key findings for each Core Service were presented in detail to the November 2016 meeting.

Risk Assurance

- The Committee received monthly updates on risks, via the QIR updates.
- The Committee received a monthly SIRI (and HIgh Risk Incident (HIRI)) update, by way of an exception report. Challenges with the lack of investigators were highlighted.
- The Health and Safety annual report for 15/16 was presented in July 2016 for onward reporting via exception to the September 2016 Board.
- The Safeguarding annual report was presented.

Operational Policies

- A list of the policies ratified by the Committee is appended to this report (see Appendix 1)

Assurances from Service Lines

Adult Mental Health Substance Misuse and Pharmacy

- The Committee were alerted to staffing issues impacting on the service and of additional rostering oversight being implemented. The October 2016 Committee were informed of a key nursing tool in place to help address staffing pressures.
- Issues with the s136 suite were noted and it was agreed that the Mental Health Act Scrutiny Committee (MHASC) would discuss further.
- A deep dive was conducted in June 2016 and included a briefing on the March 2016 homicide investigation report under the new investigation regime. Assurance was also provided that all mixed sex accommodation issues were mitigated and ligature issues identified with action plans in place.
- The Committee was informed of issues identified by the CQC of the Substance Misuse Service (SMS) and assurance was given of a comprehensive action plan in place.
- Significant IT issues within the Crisis Resolution Home Treatment Team were highlighted.
- A further deep dive was provided in September 2016 and third party provider data challenges with regards to the 136 suite were highlighted. An update was also provided on issues with prescription care planning within SMS and of sustainable changes in place to address.

Adults Services, Southampton

- The April 2016 meeting received an update on the Health and Social Care Integration project.
- The October 2016 Committee was briefed on risks associated with the Speech and Language Therapy service, post contract and of a response to a Trust letter sent, still awaited by commissioners. CEO involvement was agreed as a duty of care to service users, if deemed necessary.

- The Committee was informed of significant staffing issues on Snowdon Ward and bed closure potential. It was agreed that Adults Portsmouth share techniques of their recruitment successes.

Adults Services, Portsmouth

- A deep dive was conducted at the May 2016 meeting and an update was presented on the workforce review undertaken due to increasing staffing pressures. The Committee was assured of work being undertaken to mitigate risks and change working methods. The Committee was updated on staffing challenges throughout the year.
- The Committee was informed of accommodation challenges at Medina House and the escalation of issues was confirmed. Updates were provided at subsequent meetings.
- A second deep dive was conducted in October 2016 and context was provided on caseload numbers and activities. A pressure ulcer review process was explained. The Committee noted that additional incident information was being requested by CCGs and of work in progress on earlier CCG involvement with incident reporting.

Child & Family

- Concern was raised regarding Personal Identifiable Data (PID) sent in error and the Committee considered different thresholds of accountability from clinical incidents and incidents within corporate supporting services. The matter was escalated to Executives for discussion and resolution.
- The Committee was informed of Solent Bank Administration support challenges and of an increase in Information Governance incidents during times of temporary cover.
- The Committee was assured of lessons learnt with regards to deaths and areas of improvement were identified.
- Benefits of engagement with young people accessing the service during a membership event were highlighted.
- Staff morale concerns due to transformation challenges were highlighted.
- The Committee was informed of on-going work to focus on learning awareness of reported risks and of a database that triangulated incidents, SIRI, HRIs and plaudits.

Dental Services

- A deep dive was presented at the April 2016 meeting where the Committee was updated on prison complaint issues and of a leaflet created to provide information to prisoners on treatment provision to ensure expectations were realistic. Annual staff survey results were shared and key issues highlighted. Contextual information was also provided on incidents and action plans in place.
- Regular updates were provided on significant IT issues within the service line. The October 2016 Committee was informed of a spike in radiography IT issues.
- Lift issues at the Eastleigh Health Centre, and increase in the number of home visits undertaken as a consequence were noted.
- An additional day for General Anaesthesia had been reported to commence with UHS.
- Safeguarding Training was noted to have failed to upload onto the Learning and Development system in August 2016.

Primary & Urgent Care

- The Committee received a briefing on an in-health review being undertaken including issues relating to transport collection, waiting times being unacceptable.

- Issues with spinal surgery and pressures within the Musculoskeletal Service were highlighted. Regular updates were provided.
- The Committee was informed of continuity plans in place in readiness for the retirement of the Clinical Director, Dr Cliff Howells.
- The Committee received a deep dive from the service line in July 2016 and was updated on improvements with IT connectivity. A briefing was provided on the recent 3 day CQC intensive inspections.
- The successful recruitment of Accredited Nurse Practitioners and additional sessions of GP cover were noted at the September meeting.
- Estates strategy with regards to aiding lift repairs was discussed at the October 2016 due to 4 lifts across sites in need of repair. The matter was escalated to Directors to consider and resolve.

Sexual Health Services

- The Committee were made aware of access issues across the service and of a pilot being conducted to provide a same-day service, 2 days per week. Regular updates were to be provided.
- IT issues were reported regularly.
- Problems associated with the electronic Care Record system were noted and it was confirmed that the matter had been escalated and entered onto the Corporate Risk Register (CRR).
- Accurate data reporting was discussed at the July 2016 meeting. It was confirmed that data checks had been carried out at the QIR Group meeting and it was agreed to continue with the reporting of dashboard and review at a later date.
- The Committee were informed of a major incident relating to IT that involved an external organisation. IT was confirmed that a SIRI had been launched to investigate.
- The October 2016 Committee were informed of the successful tender of the service. It was noted that issues with telephony and difficulties in reaching the service had been resolved.

Quality Improvement and Risk (QIR) Group Updates

- The QIR received exception reports from each service line. Information Governance provided regular update reports. SIRIs, risks and complaint updates were also provided on a monthly basis. Verbal updates of the QIR were reported to Assurance Committees during meeting quick turnarounds. Historic and current exception reports were noted.

Other Matters

- The Committee noted the Annual Governance Statement at the April 2016 meeting.
- National changes to the clinical research approval process at the April 2016 meeting was explained. It was also noted that the Trust had been asked to sponsor Medicines and Healthcare Products Regulatory Agency (MHRA) registered study which was endorsed in principle pending further governance discussions.
- The Safeguarding Adults and Children's Annual Report and Infection Control Annual Report were noted at the July 2016 meeting.
- The Clinical Audit and Effectiveness six monthly update was provided at the November 2016 meeting.
- The Committee received the IG Compliance report, including national reviews and new General Data Protection Regulations.

The format of the Committee changed from January 2017 following agreement of the revised Terms of Reference. Service line reports were presented via the QIR Group exception updates as well as, SIRIs, risks and complaints. From January, the Committee received Chief Operating Officer exception reports from Southampton and Hampshire Care Groups and Portsmouth Care Group.

Highlights of the main business conducted by the Committee for the period January 2017 to and including March 2017 are summarised as follows;

- The January Committee received a Health and Safety update regarding improvements to Legionella prevention, ligature risk actions, lone working arrangements and workplace safety inspections. The Committee was assured that Health and Safety matters fulfilled statutory responsibilities.
- CQC oversight updates were provided at each meeting and a deep dive presentation was provided at the March meeting,
- The Committee received a deep dive from the Safeguarding Team and it was noted that the Trust was compliant with statutory duties and actions were being taken to address any deficits in relation to level 3 safeguarding training.
- The Committee was updated on Freedom to Speak Up matters at each meeting.
- An update on third party contracting and sub-contracting was provided at the January meeting.
- The March 2017 Committee received a six monthly Medicines Management report.
- Each meeting received a report from COOs to identify major risks to services and continued compliance with regulatory requirements.
- An overview of programmes and deep dives were provided by Thematic Leads for Falls and Dementia at the January 2016 meeting.
- Service Line Annual Governance Statements were presented to the February Committee for inclusion in the main Trust Annual Report.
- The March meeting received a quarterly review of achievements against Quality priorities for noting.

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

Objectives for 2017-18

1. **Any urgent matters of safety or concerns raised through the Freedom to Speak Up Guardian will be reported to the Committee, at the commencement of each meeting.**
2. **An Internal Audit review of the changes made, as a consequence of the revised ToR, will be sought during 2017/8 – to provide Assurance that the changes have not diluted the effectiveness of the work of the Committee**
3. **Exception reports, from the COOs and the chair of QIR, will be received at each meeting. the precise format of these may change, through-out the year; as the changes in arrangement become embedded**
4. **A series of 'deep dives', into specific areas of Governance and Regulatory Compliance, will be received at each meeting**
5. **Safe Staffing will be monitored through the receipt of the regular report from the Chief Nurse and, where necessary, by exception**

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6. Other reports will be received, following agreement by the Chair, CMO and CN	
Conclusion	
The Committee has complied with its Terms of Reference during the period under review.	
Report Author(s)	Mick Tutt, Non Executive Director and Assurance Committee Chair Jayne Edwards, Corporate Support Manager and Assistant Company Secretary

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Appendix 1 – List of Policies agreed by Assurance Committee 2016-17

APRIL 2016 • Policy for the Development and Implementation of Procedural Documents • Induction and Essential Training Policy • Records Management and Information Lifecycle Management Policy for Clinical and Corporate Records • Policy for Managing Performance of Medical and Dental Staff • Safe Use of Display Screen Equipment and Mobile Devices Policy	**MAY 2016** • Clinical Audit and Service Evaluation Policy • Management of Resuscitation Policy • MRSA Policy • Fundraising Events Management Policy • Donation and Charitable Gifts Policy • Policy for Self Administration of Medicines on Inpatient Wards • Hand Hygiene Policy • Policy for Infection Prevention and Control Standards Precautions
JUNE 2016 • Verification of Expected Death Policy • Uniform Policy • Clinical Risk Assessment and Management Policy and Procedure • Overarching IV Policy • Long Term Segregation and Blanket Restrictions Policy • DBS Check Policy • Dignity at Work Policy • Grievance Policy • Investigation Policy • Performance Management Policy • Suspension, Exclusion and Transfer Policy • Reporting Adverse Incidents • Tissue Viability Policy	**JULY 2016** • Policy for the Safe Handling and Disposal of Healthcare Waste • Control of Substances Hazardous to Health (COSHH) Policy • Supporting Learning in Practice Policy • Management of Medical Devices (Equipment) Policy • Pay Protection Policy
SEPTEMBER 2016 • Operational Policy for the Use of Seclusion Suite within Maple Ward • Standards of Business Conduct – Register of Interest, Gift and Hospitality Policy • Complaints Policy • Policy on Policies • Child and Young Person's Advance Care Plan Policy • Equality, Diversity and Human Rights Policy • Preloading of Insulin Policy	**OCTOBER 2016** • Ligature Risk Assessment Policy • Registration of Professional Staff Policy
NOVEMBER 2016 • Claim Management Policy • Mobile Working Policy • Disciplinary Policy • Chaperone Policy	**JANUARY 2017** • Isolation Policy • Staff Reward and Recognition Policy • Organisation Change and Consultation Policy • Policy on Obtaining and Providing References • Anti-Fraud, Corruption and Bribery Policy • Urinary Catheter Policy

	• Management of Allegations of Abuse Against Staff Under Safeguarding Procedure • Consent to Examination and Treatment Policy • Information Governance Policy
FEBRUARY 2017 • Dental Radiation Policy • Emergency Lockdown Policy • Pay Protection Policy	**MARCH 2017** • Investigation Policy • Suspect Package Policy • Suspension, Exclusion and Transfer Policy

Solent NHS Trust

Item 23.1

Exception and recommendation report

Committee /Subgroup name	**Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee**	**Date of meeting**	18th May 2017
Chair	**Mick Tutt**	**Report to**	Trust Board

Key issues to be escalated
This meeting took place at the Civic Offices in Portsmouth, for the first time; meaning that we have now ceased to meet within the old hospital buildings at St James we ➢ received an up-date from the Clinical Director (CD) for Children & Families services – who had been attempting to investigate an incident involving a young person under 18 years of age who had been taken to the **s136 suite**, last summer. He informed us of the limited progress made, because of the absence of information from the (then) 3rd party provider. He suggested that, within the revised arrangements for the operation of the suite, this situation was less likely to occur again and that, rather than continuing to pursue an historic matter, services should look to ensure more robust arrangements in future. In discussion committee members agreed that this was the most pragmatic way forward also received a summary of the historic governance arrangements for the suite, during the time direct provision was from a 3rd party provider, from the Clinical Director (CD). This, again, emphasised the lack of robustness overall and suggested that both the 3rd party provider and Solent should accept responsibility for this – which we accepted we did so on the basis of receipt of a second set of improved data, which was necessary for the committee to scrutinise that the use of the suite fell within the expectations of the Code of Practice also noted an up-date regarding the anticipated up-grade to the physical environment of the suite. We were informed that some, minor, improvements had been undertaken and others were programmed to take place, but that a date for the substantive renovation to the environment still had to be agreed with commissioners and Southern Health Foundation Trust – because of the requirement to provide sufficient facilities across Hampshire during the building works ➢ received a draft **Memorandum of Understanding**, with Hampshire police, which provided local operational detail of expectations announced earlier this year for the role of the police within Solent services ➢ received confirmation that the **Service User Group** had considered our request to receive copies of the minutes of their meetings and agreed to this, from the next (August) meeting ➢ heard about good practice in the **application of s4** (urgent admission on the recommendation of only one doctor) and **admission of a young person aged under 18 years** and that the improvement in compliance with the expectations of **s132** (ensuring people were 'read their rights'), and documentation generally, noted at the last meeting, appeared to have continued

- noted, however, that one person had continued to be held after the **s5:2** (doctors holding power) had lapsed and that one person's treatment had taken place without **valid Consent**. We heard management explanations for these exceptions and received assurances of the action being taken to minimise the risk of further occurrence

- noted apparent variations in the **application of s62** (provision of urgent treatment) and the management proposals to address this

- were informed that the use of **Community Treatment Orders** had resumed and noted the continued use of **long-term s17 leave**. We received assurances from the Mental Capacity & Mental Health Act (MCA&MHA) lead and the CD that each individual application was appropriate and would be reviewed in accordance with overall arrangements for reviewing detention – including referral to a Managers' (Associate Hospital Managers (AHM)) Hearing and/or Tribunal

- received a first set of data related to the **application of Deprivation of Liberty Safeguards** (DoLS) across the Trust – as required by the revised Terms of Reference and as discussed at the last meeting. Receipt identified some learning needs for some committee members; in order to, appropriately, scrutinise the information and the MCA&MHA lead agreed that he would arrange this for the next (August) meeting
  It was noted that the area using DoLS most was Jubilee House in Portsmouth and the MCA&MHA lead outlined the reasons why this might be so. It was also noted that all three Local Authorities (LAs) (Hampshire County Council, Portsmouth City Council and Southampton City Council) had outstanding Applications for Authorisation and the MCA&MHA lead assured us of the process for reminding of their responsibilities

- received reports of **management action taken to review the use of restraint and seclusion**. These contained confirmation that the use of both restraint and seclusion had been within the expectations of the Code of Practice, within mental health services
  As noted previously, the Kite Unit does not use seclusion, but we received a report of management action taken to review the use of restraint – which confirmed that this was within the expectations of the Code of Practice. We were also informed of the action taken, following the request of the Chief Nurse, to review the method of restraint used; to become compatible with that used within mental health services

- received a draft of the Annual Report for the committee's activity during 2016/7, ahead of formal receipt by the Board

- received a proposal for the provision of learning and development opportunities to enable practitioners to work, appropriately, with people diagnosed with autism. We noted that further work was, probably, necessary – but supported the general direction of travel

- noted the short summary of the implications of the publication from the Law Commission for the reform of Mental Capacity and Deprivation of Liberty, but decided to await any further indication of any change in the Mental Health Act 1983 and likely time-frames for progress through Parliament

Decisions made at the meeting

We agreed that

- the report, from the CD, which recommended that the interim arrangement for **the main door to Hawthorns ward remained locked**, should be supported. We acknowledged that this action constituted a 'blanket ban', within the definition contained in the Code of Practice, but noted

  i) the measures in place to enable those assessed as not at risk to leave the ward
  ii) the reported absence of adverse comment from people on the ward
  iii) that such a blanket ban was in keeping with '…the national trend…'

- there needed to be an urgent consideration of the mechanisms management colleagues needed to utilise in order for the committee to discharge its duty, within the revised Terms of Reference, for oversight of the learning and development opportunities available for practitioners applying either the Mental Capacity Act 2005 or the Mental Health Act 1983. It was agreed that the Chair would be able to take Chair's Action, ahead of the next meeting; to ensure the committee received some information to consider

- the Fact Sheet for prospective AHM should be circulated to all existing AHM and other committee members

- future meetings would alternate between the Civic Offices and the Trust Headquarters

- the new (CQC) Mental Health Act Reviewer should be provided with full sets of documentation from the meetings and have an open invitation to attend

Recommendations to the Trust Board

- the Board are asked to note the issues set out above

Other risks to highlight (not previously mentioned)

NHS Solent NHS Trust

Item 23.2

Mental Health Act Scrutiny Committee Annual Report 2016-17

Introduction

The Mental Health Act Scrutiny Committee (MHASC) is a formal Committee of the Solent NHS Trust Board with defined Terms of Reference (ToR) and as such is required to prepare an Annual Report on its work and performance in the preceding year for consideration by the Trust Board. This report summarises the Committee's activity for the year to 31st March 2017.

Meetings

During 2016-17 the following meetings were held:

- 19th May 2016
- 18th August 2016
- 17th November 2016
- 16th February 2017

Membership & Attendance

Attendance by members is outlined as follows:

NAME	19th May 2016	18th August 2016	17th November 2016	16th February 2017	% attendance
Mick Tutt – Chair Non Executive Director	P	P	P	P	100%
Jon Pittam Non Executive Director	P	A	P	P	75%
Alistair Stokes Trust Chairman	P	P	P	P	100%
Mandy Rayani Chief Nurse	P	P	A	P	75%
Dr Dan Meron Chief Medical Officer	P	A	P	A	50%
Alex Whitfield Chief Operating Officer, Southampton	A	A	P	P	50%
Sarah Austin Chief Operating Officer, Portsmouth	A	P	P	P	75%
***Francis Davis** Non Executive Director	n/a	n/a	n/a	P	100%

P= Present A= Apologies

*Francis Davis joined the Trust in October 2016 and expressed an interest in becoming an Associate Hospital Manager (AHM) prior to the February '17 meeting.

Terms of Reference

The ToR were reviewed at the November 2016 meeting and consideration was given to the Committee's role and the attendance of Associate Hospital Managers going forward. The revised ToR (to incorporate the application of Deprivation of Liberty Safeguards (DoLS) and training provision for both the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (MHA)) were endorsed by

the committee and ratified by the Board in January '17	
Status against the achievement of the Committee's Objectives	
Objectives for 2016-17	**Year end position**
To continue to utilise the Mental Health Act lead Report as a main vehicle for scrutinising compliance with the expectations of the Act. This will continue to seek assurance in the light of internal and external inspections, audits, reporting and national changes in policy, research and law.	*Presented by the MCA&MHA Lead at every meeting and matters of exception highlighted for discussion / challenge / action.* *Status: ongoing*
To continue scrutiny of the use of seclusion, restraint, seeking assurance from management reviews that the expectations of the Act and Code of Practice are adhered with.	*There is a standing item for reports to be provided. Further refinement, to ensure full assurance of compliance, must continue during 2017/8* *Status: ongoing*
To re-consider the past decision to separate scrutiny of the application of the Mental Capacity Act 2005 from the application of the Mental Health Act 1983, in the context of the increasing convergence lead by case-law and the Law Commission Review 2015.	*See note, regarding ToR above – the committee's remit was extended to incorporate the DoLS aspect of the MCA and further extended to include consideration of training for practitioners in both MCA and MHA, for the February 2017 meeting. Consideration of how appropriate arrangements to provide assurance on these aspects was commenced at the February '17 meeting and is anticipated to be concluded at the May '17 meeting*
With regard to AHM: • to continue the process of reflective training sessions at part B of the meeting, including at annual up-date from our solicitors	*Training provided at each meeting. Paul Barber provided the annual MHA law update in January '16, and Simon Lindsey provided a further session in November '16*
• to formally conduct a third round of reviews/appraisals for AHM based on previous recommendations to the Governance and Nominations Committee, reinforcing the importance of attendance at both parts of the quarterly committee meetings.	*Conducted during q1, with the decision to recommend, to the Governance & Nominations committee, the re-appointment of Pam Coen & Jon Pittam for 3 years and the re-appointment of Liz Burden, Richard Hibbert, Irene Jackson, Brian Mansbridge, Jackie Powell and Sue Rennison for 1 year with Tom Morton continuing to sit until suitable alternative arrangements were complete Both Richard Hibbert & Tom Morton stood down within the year 2016/7*
• to engage a further round of	*Zenna Hopkins recommended, to the Governance*

recruitment for additional AHM, with the expectation being that at least one will be a person who has accessed services – liaising with the Governance and Nominations Committee regarding those to be appointed. • to continue to advocate for a choice of venues for community hearings • to continue to review reasons for non–attendance (by those detained) at hearings	*& Nominations committee, for appointment in November '16 for 3 years* *Francis Davis expressed an interest in becoming an AHM after commencing as a Non Executive Director and has undertaken the usual training in preparation for the role* *A community venue for community hearings was offered in each case. This was confirmed for the Committee* *Status: ongoing* *Each service user was requested to give feedback on hearings. This was shared at Part B of the meeting.* *Status: ongoing*

Summary of business conducted in year

The majority of business conducted at the meetings was through the Mental Health Act Scrutiny Report; co-ordinated by the MCA&MHA Lead, with contributions from relevant clinical and service leads and seclusion reviews.

The report included an executive summary which highlighted key issues and guided committee members to more detail within the body of the document, as well as appendixes where necessary.

Governors attended the Committee, when available; to observe. There was also an opportunity to engage with the business of the Committee, through a specific agenda item. Governors were also encouraged to attend Part B.

Training sessions were provided during Part B of the meeting and psychiatrists as well as Executive Directors and other management colleagues were invited to attend, if the training was considered to be of value.

Following notification received, from the CQC; that Board endorsement of 'Blanket Ban' practice would be scrutinised, to ensure due process followed the Code of Practice 2016 for people detained under the MHA, services provided a list of items for inclusion within blanket bans which was reported onto the Board for approval, prior to the comprehensive (CQC) Inspection in June '16.

An update on plans to implement a Smoke Free Environment policy was provided at the August 2016 meeting.

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

Part B training sessions provided

Date	Session
19th May 2016	Mental Health Act and Mental Capacity Act Update (from Paul Barber's presentation January 2016)
18th August 2016	Physical Health Care in Mental Health – Jacqui Young
17th November 2015	Current service provision – operational arrangements for residential and community services
18th February 2016	Information Governance Training

Objectives for 2017-18

1. To continue to utilise the MCA&MHA lead Report as a main vehicle for scrutinising compliance with the expectations of the MHA. This will continue to seek assurance in the light of internal and external inspections, audits, reporting and national changes in policy, research and law.
2. To continue scrutiny of the use of seclusion, restraint, seeking assurance from management reviews that the expectations of the Act and Code of Practice are adhered with.
3. To refine the scrutiny of the application of DoLS, across the Trust and the outcomes of training provided for practitioners on the MCA and MHA
4. With regard to AHM:-
   - to continue the process of reflective training sessions at part B of the meeting, including at annual up-date from our solicitors
   - to formally conduct a fourth round of reviews/appraisals for AHM, based on previous recommendations to the Governance and Nominations Committee
   - to continue to advocate for a choice of venues for community hearings
   - to continue to review reasons for non–attendance (by those detained) at hearings

Conclusion

The Committee has complied with its Terms of Reference, including those revised after November '16, during the period under review.

Report Author(s)	Mick Tutt, Non Executive Director and Assurance Committee Chair Jayne Edwards, Corporate Support Manager, Assistant Company Secretary

NHS Solent NHS Trust

Presentation to	X In Public Board Meeting		Confidential Board Meeting	
Title of Paper	Freedom To Speak Up			
Author(s)	Mandy Sambrook, Freedom to Speak Up Guardian	Executive Sponsor		
Date of Paper	12TH May 2017	Committees presented		
Link to CQC Key Lines of Enquiry (KLoE)	/ Safe	/ Effective	/ Caring	/ Responsive Well Led
Action requested of the Board	/ To receive	For decision		

We have made progress in a number of areas and this report describes these achievements to date as well as some of the challenges encountered. While there is good progress in the NHS there is still a distance to go to create a universally open and honest culture.

Within Solent, the Freedom to Speak up Guardian programme is being delivered with a Lead Guardian appointed, along with six guardians working within each care group.

The Freedom to Speak Up Steering Group has been established, the composition of which includes;

- Chief Executive: Sue Harriman
- Jon Pitman: Non-Executive Director:
- Lead Guardian: Mandy Sambrook BSC RSCN Public Health

The role of the Freedom to Speak up Guardian

The lead guardian is working within a national framework along with professional bodies and systems regulators to ensure that there is a process;

- for staff to raise concerns
- to ensure that issues are acted upon in a timely way
- to ensure that staff are not penalised as a result and that
- feedback is provided to staff on actions taken.

Additional Lead Guardian duties include;
- Commence facilitation of discussion between staff and management, not to solve concerns raised
- Promotion of the role
- Further develop a culture of openness and freedom for staff to raise concerns to their managers that will be explored and resolved and lessons shared
- Escalate and Support

The Freedom to Speak up Team is providing support to ensure that their role meets the needs of staff and will support the cultural change that we wish to see across England. Freedom to Speak Up Guardians are already making themselves available to all staff, including new starters at induction. They are also attending team meetings, proactively promoting speaking up, and being contacted by staff who want to speak up.

All guardians have received Innovative training, supported by Health Education England and Public Concern at Work.

Policy and Reporting

The Trusts Whistle Blowing Policy has been updated to identify a lead Freedom to Speak Up Non-Executive Director as well as the Freedom to Speak up Guardians. The pathway for raising Freedom To Speak up issues has also been included.

Current Cases

There are currently 10 cases being considered. All cases are confidential and independent of our HR processes. A summary of these is outlined below;

- 3 x Attitudes and Behaviours
- 2 x Policies and Procedures
- 1 x Quality and Safety: Entered 28.02.17
- 2 x Service Changes
- 1 x Patient Experience

One case currently under review.

National Guardianship

The Freedom to Speak up Report, published in February 2015, describes the functions of the National Guardian office as follows:

- Support Freedom to Speak up Guardians in NHS Trusts and Foundation Trusts
- Provide national leadership on issues relating to raising concerns by NHS workers
- Review the handling of concerns raised by NHS workers, and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice
- Advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect
- Offer guidance on good practice about handling concerns
- Ensure transparency and publish reports on the activities of this office.

There are challenges ahead to ensure all NHS Trusts and Foundations Trusts have effective and thriving freedom to speak up cultures within their respective organisations. Despite the good work being implemented, there are currently inconsistencies across England and it is acknowledged that there is much to learn and improve upon.

Board Recommendation

The Board is asked to receive the update.

NHS Solent NHS Trust

Presentation to	x In Public Board Meeting		Confidential Board Meeting
Title of Paper	Governance documentation updates – amendments to key documents		
Author(s)	Rachel Cheal, Associate Dir. Corporate Affairs & Company Secretary	Executive Sponsor	Sue Harriman, Chief Executive
Date of Paper	12th May 2017	Committees presented	
Link to CQC Key Lines of Enquiry (KLoE)	☐ Safe ☐ Effective ☐ Caring ☐ Responsive		X Well Led
Action requested of the Board	☐ **To receive**	X **For decision**	

The following governance documentation has been reviewed and updated (changes tracked in red font):

- **Board Terms of Reference (TOR)** - the TORs have been reviewed to reference the Hampshire and Isle of Wight Sustainability & Transformation Plan, Control Total and notably proposed changes to the voting executive members. Current executive voting members include: the Chief Executive Officer, Director of Finance & Performance, Chief Medical Officer, Chief Nurse with the final executive vote previously residing with the Chief Operating Officer Southampton and County. In light of the recent changes to executive personnel at the Board and to ensure there is no disparity between the Operating Officers, it is recommended that the final executive vote resides with the Chief People Officer.
- **Board Code of Conduct** – the Code of Conduct has been reviewed; there are no material changes to note. References to Foundation Trust/ Monitor and the Model Constitution have been deleted and reference to Freedom to Speak Up included.
- **Remuneration Committee Terms of Reference (TOR)** – the TORs have been refreshed, amending reference from the Trust Development Authority (TDA) to NHS Improvement (NHSI). Changes to the new title of Chief People Officer (as opposed to the Director of HR and OD) have also been included.

Recommendation:

The Board is asked to:

- Approve the changes to the Board Terms of Reference (Item 25.2)
- Approve the changes to the Board Code of Conduct (Item 25.3)
- Approve the changes to the Remuneration Committee Terms of Reference (Item 25.4)

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Item 25.2

Solent NHS Trust
Trust Board Terms of Reference

Reference to "the Board" shall mean the Trust Board

1 Constitution

1.1 The Board is accountable to the Secretary of State for the effective direction of the affairs of Solent NHS Trust, setting the strategic direction and appetite for risk of the Trust, establishing arrangements for effective governance and management and holding management to account for delivery, with particular emphasis on the safety and quality of the Trust's services and achievement of the required financial performance

1.2 The Board has established the following Committees:

- Audit & Risk Committee
- Governance & Nominations Committee
- Remuneration Committee
- Mental Health Act Scrutiny Committee
- Assurance Committee
- Finance Committee
- Charitable Funds Committee

2. Purpose

2.1 The purpose of the Trust Board is to govern the organisation effectively and ensure that the Trust is providing safe, high quality, patient-centred care.

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

- Ensure the management of staff welfare and patient safety
- Formulating Strategy, defining the organisations purpose and identifying priorities
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
- Seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- Shaping a positive culture for the board and the organisation.

3 Duties

3.1 Clinical Standards and Patient Safety

3.1.1 To receive reports which provide assurance of the quality and safety of healthcare services, education, training and research delivered by Solent NHS Trust, by applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies and assure the Board that areas of concern are being monitored.

3.1.2 To ensure compliance with all legal and regulatory requirements and clinical guidance monitoring performance against the Care Quality Commission requirements and ensuring that effective systems operate for the dissemination of National Guidance and directives

3.1.3 To oversee the risk management strategy implementation of Solent NHS Trust, and ensure appropriate action in relation to adverse events that occur.

3.1.4 To ensure a focus on quality at strategic and operational levels including patient safety (including Healthcare Associated Infections), effectiveness and patient experience as well as the promotion of health and wellbeing

3.1.5 To be responsible for overseeing the development and implementation of a workforce strategy, ensuring the workforce meets the needs of the organisation and is fit for purpose.

3.2 Formulate Strategy

3.2.1 To set the strategic direction to be pursued by the Trust being cognisant of the Sustainability and Transformation Plan for Hampshire and the Isle of Wight

3.2.3 To develop and approve a long term clinically informed Trust Strategy which is designed to bring healthcare benefit to the population, build reputation and ensure the sustained success of Solent NHS Trust enabling the organisation to compete effectively in the healthcare market.

3.2.4 To oversee the implementation of the long term financial model (LTFM) to deliver the long term success of Solent NHS Trust as well as oversight of the achievement of the Trust's Control Total.

3.2.5 To ensure the necessary financial and human resources are in place to meet strategic objectives and review management performance.

3.2.6 To approve business cases and new business opportunities as recommended by the Chief Executive, Trust Management Team Meeting (TMT) and Finance Committee and in accordance with the Trust's SFI's and Scheme of Delegation

3.2.7 To approve the development of innovative models of service delivery and redesign proposed by the Chief Executive and TMT

3.2.8 To ensure that a Board development and organisational development plans are in place to support the Trust's delivery of the strategic direction.

3.3 Shape Culture & Partnership Working

3.3.1 To foster positive and productive external relationships with partners and stakeholders in the local health economy, in particular with patient/user groups and forums; Local Authority, Health and Wellbeing Board, Sustainability & Transformation Plan partners, Healthwatch and Primary Care.

3.3.2 To maintain public and staff confidence and engagement with Solent NHS Trust and facilitate the effective involvement of the public

3.3.3 To ensure that the culture of the organisation reflects NHS values as reflected in the NHS Constitution, namely: respect and dignity; commitment to quality of care; compassion; improving lives; working together for patients and everyone counts.

3.4 Performance Management

3.4.1 To continuously monitor and respond to performance of all Solent NHS Trust services ensuring close links to operational plan objectives and vital signs.

3.4.2 To agree and approve SLAs with NHS providers.

3.4.3 To consider directives, comments and recommendations from the Board's committees and take

the appropriate action.

3.5 Governance

3.5.1 To be assured that an appropriate governance framework of prudent and effective controls is in operation which enables resources and risk to be assessed and managed allowing transparency, probity, integrity and the efficient use of resources.

3.5.2 To deliver financial balance/surplus and continuously monitor the organisations viability as a going concern

3.5.3 To approve the Annual Report, Quality Account and Annual Accounts

3.5.4 To be responsible for ensuring the effective stewardship of assets

3.5.5 To provide advice concerning action against litigation.

3.5.6 To receive and review the Board Assurance Framework and request the presentation of reports where additional assurance is required.

3.5.7 To embed the Learning Organisation and Quality Improvement ethos into all activities.

4 Membership

4.1 The Trust Board will comprise the following:

Voting members:

- Independent Chair (Chairperson)
- Five Non-Executive Members
- Chief Executive
- Chief Nurse
- Director of Finance & Performance
- Chief Medical Officer
- Chief People Officer

Non voting members:

- Chief Operating Officer Portsmouth and Commercial Strategy
- Chief Operating Officer Southampton and County

4.2 In the case of the number of votes for and against a motion being equal, the Chair of the Board will have a second, casting vote.

4.3 A manager who has been appointed formally to act up for an officer member during a period of incapacity or temporarily to fill an officer member vacancy, shall be entitled to exercise the voting rights of the officer member.

4.4 Members will be expected to attend at least 75% of meetings.

4.5 When an executive director member is unable to attend a meeting, a nominated deputy must be identified. The nominated deputy must be a direct report to the Board member.

5 Attendees

5.1 The following will be attendees at the meeting;

- Associate Director of Corporate Affairs and Company Secretary
- Corporate Support Manager and Assistant Company Secretary

5.2 In addition, lead officers representing other services/departments may attend when required or at the invitation of the Chair.

6 Secretary

6.1 The Corporate Support Manager or their nominee shall act as the secretary of the committee**.**

6.2 The administration of the meeting shall be supported by the Corporate Support Manager who will arrange to take minutes of the meeting and provide appropriate support to the Chairman and committee members.

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

7 Quorum

7.1 No business shall be transacted at meetings of the Board unless the following are present;

- a minimum of two Executive Directors
- at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair

8 Frequency

8.1 Meetings will be held every other month or more frequently if required, under the Chairmanship of the Solent NHS Trust Chair.

8.2 The following meetings will be held:

- Seminar (to brief the Board on current issues)
- In Public Meeting
- Confidential Meeting

8.3 Additional Board Development Workshops will be scheduled throughout the year as appropriate to support Board development and strategic planning.

9 Notice of meetings

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

9.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

10 Minutes of meetings

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

10.2 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of

interest and minute them accordingly.

10.3 Minutes of meetings shall be circulated promptly to all members once agreed.

10.4 Minutes will be available under the Freedom of Information Act 2000.

11 Authority

11.1 The Board may :

- seek any information it requires from any employee of the Trust in order to perform its duties
- obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- call any employee to be questioned at a meeting of the Board as and when required.

12 Reporting

12.1 The Board will develop an Annual Cycle of Business where scheduled items throughout the year will be presented.

12.2 The Board will receive copies of minutes, and updates (including exception reporting) from its reporting Committees via the relevant Committee Chairs

12.3 The Chairs of Committees will also be responsible for ensuring relevant information and decisions are reported and cascaded back through the appropriate communication channels.

12.4 The Board will receive project reports on an ad-hoc basis.

12.5 Member's attendance at meetings will be disclosed in the Trust's Annual Report.

Version	7
Agreed at Trust Board	May 2017
Date of Next Review	May 2018

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Item 25.3

Board of Directors: Code of Conduct

Purpose of Agreement	To outline the behaviours and requirements expected of the Board
Reference Number	Solent/Corporate / BoDCoC/01
Version	Version 4
Name of Approving Committees/Groups	Board of Directors
Operational Date	May 2017
Document Review Date	May 2018
Document Sponsor (Name & Job Title)	Alistair Stokes, Chairman
Document Manager (Name & Job Title)	Rachel Cheal, Company Secretary

Version	Summary of amendments
2	Overall document review and incorporation of Regulation 5 Fit and Proper Person requirements – amended Appendix 2.
3	Annual Review- updated section 3.1 to reflect new organisational values, changes made to reference 'Members Council' throughout, no other material amendments required
4	Annual Review

Foreword – this Code of Conduct applies specifically to the Board of Directors (as defined below); however the principles described equally apply to all members of staff.

1. Introduction

1.1 High standards of corporate and personal conduct are an essential component of public services. Solent NHS Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant Code of practice.

1.2 The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of the [1]Board of Directors.

1.3 This Code, ~~with the NHS Constitution (and the Code of Conduct for the Members Council)~~ forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust.

1.4 The Code is intended to operate in conjunction with the Standing Orders. The Code applies at all times when the Board are carrying out the business of the Trust or representing the Trust.

1.5 The Board must also comply with the statutory and general duties requirements conferred by legislation as set out in the NHS Act 2006 ("NHS Act"), as amended by the Health & Social Care Act 2012 ("HSCA").

1.6 The Board must also comply with the following;

- Standards for NHS Board Members 2012
- Code of Conduct - Code of Accountability in the NHS 2004

2. Principles of public life

All Directors are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

2.1 Selflessness**:** Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

2.2 Integrity**:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

2.3 Objectivity**:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

[1] *For the purpose of this document the Board of Directors/ Directors means, Board members (voting) and non-voting (i.e. other executive directors and lay members)*

2.4 Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

2.5 Openness: Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

2.6 Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

2.7 Leadership: Holders of public office should promote and support these principles by leadership and example.

3. Corporate vision & values

3.1 Solent NHS Trust Board of Directors will also adhere to the following organisational values developed with staff and the Board:

4. General Principles

4.1 The Board of Directors has a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

4.2 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for service users and for the public.

4.3 The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Standing Orders, Financial Standing Orders and an accompanying Scheme of Delegation conform to best practice and serve to enhance standards of conduct.

4.4 The Board of Directors expects that this Code will inform and govern the decisions and conduct of all Directors.

5. Confidentiality and Access to Information

5.1 Directors must comply with the Trust's confidentiality policies and procedures.

5.2 Directors must not disclose any confidential information, except in specified lawful circumstances.

5.3 Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable.

5.4 Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

5.5 The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by Board of Directors and all staff.

5.6 As part of this Code of Conduct, the Board are asked to confirm their agreement with the Non-Disclosure Agreement, located in Appendix 1.

6. Register of Interests

6.1 Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the Standing Orders.

6.2 It is the responsibility of each Director to update the register entry if their interests change.

6.3 A pro forma is available from the Company Secretary - failure to register a relevant interest in a timely manner may constitute a breach of this Code.

7. Conflicts of Interest

7.1 Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

7.2 Directors have a further statutory duty not to accept a benefit from a third party by reason of being a Director or for doing (or not doing) anything in that capacity.

7.3 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the Director must declare the nature and extent of that interest to the other Directors. It is equally important to register any potential conflicts.

7.4 If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

7.5 The Chair will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the Director should withdraw from the meeting for the period of the discussion.

7.6 In the event of disagreement it is for the Board of Directors to decide whether a Director must withdraw from the meeting. The Company Secretary will provide advice on any conflicts that arise between meetings.

7.7 Further information can be found within the Standing Orders.

8. Gifts and Hospitality

8.1 The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure.

8.2 The use of the Trust for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered.

8.3 All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust in the eyes of the community.

8.4 The Board of Directors has adopted a *Standards of Business Conduct – Register of Interests, Gifts and Hospitality Policy* which will be followed at all times by Directors and all employees. Directors and employees must not accept gifts or hospitality other than in compliance with this policy.

9. Freedom to Speak Up /Whistle – Blowing

9.1 The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature.

9.2 The Board of Directors has adopted a Freedom to Speak Up Policy (whistle-blowing policy) on raising matters of concern which will be followed at all times by Directors and all staff. The policy sets out the arrangements and procedures to be followed in situations where staff wish to raise a concern, the document also outlines the scrutiny and oversight by the Audit & Risk Committee.

10. Personal Conduct

10.1 Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute.

10.2 Specifically Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code of Conduct
- Respect others and treat them with dignity and fairness

- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion
- Be honest and act with integrity and probity
- Contribute to the workings of the Board of Directors as a Board member in order for it to fulfil its role and functions
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the Trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate
- Recognise the differing roles of the Chair, Deputy Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors
- Make every effort to attend meetings where practicable
- Adhere to good practice in respect of the conduct of meetings and respect the views of others
- Take and consider advice on issues where appropriate
- Acknowledge the responsibility of the Members Council to represent the interests of the Trust's members and partner organisations in the governance and performance of the Trust, and to have regard to the views of the Members Council
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person
- Accept responsibility for their performance, learning and development.

11. Fit and Proper Person Requirements

11.1 In accordance with Monitor's NHS Provider Licence Condition G4 and Regulation 5 of the Regulated Activities Regulations, Health & Social Care Act 2008, Directors are asked to confirm their compliance with the Fit and Proper Persons Test as outlined in Appendix 2. Although the Fit and Proper Person requirements of Regulation 5 do not apply to the Members Council, the Trust has implemented its own governance procedures, including reference to Fit and Proper Person requirements ~~within the draft constitution (as per Monitor's model template)~~, the introduction of standard DBS checks, and Companies House checks.

12. Fraud, Corruption and Bribery

12.1 In accordance with the Bribery Act 2010 and the Trust's 'Fraud, Corruption & Anti –Bribery Policy', Solent NHS Trust is committed to supporting anti-bribery and corruption initiatives and recognises the importance of ensuring that there are appropriate policies and procedures in place to ensure that all staff are aware of their responsibilities. Solent NHS

Trust is absolutely committed to maintaining an honest, open and well-intentioned atmosphere. It is also committed to the elimination of any fraud within the Trust and to the rigorous investigation of any such cases. The Board of Directors will comply with the Trust's policy.

13. Board Principles regarding meeting etiquette and administration

14.1 Principles of meeting etiquette and administration are summarised in Appendix 3.

14. Compliance

14.1 The members of the Board of Directors will satisfy themselves that the actions of the Board of Directors in conducting Board business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon.

14.2 All directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code of conduct.

Appendix 1 - Non Disclosure Agreement

Dear Director

As a member of the Board of Directors, you will hold a valued and trusted position within our organisation. In the course of discharging your role, you will receive Confidential Information (please see further below). To protect the interests of the Trust and its service users, the Code of Conduct expects you to agree to respect the confidentiality of such information.

Please confirm your agreement to do so by signing and returning to the Trust the enclosed compliance form. Please direct any questions you may have to the Trust Secretary.

For the purposes of this commitment, "Confidential Information" means:

(a) all information (whether communicated orally or in writing) relating to the business, financial, staff or other affairs of the Trust disclosed to you in your capacity as a Director of the Trust (including, without limitation, agendas and minutes relating to meetings); but excluding any information already in the public domain (for example, Part 1 In Public Board agendas and associated papers) and

(b) all notes, memoranda or other documents prepared by you which contain, reflect or are generated from the information referred to in (a) above.

If you are in any doubt as to whether particular information is Confidential Information, please check with the Trust Secretary.

It is worth emphasising that the Trust is committed to transparency and openness, as well as to meeting its statutory obligations. To be clear, nothing in this letter or the commitment which it seeks from you shall prejudice any rights that you may have under the Public Interest Disclosure Act 1998 and/or any obligations that you have or may have to raise concerns about patient safety and care with regulatory or other appropriate statutory bodies pursuant to applicable professional and ethical obligations (including those obligations set out in guidance issued by regulatory or other appropriate statutory bodies from time to time).

Yours sincerely

Rachel Cheal, Associate Director of Corporate Affairs & Company Secretary, on behalf of Solent NHS Trust.

Appendix 2 - Fit and Proper Person Declaration

Pre-employment and annual declaration for Director and Director-equivalent posts

Solent NHS Trust ("the Trust")

1. It is a condition of employment that those holding director and director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by Monitors NHS Provider Licence Condition G4, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations"), and the Trust's draft constitution (which will come into force at the point of being licenced).

2. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

Monitors NHS Provider Licence Condition G4,

3. Condition G4 provides that the Licensee shall not appoint as a director any person who is an unfit person, except with the approval in writing of Monitor.

4. Directors contracts contain a provision permitting summary termination in the event of a director being or becoming an unfit person. The Trust shall also ensure that it enforces that provision promptly upon discovering any director to be an unfit person, except with the approval in writing of Monitor.

   (Regarding governors, no person who is unfit may become or continue as a governor, except with the approval in writing from Monitor).

   If Monitor has given approval in relation to any person in accordance with the above the Trust shall notify Monitor promptly in writing of any material change in the role required or performance by that person.

5. An "unfit person" is defined at condition G4 as:

   (a) an individual:

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

Trust's draft constitution

9. The Trust's constitution (section 35) places a number of restrictions on an individual's ability to become or continue as a director. A person may not become or continue as a director of the Trust if:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;
- a person who, in the case of a non executive director other than the initial non-executive directors, no longer satisfies paragraph 29 (if applicable);
- a person whose tenure of office as a chairman or as a member or Director of a health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- a person who has had their name removed from a list maintained by a direction under any NHS act or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable), and due to such reasons is considered by the Trust to be unsuitable to be a Director;
- a person who by reference to information revealed by a disclosure and barring service (established under section 87 of the Protection of Freedoms Act 2012) check is considered by the chief executive to be inappropriate on the grounds that their appointment may adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;
- a person who has, or has been in the last five years prior to their application to be a member, been involved as a perpetrator in a serious incident of assault or violence, or in one or more incidents of harassment, against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust (including volunteers), and following such behaviour has been asked to leave, has been removed or excluded from any hospital, premises or establishment, in accordance with the relevant Trust policy for withholding treatment from violent / aggressive patients;
- a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

- a person who is a governor of the Trust or an executive or non-executive director or a governor of another NHS foundation trust, an executive or non-executive director, chair, chief executive officer of another Health Service Body or a body corporate whose business includes the provision of health care services, or which includes the provision of any service to the Trust;

- a person who is a member of a local authority health overview and scrutiny committee;

- a person who is a subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

- a person who has failed without reasonable cause to fulfil any training requirement established by the Board of Directors;

- a person who has failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the Directors' Code of Conduct;

- a person who has knowingly or recklessly made a false declaration for any purpose provided for under this constitution or in the 2006 Act;

- a person who is the spouse, partner, parent or child of a member of the Board of Directors (including the chairman) of the Trust; or

- a person who is the subject of a sex offenders order and/or his name in included in the sex offenders register.

I declare that I have not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying out of a regulated activity in any former roles. If the Trust discovers information, after appointment, that suggests an individual is not of good character, or if concerns or findings regarding misconduct or mismanagement under the Fit and Proper Person requirements are made, these will be shared with Regulators as appropriate and may lead to action in accordance with the Trust's disciplinary policy.

Appendix 3 - Solent NHS Trust Board Principles

The members of Board of Directors hereby agree to follow the below principles:

1. Apologies sent to the Company Secretary ASAP
2. Agenda items to be agreed by Chair and Chief Executive Officer at least 2 weeks prior to meeting
3. In accordance with the Intelligent Board Recommendations, every member of the Board needs sufficient information at a high enough level to be confident that the organisation is well run. Papers must be presented in accordance with the *'Board Report Guidance'* The submitted board paper while succinct must contain sufficient information to act as a stand-alone paper without reference to any additional papers which may be made available outside the formal board papers. Executive sponsors must not rely upon board members reading additional papers as a means of communicating critical information.
4. Papers received after the deadline stipulated will not be accepted and will be deferred, unless with express permission from the Chair.
5. Authors of papers to ensure that they are sponsored by the relevant Executive Lead, prior to being submitted for circulation to the Board with the agenda
6. Agendas and papers to be circulated 5 working days prior to meeting
7. All papers to be read prior to meeting
8. A.O.B to be agreed at the start of the meeting
9. A Register of Interests will be maintained and all members will separately declare any interests in agenda items at the start of the meeting, which will then be recorded in the minutes.
10. Throughout the meeting Members will address the Chairperson as 'Chair'.
11. Attendance at the meeting should take priority over other meetings, however it is recognised that on occasions there will be competing priorities. In these circumstances the Board Member shall negotiate with the Chair/Chief Executive Officer regarding attendance
12. Mobile phones and blackberries will be switched off during the meeting and not used (except in the case where the attendee is on-call. The Chair should be notified at the start of the meeting in such cases). Use of laptops/ ipads is only permitted for the sole purpose of supporting the meeting.
13. These principles are extended to Board Committees.
14. An annual agenda cycle will be maintained by the Secretary to the Board and will include the standing items that are required to be presented each month.

Annual Declaration of Compliance with Code of Conduct

1. I confirm that I have received and read the **Code of Conduct** for the Board of Directors. I confirm that I have complied with the Code to date and I agree to comply with it in the future in carrying out my role as a Director of Solent NHS Trust.

In doing so, I also;

2. confirm my agreement to preserve the confidentiality of confidential information, as outlined in the **Non Disclosure Agreement**, Appendix 1

3. acknowledge the extracts from Monitors Provider Licence, Regulated Activities Regulations ~~and the Trust's draft constitution~~ concerning **Fit and Proper Persons requirements** as outlined in Appendix 2. I confirm that I do not fit within the definition of an "unfit person" as listed and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post**.**

4. confirm I understand and respect the details outlined in **Solent NHS Trust Board principles**, Appendix 3.

Name (please print)	
Signature	
Date	

Please return this completed signed form to: - **Company Secretary, Solent NHS Trust, Solent NHS Trust Headquarters, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR**

NHS
Solent
NHS Trust

Item 25.4

Solent NHS Trust
Remuneration Committee Terms of Reference

The Solent NHS Trust Board hereby establishes a Committee of the Board to be known as the Remuneration Committee ('the Committee') in accordance with its Standing Orders and Scheme of Delegation.

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. Membership

1.1 Membership of the Remuneration Committee will comprise:
- The Non-Executive members of Solent NHS Trust
- The Trust Chair

1.2 One of the members of the Remuneration Committee will be appointed as Chair of the Committee by the Chair of Solent NHS Trust Board. 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.

1.3 The Trust Chair shall not be the Chair of the Committee.

1.4 The composition of the Committee will be disclosed in the Solent NHS Trust Annual Report.

2. Purpose

2.1 The Committee makes decisions on behalf of the Board regarding remuneration and terms of office relating to the Chief Executive and other Executive Directors and also agrees/oversees Clinical Excellence Awards as well as overseeing severance payments over £50k.

3. Duties

The committee will:

3.1 Be responsible for aligning the Trust's Remuneration Policy for Directors with national Very Senior Management (VSM) terms.

3.2 Make decisions on behalf of Solent NHS Trust Board and where necessary make recommendations to NHS Improvements about appropriate remuneration, allowances and terms of service for the Chief Executive, and other Executive Directors, to include:-

- Salary
- Pensions
- Performance related pay *[and whether Directors are eligible for annual bonuses]*
- Provision of other contractual terms and benefits
- Approval of settlement agreements/severance pay or other occasional payments to individuals and out of court settlements, taking account of national guidance
- Receive and note decisions of the Clinical Excellence Awards (CEA) panel

3.3 Within the constraints of national frameworks, the Committee will agree the remuneration package, allowances and terms of service of the Trust's executive directors. No executive director shall be involved in any decisions as to their own remuneration

3.4 Monitor and oversee the evaluation of the performance of the Chief Executive and other individual Executive Directors

3.5. Approve participation in any performance related pay schemes, where operated by the Trust, and approve the total annual payments made under such schemes.
The Committee will ensure:
- that any pay-outs or grants under any incentive schemes are subject to challenging performance criteria reflecting the objectives of the Trust.
- that any performance criteria and upper pay limits for annual bonuses and incentive schemes are disclosed

3.6 Ensure that contractual terms on termination, and any payments made, are fair to the individual, and the NHS, aligned with the interests of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate.

3.7 The Committee will refer the following matters to the NHS Improvements (NHSI) in accordance with the 'NHS TDA Guidance for NHS Trusts on processes for making severance payments[1]';

- All severance payments (contractual or non-contractual) to Chief Executives and Directors of NHS Trusts. For these purposes, "Director" means any Director reporting to the Chief Executive whether or not an executive member of the Board.

- Non-contractual severance payments to all staff (including to Chief Executives and Directors as defined in 2.1).

- Contractual payments over £50,000 to all staff (including to Chief Executives and Directors as defined in 2.1)

3.8 Be responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any Remuneration Consultants who advise the committee, and to obtain reliable, up-to-date information about remuneration in other Trusts. Where Remuneration Consultants are appointed, a statement will be made available of whether they have any other connection with the Trust or conflicts of interest.

3.9 Consider any pension consequences and associated costs to the Trust of basic salary increases and other changes in pensionable remuneration.

3.10 Ensure that levels of remuneration for the Chair and other non-executive directors reflect the national terms

3.11 Consult the Chair and/or the Chief Executive concerning proposals relating to the remuneration of other Executive Directors

3.12 Recommend and monitor the level and structure of remuneration for Senior Management (the definition of Senior Management to be determined by the Trust Board, but will normally include the first layer of management below Board level).

Deleted: Trust Development Authority

[1] It is acknowledged that the title of this document may be amended in the future to acknowledge NHSIs new title

3.13 Disclose in the Annual report, where the Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, whether or not the Director will retain such earnings.

3.14 To have oversight of Mutually Agreed Resignation Schemes (MARs) and to approve schemes as necessary.

4. Attendance

4.1 The Chief Executive, Chief People Officer and Director of Finance and Performance will be invited to attend the meeting as required to provide advice but will not be in attendance for discussions concerning their own remuneration and/or terms of service, and will therefore withdraw from those parts of the meeting.

Deleted: Director of HR & OD

5. Secretary

5.1 The Secretary to the Committee will be coordinated by the Chief People Officer with the Committee Chair.

Deleted: Director of HR & OD

6 Quorum

6.1 The quorum necessary for the transaction of business shall be three 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.

7 Notice of meetings

7.1 The Chair or their deputy shall summon the meeting.

7.2 Whenever possible, members will be given 5 working days' notice before the date of the paper and associated supporting papers will be circulated in advance of the meeting. However, it is acknowledged that it may be necessary to convene a meeting (or virtual meeting) at short notice and members will be informed accordingly.

8 Minutes of meetings

8.1 The secretary shall minute the proceedings and resolutions of all committee meetings, including the names of those members present and those in attendance. In the case of virtual meetings, a written confirmation of the meeting and agreements will follow as soon as practically possible.

8.2 Minutes of committee meetings shall be circulated promptly to all members of the committee

9. AGM attendance

9.1 The Chair of the Committee shall attend the Annual General Meeting prepared to respond to any stakeholder queries in relation to the committee activity.

10. Authority

10.1 The Committee is authorised by the Board to review and approve any activity within its Terms of Reference. In so doing, the Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

10.2 The Committee will make satisfactory arrangements to ensure it receives adequate independent advice on remuneration levels elsewhere in the NHS, with due reference to national policy and guidance, as well as trends and developments in areas of benefits and terms and conditions of employment.

11. Frequency of Meetings

11.1 The Committee shall meet at least annually and at such other times as the Chair of the committee shall require.

12 Reporting responsibilities

12.1 The Committee shall report formally to Solent NHS Trust Confidential Board meeting, the basis for its decisions and recommendations. The Chair of the Committee shall draw to the attention of the Board any significant issues that require specific consideration or action by the Board. Minutes of the Trust Board's meetings will record receipt of the report of the Remuneration Committee and the decisions of the Board.

Deleted: Part 2 (private)

12.2 Notes for each meeting, including decisions and actions, will be recorded and retained by the Chief People Officer.

Deleted: Director of HR & OD.

12.3 The Committee shall produce an annual statement of the Trust's remuneration policy and practices which will form part of the Trust's Annual Report, including:

- the disclosure of any remuneration received by an Executive Director serving as a Non-Executive Director elsewhere and whether this is retained or not by the Executive Director
- membership of the Remuneration Committee, this means the names of the Chair and members of the Remuneration Committee
- the number of meetings and individual's attendance at each
- the name of any person (and in particular any director of the Trust who was not a member of the committee) who provided advice or services to the committee that materially assisted the committee in their consideration of any matter. Where such a person is not a director of the Trust: a description of the nature of any other services that person has provided to the Trust during the financial year and whether that person was appointed by the committee

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

Version	6
Date of Next Review	Date: June 2017

Deleted: 5

Deleted: July 2017

NHS Solent NHS Trust

Board Report – In Public Meeting

Title of Paper	**NHS Improvement : Self Certification against NHS Provider Licence (Single Oversight Framework requirement)**		
Author(s)	**Rachel Cheal, Associate Director of Corporate Affairs and Company Secretary**		
Date of Paper	10th May 2017	**Committees presented**	n/a
Action requested of the Board	☐ To receive ☒ For decision		
Link to CQC Key Lines of Enquiry (KLoE)	Safe ☐ Effective ☐ Caring ☐ Responsive ☒ Well Led		

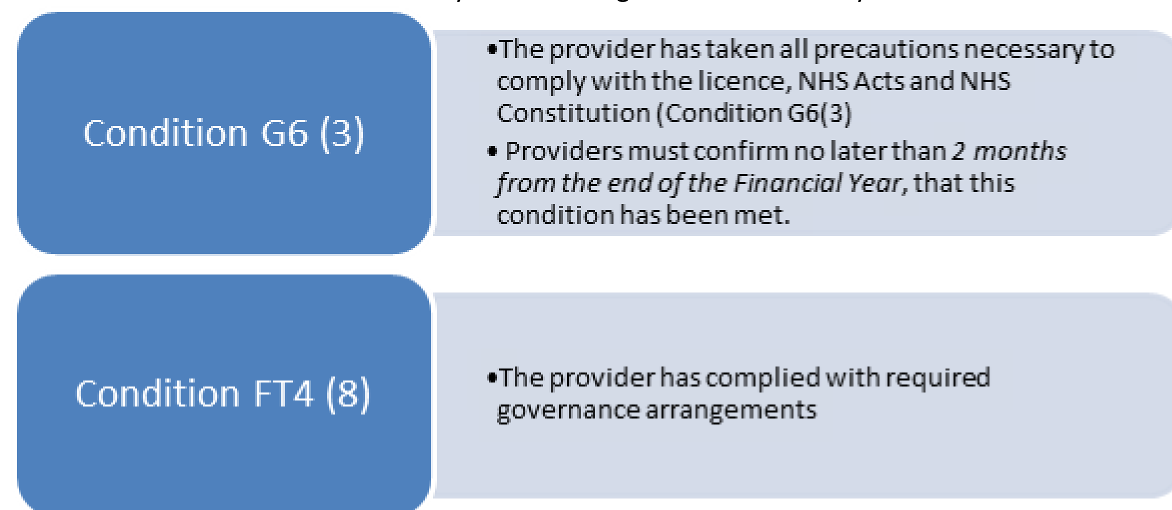
The requirement

From April 2017, NHS Improvement introduced a new requirement on all NHS Trusts for 2017/18 whereby each Trust is asked to **self-certify in accordance with the NHS Provider Licence**. Although NHS Trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.
The Single Oversight Framework (SOF), bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

Solent NHS Trust, is therefore required to self-certify that we meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that we have complied with governance requirements. The Trust completed a similar exercise (in shadow) when it was actively pursuing Foundation Trust status.

The process

NHS Providers are asked to self-certify the following after the financial year-end:



A template has been provided by NHSI to capture Trust responses on a 'comply or explain' basis, which has been adapted for internal use to capture assurance.

There is no set process for assurance or how conditions are met, which is reflective of autonomy - each Trust is therefore required to determine how compliance is met (or otherwise). NHSI also requires each **Board to formally 'sign'** in agreement of compliance against the conditions.

Providers are required to have effective systems and processes in place to ensure compliance; to identify risks to compliance and take reasonable mitigating actions to prevent those risks/or compliance failures.

Compliance with the conditions must be **published** (via the website) and can be **spot audited by NHSI post July 2017**. Evidence must therefore be collected to support each condition compliance.

A copy of Solent NHS Trust's compliance with these conditions are found on pg 3.

A copy of the full Licence Conditions for G6 and FT4 are found in Appendix 1, pg 7.

Recommendations:

The Board is asked to confirm its agreement with the responses outlined against each of the Provider Licence requirements; or provide alternative responses as agreed. Representatives of the Board (e.g. the Chairman and the CEO) are asked for formally sign in agreement.

As NHSI are conducting spot audits it is recommended that the Board reconsiders compliance at each meeting. It is therefore suggested that in future, compliance is included within the Single Oversight Framework reporting requirements incorporated within the Performance Report. The Board are asked to agree with this approach.

Self-Certification 2017/18 – NHS Provider Licence

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.	
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 or the impact of vacancies effecting quoracy. The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.	

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	The Board is not aware of any departures from the requirements of this condition. 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.	Concerning CQC compliance: A comprehensive action plan is in place and being monitored in response to the CQC comprehensive inspection during 2016. The external auditors are in the process of finalising their VFM opinion. The draft opinion shared with Solent is that the accounts for 2016/17 will be unqualified on this point.

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. Established escalation processes allow staff to raise concerns as appropriate.	Concerning Board level capability- appointment has been made to the Chief Nurse position and COO Southampton and County and transition arrangements/ handovers are being implemented. The Board will also actively recruiting to a NED vacancy with support from the NHSI, post purdah as the current NED post holder leaves at the end of May 2017.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Signed on behalf of the Board of Directors;

Signature

Title

Date

Signature

Title

Date

Appendix 1 – details of full relevant Licence conditions:

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence,

   (b) any requirements imposed on it under the NHS Acts, and

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
(b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
(a) effective board and committee structures;
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:
(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:
(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and
(b) if required in writing by Monitor, a statement from its auditors either:

> (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or
> (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.