Agenda
Solent NHS Trust In Public Board Meeting

Monday 27th November 2017 10:30am – 13.35pm
Kestrel 1+2, Top Floor, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

**Timings are tentative*

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter
1	10:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive** *To receive*	Chair
2			**Register of Interests & Declaration of Interests** *To receive*	Chair
3			**Confirmation that meeting is Quorate** *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair
4			***Minutes of Last Meeting and action tracker** *To agree*	Chair
5	10:35	5mins	**Matters Arising**	Chair
6	10:40	5mins	**Any Other Business** *(not on the agenda but advised and agreed with the Chair for inclusion at this meeting)*	Chair
7	10:45	30mins	**Safety and Quality First – including** • **Recent Quality Visits** - *To receive verbal update from NED and Board attendees including Board visits conducted on 13th November*	Chief Executive / Chief Nurse
Strategy & Vision				
8	11:15	10mins	**Chief Executive's Report** *To receive*	Chief Executive
Programme Delivery				
9	11:25	20mins	**Performance Report** - including • Operational Performance • Quality Performance • Financial Performance • Workforce Performance • NHSI Compliance *To receive*	Executive Leads

10	11:45	10mins	**Equality and Diversity** *To receive*	Chief People Officer
11	11:55	10mins	**PSEH ACS Improvement Plan** *Verbal update*	CEO
12	12:05	5mins	**Smoke Free Implementation Update** *To receive*	COO Southampton and County
13	12:10	10mins	**Professional Engagement and Leadership Report** (inc. professional strategic framework and nurse revalidation) *To note*	Chief Nurse
14	12:20	10mins	**Patient Experience Quarterly Report** *To note*	Chief Nurse
15	12:30	5mins	**Information Governance** *To receive*	COO Southampton and County
***Reporting Committees and Governance**				
16	12:35	5mins	***Chairs report on Members Council** *To receive*	Chairman
17	12:40	5mins	***People and OD Group** *To receive verbal update*	Committee Chair
18	12:45	5mins	***Charitable Funds Committee Minutes & Chairs update** *To receive verbal update*	Committee Chair
19	12:50	10mins	***Assurance Committee Chair's Update** *To receive*	Committee Chair
20	13:00	10mins	*** Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update** *To receive verbal update*	Committee Chair
21	13:10	5mins	***Governance and Nominations Committee update** *No meeting held to report*	Committee Chair
22	13:15	5mins	***Audit & Risk Committee** *To receive*	Committee Chairs
23	13:20	5mins	**Complaints Review Panel** *To receive*	Committee Chair
Any other business				
24	13:25	5mins	**Governor comments and questions**	Chair
25	13:30	5mins	**Any other business & future agenda items**	Chair
26	13:35	------	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the	Chair

			business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	

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Supplementary papers are available on request from the Assistant Company Secretary

Date of next meeting: 29th January 2018

Minutes

Solent NHS Trust In Public Board Meeting

Monday 25th September 2017
10:30am-12:50pm
Kestrel 1 & 2, Solent NHS Trust Headquarters, Highpoint Venue, Bursledon Rd, Southampton, SO19 8BR

Chair: Alistair Stokes, Chairman (AMS)	
Members: **Sue Harriman,** Chief Executive (SH) **Andrew Strevens,** Director of Finance (AS) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Dan Meron,** Chief Medical Officer (DM) **Lesley Munro**, Chief Nurse (MR) **Helen Ives,** Chief People Officer (HI) **Jon Pittam,** Non-Executive Director (JPi) **Mick Tutt,** Non-Executive Director (MT) **Francis Davis,** Non-Executive Director (FD) **Mike Watts,** Non-Executive Director (MW)	**Attendees:** **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **Jayne Edwards,** Corporate Support Manager and Assistant Company Secretary (JE) **Sam Stirling,** Corporate Affairs Administrator **Apologies:** **Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA) **Stephanie Elsy**, Non-Executive Director (SE)

1	**Chairman's Welcome and Update**
1.1	Apologies were received as noted above. SH updated the Board on the status of absent colleagues.
2	**Register of Interests & Declarations of Interests**
2.1	There were no further updates to report.
3	**Confirmation that meeting is Quorate**
3.1	The meeting was confirmed as quorate.
4	**Minutes of Last Meeting and action tracker**
4.1	The minutes of the meeting held on 31st July were agreed as an accurate record.
5	**Matters Arising**
5.1	The following actions were confirmed as complete: 552, 566, 575, 576, 578, 579, 580
5.2	No other matters arising were raised.

6	**Safety and Quality First**
6.1	The Board were briefed on a recent jury inquest and of the lessons learned. LM highlighted issues relating to out of date resuscitation training and of the need to review fitness to practice. It was confirmed that a full update will be provided by the end of the week.
7	**Any other business**
7.1	RC reminded the In-Public Board not to discuss business of a confidential nature regardless of there being no public members in attendance.
7.2	<u>Board to Floor Visit-Turner Centre</u> • MT reported on the breadth of services provided within the Centre and of the dedication and professionalism of staff. • Key risks identified within the service and of staffing level challenges resulting in the cancellation of service user sessions were noted. • MT raised concern regarding the limited knowledge of the Freedom to Speak Up Guardian's role and changes to the 'Whistleblowing' policy. The Board acknowledged work required to ensure awareness within services. • MT reported there to be an out of date Board structure on display in the public area of the centre. RC confirmed that new structures have been circulated to services. • MT suggested that an admin review be undertaken to ensure appropriate use of practitioners' clinical time. • Issues regarding the limited use of Skyguard, particularly amongst senior experienced lone working staff were highlighted. It was agreed that LM encourage usage. **Action: LM** • MT explained the revised structure being used on Board to Floor visits based on the 5 CQC key lines of enquiry. **The Board noted the update.**
Strategy & Vision	
8	**Chief Executive's Report**
8.1	<u>Sustainability Transformation Partnership (STP)</u> SH briefed the Board on version 7 of the Portsmouth South East Hampshire Accountable Care System Plan. It was noted that the plan is to be circulated to local Chairs, CEOs, Commissioners and the ACS Board to encourage change across all organisations. SH provided context to the paper and expected timescales for a public debate. The Board were encouraged to read the paper and feedback any comments.
8.2	FD asked if changing the Trust's Scheme of Delegation would enable an increase in STP spending. AMS explained that the scheme of delegation is for Solent only and there is currently no agreement in place to pool resources across organisations.
8.3	MT highlighted the importance of appropriate consideration at emerging ACS governance groups.

8.4	<u>CQC Reports</u> SH referred to the CQC re-inspection report relating to CAMHs and Substance Misuse Services and of the proud achievements made due to the effort and commitment of staff.
8.5	AMS asked if there is any time scale for achieving an overall CQC standard. SH explained preparation work being undertaken and of the process going forward. It was noted that activity is expected to commence in January 2018. . It was noted that DM is to join the CQC as a specialist advisor to conduct inspections.
8.6	• SH reported on the management and significant reduction in the number of people deemed medically fit for discharge that remain waiting for discharge across acute hospitals and of positive collaborative leadership in place to support. • SH briefed the Board on the Medically Fit for Discharge project and of the support provided from a system perspective. • DN reported on Dental negotiations relating to general anaesthesia theatre slots. It was noted that locations, timing and price are yet to be agreed. • SH shared positive outcomes following a review of well led initiatives and organisation strategy leadership at the recent strategic away day.
8.7	<u>Risk Register</u> The Board noted a reduction in the Estates corporate risk due to the commencement of work on the Kite Unit. It was confirmed that definitive completion timescales have been requested. JPi asked how the workforce capacity risk is being quantified and asked if the mitigations in place are sufficient. HI explained the historical challenges and fundamental issues particularly associated with Mental Health workforce and of the positive improvements achieved to date. It was noted that not all issues are solvable by the Trust and are being addressed nationally. MW reported that the newly established People and Organisational Development Group is to focus on workforce over the next year.
8.8	Concerning the NHS England pilot on the use of Psychological Therapies (IAPT) to help manage Long-Term Physical Health conditions, queries were raised regarding the linkage to the Recovery College and as to what LTCs were considered. **Action: It was agreed to seek clarification from Matthew Hall.**
8.9	MT confirmed ongoing review of The Policing and Crime Act 2017 at the Mental Health Act Scrutiny Committee. **The Board received the CEO Report.**
Programme Delivery	
9	**Performance Report**
9.1	SH requested that further narrative is included within the Performance Dashboard for August 2017/18 to provide context for numbers reported.

9.2	AMS queried the number of CQC actions not yet met. LM explained the definition of 'CQC actions not met' and provided assurance that red and amber RAG rating actions are in progress. The Board was informed that all 'must do' actions are complete and regularly reviewed.
9.3	Operational • DN informed the Board of a new care model within the Southampton System which will provide challenge across care groups. • Progress on the redesign of Community Nursing was shared. • Thematic issues associated with 'Looked after Children' were highlighted. • DN informed the Board that the relocation of the Kite Unit has commenced and highlighted positive plans in place for the management of beds. • DN informed the Board of awaited costs for general anaesthesia within Dental Services and reported on three new appointments made.
9.4	MW queried the differences between what has been 'achieved' and 'due to be achieved'. AS reported on a more collaborative approach being taken with contract management and provided assurance that no contract notices have been received this year.
9.5	Quality AMS queried the differences in grade 2 pressure ulcer reporting and potential mixed information being reported across committees. LM explained the changes in reporting following a national standard request from commissioners resulting in a possible effect on totals. *Post meeting note-* *Data processes have been reviewed with the Quality Team Analyst. The 2016/17 total was year-end and not YTD, like 2017/18. This was the first month that data was produced through formulae rather than previous manual count. The formula has been rectified with the Analyst so future reporting should be accurate.*
9.6	LM informed the Board of the publication of the system wide thematic report for Looked After Children and confirmed actions for the Trust and governance processes being established.
9.7	Finance • AS highlighted an amendment made to the report regarding surplus. • Credit notes received from NHS Property Services for 16/17 was noted. • The Board was informed of a request to review capital bid for St Mary's Hospital redevelopments.
9.8	St James' Hospital Re-location SH suggested a review of risk escalation and appropriate staff communication. AMS queried the number of staff currently working on the St James' site and of the future of catering staff. AS confirmed further reviews being undertaken and suitable options being considered.
9.9	JPi highlighted the importance of lessons learned surrounding future service line budgets. AS confirmed that plans are in place and suggested considering a review of the role of Service Transformation Managers. **Action- AS & HI to review.**

9.10	<u>Workforce</u> • HI reported on a continued high level of agency usage due to summer holidays and low bank availability. The Board was assured of actions in place to address, following an initial review. • HI informed the Board of a review being undertaken following a 0.5% increase in sickness levels over the summer period. • The completion of the first stage of workforce planning was noted and HI confirmed appropriate baseline and entry level workforce plans. • HI provided an overview of turnover rates and of work being completed to improve culture.
9.11	SH asked if there is a common theme connected with staff turnover. HI reported work-life balance as being the most common cause and highlighted the need to consider solutions across the system, to reduce the number of staff joining other Trusts.
9.12	MT referred to appraisal rates and asked why 100% compliance has not been achieved. HI reported on issues in uploading information onto the system and confirmed that reminders to complete appraisals are being raised at regular meetings.
9.13	Regarding the Apprenticeship Levy, MT suggested that consideration is given to offer apprenticeships to people accessing Solent services. It was agreed to consider further promotion and advertising outside of the meeting.
9.14	AS asked if the Trust is content that appropriate interviews are being held with staff after a period of sickness. HI reported on work being undertaken to look at management training and overall expectations.
9.15	SH highlighted the importance of appropriate planning for expected periods of low staffing levels such as holiday seasons and the need to consider innovative methods to encourage staff cover. It was noted that child care is being reviewed to improve flexible arrangements.
9.16	AMS referred to the NHS provider licence- Self Certification 2017/18and suggested the inclusion of narrative to reflect that Solent had recorded a deficit in 2016/17 which was an improvement on the deficit control total agreed with NHS Improvement. **The Board noted the Performance Report.**
10	**Quarterly progress on IT programme implementation**
10.1	DN briefed the Board on key areas within the report: • DN updated the Board with regards to modernisation of telephony and provided an overview of associated savings. • DN highlighted IT operational issues and informed the Board of an audit being undertaken on the digital roadmap and of the resources required. • A review of the SharePoint implementation plan and adjustments to roll out timescales was noted. Future IT support arrangements are also to be reviewed. **The Board noted the Quarterly progress on the IT programme implementation report.**

11	**Compliance with NHS Constitution**
11.1	RC briefed the Board on the legal requirements and good governance associated with the Board review and confirmed that the Trust is fully compliant with NHS Constitution whilst recognising that Value for Money (VFM) was not achieved last year.
11.3	FD queried the reporting structure for Equality and Human Rights and HI reported on a review to be undertaken at the new People and OD Group. **Action: It was agreed that HI review to ensure visibility of the Equality and Diversity agenda through to Board.**
11.4	JPi enquired about care plan alignment to end of life care. LM reported that the end of life strategy is in the process of being reviewed and will be reported to the January Board. **The Board noted the Compliance with NHS Constitution Report.**
12	**Health and Safety Annual Report and Health and Safety Statement of Intent**
12.1	The Board discussed the use of the term 'sub-committee'. AMS asked who was responsible for the official naming of the Health and Safety meeting. **Action: AS to clarify naming convention.**
12.2	As responsible NED for Health and Safety, AMS enquired about expected attendance at meetings. **Action: AS to enquire what terminology and attendance is appropriate. The Board noted the Health and Safety Annual Report and Health and Safety Statement of Intent.**
13	**Annual Report for Emergency Preparedness, Resilience and Response**
13.1	The importance of including an executive summary with all papers to ensure the Board focuses on key lines of discussion was highlighted. AMS confirmed SE as the new designated Non-Executive lead for Emergency Planning.
13.2	DN confirmed assurance from CCGs regarding current position and request for a focus on training programmes and scenario testing, particularly for on-call directors. DN provided assurance that business continuity plans and associated policies were in place. The need for remaining vigilant with emergency planning in light of recent national events was emphasised.
13.3	AMS commented on potential issues in ensuring consistent lockdown and security due to the large number of Solent sites and queried regular practice. AS confirmed security, CCTV and door controls were in place and highlighted the specific responsibilities of landlords. The Board discussed issues surrounding the ease of public access to wards and potential lack of procedures. It was agreed that AS and DN liaise with Chris Box to provide assurance regarding lockdown and security measures across the estate that Solent operates out of, the detail of which would be shared with SE for consideration. **Action: AS and DN to liaise with Chris Box, SE to then review findings.**
13.4	AS enquired about the communication of the 'Run, Hide, Tell' policy. DN confirmed that messages have been circulated and information provided regarding the download of new App.

13.5	AMS queried the typical practice for screening incoming mail and packages. It was confirmed that the Trust has a Suspicious Packages policy in place. **The Board noted the Annual Report for Emergency, Preparedness, Resilience and Response and self-assessment against the 2016/17 Core Standards.**
***Reporting Committees and Governance**	
14	**Amendments to Scheme of Delegation**
14.1	AS informed the Board of a change to the Scheme of Delegation (SoD). NHSLA to be amended to read NHS Resolution. It was confirmed that the amendment has been approved by the Finance Committee. **The Board noted the update.**
15	***Chairs report on Members Council**
15.1	There was no meeting held to report.
16	***Charitable Funds Committee Minutes & Chairs Update**
16.1	FD reported on discussions held at the August meeting. • FD noted a typographical error within the report • Organisational funding and letters drafted to implement nil and low cost was noted. • FD informed the Board of a local trustee identified and of progression made with regards to a landfill site. **The Board noted the update.**
17	***Assurance Committee Chair's Update**
17.1	• MT reported that Suzannah Rosenberg from Portsmouth CCG attended the meeting and highlighted the positive strengthening of relationships. MT informed the Board of attendance requests received from other CCGs and of a review being undertaken to ensure effective Committee business. • The Committee noted receipt of a substantive CQC report and assurances were provided that managerial staff had addressed concerns and actions were raised to mitigate issues. An outstanding action relating to pastoral care was highlighted to the Committee and a resolution associated with forensic beds and competency frameworks within CAMHs was noted. • The Committee received exception reports for mortality, serious incidents, Research and Development and Chief Operating Officer Reports.
17.2	**The Committee ratified the following policies:** • **NICE Policy (formally CLS05 Implementation of National Guidance Policy)** • **HR12 Freedom to Speak Up (formally Whistleblowing Policy)** • **Policy on Policies** **Chairs action was taken to ratify the following policies:** • **Managing Performance of Medical and Dental Staff Policy** • **Searching In-patient Policy**

	The Committee identified amendments to two further policies: • **Mortality Policy** • **Social Media Policy**
17.3	Mortality Update AMS queried discrepancies between the total deaths detailed within the dashboard. DM explained reasoning and it was agreed to include narrative to avoid confusion.
17.4	MT confirmed nationally-provided training on Structured Clinical Judgement Tools being undertaken by the Associate Director of Quality & Safety and discussed the usefulness of alignment to Mortality work.
17.7	MT reported that it is a statutory requirement of the Board to approve the Mortality Policy. MT confirmed completion of amendments suggested by Assurance Committee and DM provided an overview of guidance taken to create. DM confirmed constant review required with clarity from national bodies. SH highlighted the importance of ensuring consideration of learning. **The Board approved the Mortality Policy.**
17.7	It was agreed to circulate the report as an appendix to the minutes. **The Board noted the update.**
18	***Mental Health Act & Deprivation of Liberty Safeguards Scrutiny Committee Chairs update**
	• MT reported that a CQC Mental Health Act reviewer and the Medical Director and Associate Director of Quality and Safety from PHT attended the meeting. • MT shared a presentation provided by the Clinical Lead of Children's Services regarding provision for young people requiring detention under the Mental Health Act. MT highlighted the importance of noting significant gaps and potential implications to section 2 qualified practitioners and highlighted the need for the Board to consider escalation. • MT provided highlights of the incident presented. AMS queried the frequency of such incidents and DM explained previous processes. MT informed the Board of a review being undertaken jointly with other organisations. • MT reported on the insistence of the Tribunal Office of practitioner attendance at court and of patient care being the priority of practitioners which can result in contempt of court for non-attendance. • MT raised concern regarding a recent lengthy transfer to a 136 seclusion due to being significantly out of area. It was noted that this is not an isolated case. SH suggested linking with Hampshire Constabulary and local councils on seeking an appropriate solution. MT suggested that such transfers are actively monitored and trends identified. **The Board noted the update.**
19	***Governance and Nominations Committee Update**
19.1	There was no meeting held to report. **The Board approved amendments to the Terms of Reference.**
20	***Audit and Risk Committee**

20.1	JPi briefed the Board on the procurement plan and associated timeline for to appointment Internal and External Auditors in readiness for the 2018/19 financial year. RC confirmed that separate internal and external audit panels are being held in November. **The Board noted the update.**
Any other business	
21	**Governor Comments and questions**
21.1	No governors were in attendance.
22	**Any other business & future agenda items**
22.1	There was no further business discussed and the meeting was closed.
23	**Close and move to Confidential meeting**

Board Part 1

Action no.	Date of Meeting	Agenda item ref:	Concerning	Action detail	Exec Lead / Manager	Completion date	Update
582	25/09/2017	7.6	Any Other Business	Regarding Lone Working, MT highlighted issues surrounding the lack of Skyguard use amongst senior experienced staff. The Board agreed the importance of addressing this issue **Action- LM to consider use of Skyguard system.**	LM		Monthly monitoring of use of Skyguard in place via Health and Safety. Reports shared with services and actions taken where required. All services have previously confirmed their lone working processes.
583	25/09/2017	8.12	Chief Executive's Report	Concerning the NHS England pilot site for the use of Psychological Therapies (IAPT) to help manage Long-Term Physical Health conditions, queries were raised regarding the linkage to the Recovery College and as to what LTCs were considered. **Action: It was agreed to seek clarification from Matthew Hall.**	SH		
584	25/09/2017	11.3	Compliance with NHS Constitution	FD queried the reporting structure for Equality and Human Rights. HI commented that reports will be reviewed the new People and OD Group. **Action: It was agreed that HI review to ensure visibility of the Equality and Diversity agenda through to Board.**	HI		
585	25/09/2017	12.1	Health and Safety Annual Report and Health and Safety Statement of Intent	The naming of the Health and Safety Subcommittee was queried. **Action: AS to clarify naming convention.**	AS		This meeting is to be called the Health and Safety Group going forward.
586	25/09/2017	12.2	Health and Safety Annual Report and Health and Safety Statement of Intent	AMS queried attendance at the meeting as NED responsible lead for Health and Safety. **Action: AS to liaise with the H&S Manager concerning attendance /membership.**	AS		In hand.
587	25/09/2017	13.4	Annual Report for Emergency Preparedness, Resilience and Response	It was agreed that AS and DN liaise with Chris Box to provide assurance regarding lockdown and security measures across the estate that Solent operates out of – the detail of which would be shared with SE for consideration. **Action: AS and DN to liaise with Chris Box. SE to then review findings.**	AS & DN		
571	31/07/2017	7.2	Safety and Quality First- Board to Floor (April)- Nicholstown Surgery	MW highlighted the commitment of staff caring for patients under difficult conditions. SA reported that issues have been escalated and agreed to make enquiries and provide an update outside of the meeting.	SA		**25.09.2017**- AS confirmed ongoing discussions with Jo Pinhorne and Estates. MT highlighted conversations held at Assurance Committee regarding the need to plan ahead for 2018 from a well-led perspective.
572	31/07/2017	7.4	Safety and Quality First- Board to Floor (April)- Nicholstown Surgery	The Board noted the importance of considering the larger strategic picture. DM highlighted the need for clinical input and involvement with decisions effecting clinical environments. It was agreed that the Board consider strategic options at Directors and provide an update at the next meeting.	Execs		**25.09.2017**- AS confirmed ongoing discussions with Jo Pinhorne and Estates. MT highlighted conversations held at Assurance Committee regarding the need to plan ahead for 2018 from a well-led perspective.
573	31/07/2017	7.4	Safety and Quality First- Board to Floor (April)- Nicholstown Surgery	SA commented on the need to resolve minor issues in the interim. The Board agreed to brief DN for his consideration outside of the meeting.	DN		**25.09.2017**- AS confirmed ongoing discussions with Jo Pinhorne and Estates. MT highlighted conversations held at Assurance Committee regarding the need to plan ahead for 2018 from a well-led perspective.

574	31/07/2017	8.7	Chief Executive's Report	AMS asked what additional staff is required to speed up existing processes and improve waiting times within CAMHS. The Board was informed of a review being considered to broadly spread qualifications. It was agreed that the Executive Team review with Jonathon Prosser to fully understand challenges in order to consider a suitable solution.	Execs		**25.09.2017**- **Action**- **It was agreed that a further update be provided to Assurance Committee after review at the Directors meeting.**
577	31/07/2017	14.2	Professional engagement and leadership report	MS enquired about funding for local nurse training apprenticeships. HI reported on considerations given from an STP perspective and on current financial issues. FD suggested using charitable funds resource to fund training and it was agreed that FD & HI discuss further outside of the meeting.	FD/HI		**25.09.2017** - FD confirmed ongoing conversations regarding finding a new partner for work on apprenticeships and retention issues. HI confirmed meetings with Southampton Solent University and SH highlighted the importance of ensuring consideration of the Portsmouth locality.
581	31.07.2017	18.3	Assurance Committee Chairs update	AMS commented that as responsible NED for health and Safety, he had not received any other information on security in addition to the health and safety report. It was noted that such matters are reported to a number of committees, however, LM agreed to reflect on a suitable process to brief AMS. To be discussed further outside of the meeting.	LM		**25.09.2017 – Action: AS to liaise with security and health &safety advisors to ensure appropriate briefing to Chairman**
564	30.05.2017	7.3	Deficit position / Breach of statutory duties	Concerning the deficit control total position, it was recommended that the CEO and Director of Finance make formal enquiries with NHSI and NHSE regarding the breach in statutory duties and implications. Action: It was agreed that further consideration /feedback would be sought at the July Board meeting (AS /SH).	AS /SH		**July 2017** - NHSI have confirmed that they are aware of the issue and are considering the matter. **September 2017**- still awaiting NHSI considerations.
565	30.05.2017	12.6	Consideration of ICT Return on Investment - via Finance Committee	JPi commented on the need for the Finance Committee to consider the return on ICT investment (ROI). SA acknowledged that such a review would be timely and JS suggested that the 'business as usual' costs are also considered. Action: Finance Committee to consider ICT ROI (DM /AS)	DM / AS		**July 2017** - This will be picked up at the September Workshop (11 Sept 17) **September 2017 -** To be discussed as part of CGI options on agenda. **Action: Finance Committee to consider ICT ROI (DM /AS)**
566	30.05.2017	12.8	Consideration of ICT Return on Investment - at Board	MW queried whether the original business case quantified anticipated efficiency savings. The Board were informed of the 'Working Differently' programme and it was agreed that consideration be given to the ROI at a future Board Workshop, following consideration by the Finance Committee. Action: AS/ DM and RC for agenda.	DM/ AS (RC)		**July 2017** This will be picked up at the September Workshop (11 Sept 17) **September 2017** - To be discussed as part of CGI options on agenda. **Action: Finance Committee to consider ICT ROI (DM /AS)**

Title of Paper	CEO Report –November 2017		
Author(s)	Sue Harriman, Chief Executive Officer		
Link to strategic Objective(s)	[x] Improving outcomes [x] Working in partnership [x] Ensuring sustainability		
Link to CQC Key Lines of Enquiry (KLoE)	[ ] Safe [ ] Effective [ ] Caring [ ] Responsive [x] Well Led		
Date of Paper	November 2017	**Committees presented**	N/A
Action requested of the Board	[X] To receive [ ] For decision		

1. Statement on quality, finance and performance

This is covered in full within the integrated performance report.

2. Strategic update

Sustainability and Transformation Partnerships (STP)

Progress continues to be made within the HIOW STP, although significant challenges remain within the system including; constrained and challenged finances across most health and care partners, extreme pressures in urgent care services and workforce shortages. A review of progress one year after the Sustainability and Transformation Plan was published describes some early success. However it also describes a potential lack of ambition in relation to the transformation of health and care services that would ensure the services are sustainable now and into the future. The Executive Delivery Group of the STP will now focus and reflect on the scale of our ambition and re-calibrate our ambitions accordingly.

In the Portsmouth and South East Hampshire Local Delivery System a plan to create an Accountable Care System to address the challenges the system faces has been presented to most Boards in recent weeks. The draft now in its final stages will be re-presented to this Board in January. It calls for partners in health and care to work in partnership to support the transformation of services whilst focusing on the PSEH priorities, the plan includes:

- Urgent and Emergency Care Programme
- Mental Health Programme
- New Models of Care Programme – primary and communities care
- Elective Care Programme
- Enabling programmes for IT, workforce, estates

Winter Preparations

The Trust has been reviewing and preparing its plans for winter resilience and although this happens every year, it is widely believed that this winter will be particularly challenging. We know our staff are already working incredibly hard and there is a vacancy factor that impacts on this. In addition we can see that the urgent care services are already at capacity and that there is a potential that we will experience the impact of increased flu prevalence. This year we have had a focus on flu vaccination uptake and careful planning of services in a number of testing scenarios. We will be conducting a number of winter planning exercises as an organisation and as a part of the health and care systems in which we work. I will continue to brief the Board on operational performance and resilience throughout the winter period.

Southampton and County Services

Adults Southampton

We have continued to work with system partners from both University Hospitals Southampton (UHS) and Social Care to further enhance and develop our approach to facilitating flow through the care system and reducing Delayed Transfers of Care (DTOC). Since the summer, we have implemented a Care Act compliant meeting (i.e. has a Social Services manager or representative) each week to evaluate any delays and jointly take action. This builds on the work of the UHS based integrated Discharge Bureau.

In our planning for winter we have conducted a favourable gap analysis against the NHS Improvement 'Managing patient flow in community services over winter' guidance. In order to take operational winter planning in Southampton to the next level we intend to co-host (along with partners from UHS, Southern and Social Care) a joint presentation from teams from across the sector to test assumptions and dependencies.

We are also working to expand our offer in the community for both palliative care services and the provision of Intravenous Venous therapy. Work at the Western Community Hospital site continues to facilitate the move of the Kite ward early in 2018.

Primary Care / MPP service line

There is a combination of staffing challenges and high number of referrals that is impacting on our achievement of targets for specialist Muscular-skeletal (MSK) services. These factors are impacting on our performance in our rheumatology pathway and the Behavioural Change contract, both have recovery plans to address the issues.

We continue to work with commissioners and UHS to audit the current Rheumatology pathway, in order to agree what elements of the current pathway need to be addressed.

Children and Families (West)

Pleasingly the waiting times for CAMHS is steadily reducing and if we maintain the current trajectory of improved performance, we should achieve the 19 weeks waiting time target this month. We are also working up options to share with commissioners and system partners to address the issue of conducting health checks for Looked After Children (LAC) who are placed in other areas of the country. The service had a positive meeting in early November with UHS colleagues to identify and explore further opportunities for integrating services in order to improve the experience of service users.

Special Care Dental Services

The Special Care Dental Service have made good progress in obtaining additional theatre space at Portsmouth Hospitals Trust (PHT) and we are hopeful that we will shortly also be able to use capacity at Hampshire Hospitals Foundation Trust (HHFT). The service has also had good results in recruitment of dentists recently which provides greater capacity and resilience, and a long standing IT related issue regarding access to historical x-ray images has been satisfactorily resolved.

Portsmouth System

Staffing Pressures

The top risk in mental health services remains staffing shortages and agency usage as a result of nationwide shortages of qualified nurses and psychiatrists. Solent currently has over 20WTE staff nurse vacancies and five whole time equivalent (WTE) Psychiatrist vacancies. Safety and service continuity is maintained by the use of agency staff, however the cost pressure associated with this approach presents a significant financial risk in itself. A different workforce deploying band four associate nurses is being actively worked up

Staffing pressures also exhibit in some inpatient wards and Childrens Community nursing and for the latter a new item has been raised to the Risk Register regarding the sustainability of the Community Childrens' Nursing service in Portsmouth. Difficulties in staff recruitment and high turnover have led to a current vacancy rate of 30.7%, during a period in which overall referrals and workload is increasing. At present service delivery standards are being maintained by the use of Agency staffing, whilst the service management work on sustainable solutions. A full risk analysis is underway

CQC Inspections of Children and Young People's Service

CQC made a follow-up visit to two special schools in Portsmouth in October that is supported by Solent NHS Trust staff. They noted improvements to prescribing, medicine management and record keeping practice – singling out Rosewood especially for its high standard of care planning. Further work is required to sustain and further improve delivery in the Mary Rose School

Service Quality

An internal Trust inspection team visited Jubilee House on 26th October after some concerns were raised about the case mix of patients at the unit. Jubilee House has been supporting the PSEH system to discharge patients from PHT in a timely way and as such the care needs of the patients had changed. The internal inspection found a very dedicated and caring group of staff who required additional support with their learning needs. A quality Improvement plan was initiated and on-going senior support has been provided.

System pressures

PHT has been experiencing extreme operational pressures in its emergency pathway and on 13th November escalated into a heightened state of 'black alert' and an internal major incident was called. Any increase in operational pressures in urgent care is as a result of system wide issues and as such the wider system responded accordingly to reduce bed occupancy.

Solent is operating an extended plan to further remove patients from the medically fit for discharge numbers so that the agreed target is achieved before end December.

However it should be noted that there are significant risks to care home and domiciliary care capacity in the city. Solent will work with partners to support the sector.

Finance

The year to date position at month 7 is a deficit of £1.1m, which is £0.1m favourable to plan. The forecast out-turn remains on place, i.e. £1.5m deficit. The draw-down of cash to fund this year's deficit is expected in month 11.

Estates and Capital

The decision over the funding for the re-development of St James' and St Mary's hospital sites is expected to be announced in the Budget Statement on 22 November, any update will be provided verbally at Board.

The proposed move of the teams from Falcon House to Battenburg House has been stopped, as the payback period was too long. We are working with partners to look at what alternatives there are within the Portsmouth and South East Hampshire system; there is no requirement to move out of Falcon House, although it makes sense to aid the redevelopment of the St James' site.

ICT

Work has continued to transition to the Trust's new telephony solution which will replace multiple solutions that were inherited from predecessor organisations. The majority of sites in the Southampton localities are now complete and work has commenced in the East. The project is on track to complete late this financial year and will provide a more flexible and reliable solution for the organisation.

The launch of the Trust's new internal intranet site (SOLNET) is due for the end of November with a number of roadshow events happening across the Solent sites to raise awareness. Following a review of the intended uses for SOLNET, the team are now working with an expert provider to plan the roll out of additional functionality over months following the November launch.

3. Current news

Current Trust news is available on the trust website www.solent.nhs.uk

4. Complaints

A total number of 11 formal complaints were received in October 2017, with 16 different themes being raised within the complaint. This figure includes one instance of professional feedback.

Complaints per Service Line can be broken down as follows:

- Adult Mental Health 1
- Primary Care 2
- Sexual Health 1
- Adults Southampton 3
- Child & Family 1
- Adults Portsmouth 2
- Corporate 1

The breakdown of themes across Service Lines is detailed in the table below:

Appointments	2
Attitude of staff	6
Clinical	3
Communication / Information	4
Procedures	1

The number of formal complaints received throughout 2017/18 has continued to remain relatively low to previous years. As of the 31 October 2017 102 formal complaints had been received. This compares to 152 complaints received in the corresponding period for 2016/17.

47 Service Concerns were received in October and, to date in 2017/18, 117 such complaints have been received. This compares to 255 for the whole of 2016/17. Longer term analysis will be required to ascertain if this is as a result of increased levels of

dissatisfaction with the Trust or whether this is as a result of service Lines improving their reporting of the locally resolved complaints.

At the end of October 2017 24 Complaints remained open and these had been responded to within the agreed timescale. The remaining complaints were within date. As reported previously the revised response times matrix has been introduced. This has been applied to three new complaints and these are still within their revised response timeframes.

Learning from recently closed complaints included the following:

Adults Southampton implemented a process where patients with a new catheter are visited 2 weeks after initial contact to ensure all equipment is in place and to review how the patient and their family/carers are managing.

Adults Portsmouth Community Nursing Team have worked with patients to understand how they want to be communicated with as some patients did not feel their needs were being prioritised and met. Welfare checks and phone calls to ensure timely communication with patients are now taking place if it is necessary to reschedule an appointment.

5. Update from the Trust Management Team (TMT) meeting

TMT meet on 18th October and at time of writing this report are due to meet again on 22nd November. In the October TMT the themes considered were:

- Flu vaccination
- Staff survey
- Staff communications
- An update of the STP
- Wicked issues programme covered: embedding learning and Hierarchy update
- What makes a 'Well Led' organisation
- Workforce update
- Performance review

The TMT wished to escalate to Board:

- Reflections on the Business planning approach
- The balance of system working whilst ensuring 'Solent' remains strong and steady
- System wide Quality Impact Assessments
- How we really embed learning in a systematic and efficient way ;such as embracing technology

6. Board Assurance Framework and Corporate Risk Register

Board Assurance Framework – the following table summarises the key strategic risks:

BAF number	Concerning	Lead exec	Raw score	Mitigated score (Current score)	Movement since last reported (and previous score)	Target score
58	Future organisational function	Sue Harriman	S5 X L4= 20	S4 X L4 = 16	⇔ (16)	S3 X L2 = 6

55	Workforce capacity	Helen Ives	S5 X L4 = 20	S4 X L4 =16	⇧ (12)	S3XL3= 9
57	Quality Governance and quality improvement	Lesley Munro	S4 XL4 = 16	S4 X L3 =12	⇔ (12)	S3 x L2 = 6

KEY: ⇔ = same as previous, ⇧ increase in score ⇩ decrease in score

Corporate Risk Register - Key themes and mitigations are summarised as follows:

Risk Themes	Key Mitigations
Information Technology – there is a risk to patient care within Sexual Health Services in relation to delayed results being shared with patients in the absence of an electronic solution. There is a risk to patients as social services and Solent staff do not use the staff patient's records system.	Manual Workarounds have been implemented. Discussions are being held with the IT system provider to identify an appropriate solution. IT representation from SCC and Solent to attend meeting to discuss in November.
Workforce - there is a risk that the Trust cannot attract and retain sufficient numbers of staff. The impact being that safe and effective care for our patients may not be delivered. Services with the greatest pressures include, Children's services and Adults Southampton and Adult Mental Health.	Adult Mental Health are block booking temporary staff to ensure consistent and safe care is delivered. Recruitment continues across services and there has been a reduction in the number of vacancies in various areas Quality Improvement approach is in place to ensure our workforce is supported and developed to have a positive impact on rates of retention. Rostering practices are being reviewed to ensure current staff resources are managed and planned as effectively and safely as possible.
Estates- there is a risk that a suitable location will not available to deliver long term sexual health services in Winchester.	Clinics are running from a temporary location. Estates continue to search for suitable accommodation.
Equipment – there is a risk that children requiring wheelchairs may sustain serious and potentially long term harm as a result of a lack of wheelchair provision.	A Serious Incident Investigation has been commissioned and will be completed by the 31st December 2017. The contract provider has shared revised guidance on their escalation process.

7. Quality Visits

The Solent NHS Trust Quality Review (Board to Floor) programme recommenced in September. Two service lines have been visited Adults Southampton and Adults Portsmouth and five services have been reviewed. Four visits were announced and one unannounced. In addition there has been one unannounced CQC visit to Special Schools. Themes have emerged from these visits and will be tested during the Quality Review visits planned for across the organisation in November.

Sealing's

No.	Date	Concerning
65	25/10/2017	Second Deed of Variation extension of an agreement made under section 75 of the NHS Act 2006

Signings

No signings to report.

Sue Harriman
Chief Executive

October 2017
Performance Report Part I

STATEMENT OF PURPOSE	To provide the Trust Board with the Performance Report
DOCUMENT OWNER	Andrew Strevens, Director of Finance & Performance
TARGET AUDIENCE	Trust Board
FOR INTERNAL OR EXTERNAL PUBLISHING	External Publishing
MARK AS APPROPRIATE	To be published via our public website: No
	Commercial Sensitive / Confidential – for internal use only: Yes
	Restricted circulation: No
VERSION:	**V0.1**

Document Control

The latest approved version of this document supersedes all other versions, upon receipt of the latest approved version all other versions should be destroyed, unless specifically stated that previous version (s) are to remain extant. If any doubt, please contact the document author.

Version	Date	Author / Editor	Details of Change	File Reference
V0.1	17/11/17	Alasdair Snell – Head of Performance	Document Creation	R:\Provider Services\Trust Board Reports\2017-18\M07-October

Approval Sign-off (For formal issue)				
Approver	**Role**	**Signature**	**Date**	**Version**
Alasdair Snell	Head of Performance		17/11/17	V0.1

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2017/18 Quarterly Business Plan Review – Quarter 2

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CPMO Engagement

During Quarter 2 2017/18, the CPMO has continued to work with all service lines to obtain objective and milestone updates on a monthly basis.

The numbers of milestones has risen slightly from Quarter 1, with seven new delivery milestones being added to the plan following further review of project deadlines across Estates & Facilities, ICT and Dental.

Full plan Business Objectives and Milestones as at end of September 2017:

	Number of Objectives	Number of Milestones
Adults Portsmouth	8	54
Adults Southampton	24	103
Child & Family	20	98
Commercial	4	14
Dental	9	28
Estates & Facilities	7	69
Finance & Performance	16	41
HR	15	47
ICT	16	50
Mental Health	6	40
Primary Care Services	10	39
Quality	10	37
Research & Improvement	11	27
Sexual Health	7	45
	163	692

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Quarter 2 Successes

12 Business Objectives have been completed in Quarter 2. They are detailed below:

Finance & Performance	Review current Shared Business Services (SBS) Contract, and review and develop outcome user requirements of Hampshire & Isle of Wight SBS working group in order to go out to completion in March 2019
Primary Care Services	We will centralise administrative functions in the GP surgeries by end Q1 and streamline administration across MSK, Pain and Podiatry by the end Q2
ICT	Ensure 3rd party contracts are fit for propose and can deliver and support the Trust's requirements
ICT	Implement Internal Clinical SystmOne Viewer to provide offline access to SystmOne when it has downtime
Child & Family	To increase leadership capacity at 8a level of seniority to support the delivery of management plans and cost reduction schemes in the East
Child & Family	To increase leadership capacity at 8a level of seniority to support the delivery of management plans and cost reduction schemes in the West
Child & Family	To pursue the development and leadership of a Children's Health Providers Alliance to support implementation of STP
Quality	Develop a Career Framework for Nurses & Allied Health Professionals
HR	Review and reposition the role of the Communications team within the Trust
Adults Southampton	Formalise Assess at Home pathway with funding from Commissioners
Adults Southampton	Support implementation of Wellbeing post tender maximising, joint working and integration opportunities
Adults Southampton	Engage and influence development of future models for community and primary care provision

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Quarter 2 Challenges

There have been a number of challenges in Quarter 2 as detailed below. The below objectives are currently rated Red.

Service Line	Objective	Issue	Mitigation
Dental	Work with Estates to ensure New Milton and Romsey are fit for purpose	These NHSPS owned premises have been assessed as being not fit for purpose and requiring significant improvement.	The Solent Estates Team have assessed these Surgeries and identified required works. The Estates & Asset Management Teams are now in dialogue with the Landlord around lease arrangements in place, obligations under those arrangements, and a plan for remedial works to address actions.
Research & Improvement	To identify a suite of Patient Reported or Clinical Outcomes that can be captured by SystmOne	In order to ensure reporting from SystmOne is robust, a review of the Business as Usual Templates are correct before new ones are placed in the system. This has taken longer than anticipated.	Research and Improvement are surveying all services to collate a list of current outcome measures. This is anticipated to be completed by the end of December. We will then work on the feasibilities of monitoring by SystmOne.

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Child & Family	To improve our information management function as a service line, including the use of SharePoint, Viewpoint, System One, agile working, and other digital issues and opportunities	There have been a series of delays in launching viewpoint.	Rollout to children's is now linked to hierarchy project. Will require close working between ICT and Children & Families to plan and test to satisfaction of service line. This is planned to deliver in December 2017.
ICT	Unified Communications Skype Rollout	Initial pilot site identified a number of unforeseen issues which took longer to resolve than expected. The project team were unable to be resourced efficiently in order to be progressed to original timescales.	We have now managed to resource the team appropriately and the project is now tracking to new timescales with a scheduled completion date of February 2018.
ICT	Wi-Fi Pragmatic Rollout	We are reviewing project to see if we can deliver more secure Wi-Fi across the board.	Project is on hold. The team are in the process of reviewing the proposal from CGI to come to an agreement on the most effective deployment of Access Points.
ICT	Wi-Fi Full Solution		
ICT	Electronic Communication within SystmOne (Working differently project)	GPs are outstanding and now we are working with ICT leads and practice managers.	The Project End Date has been revised until March 31 2018, as getting the practices to engage is largely out of our control.

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ICT	Implement External TPP SystmOne Viewer across the relevant areas in the trust	54 Teams (Solent + External Organisations) have been identified so far. 'Work in progress' for 20 Teams.	The Project End Date has been revised until March 31 2018. This is due to the initial delays with TPP agreeing for us to use the Viewer as we planned. Additional delays expected from requiring Data Sharing Agreements with each individual Service at an external Organisation, rather than with the Organisation as a whole.

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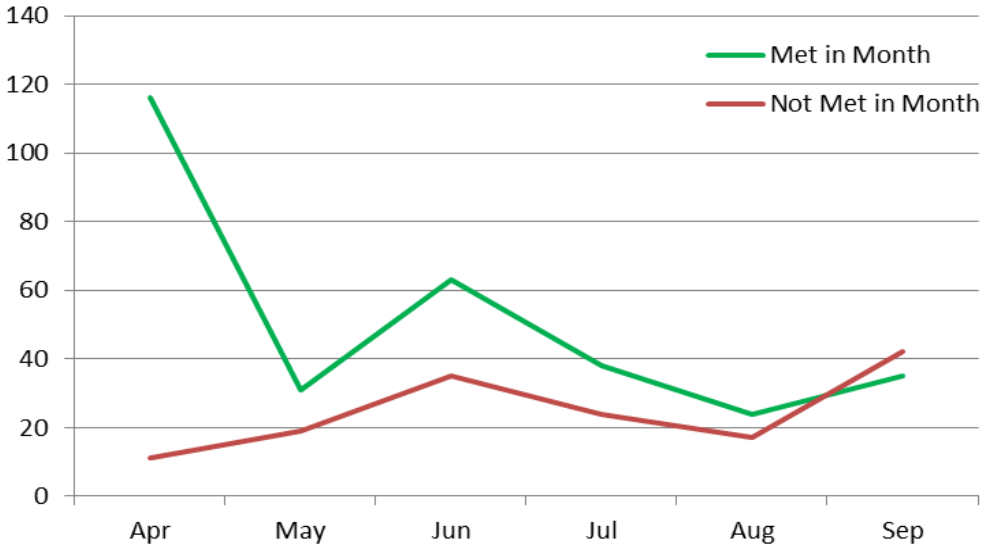
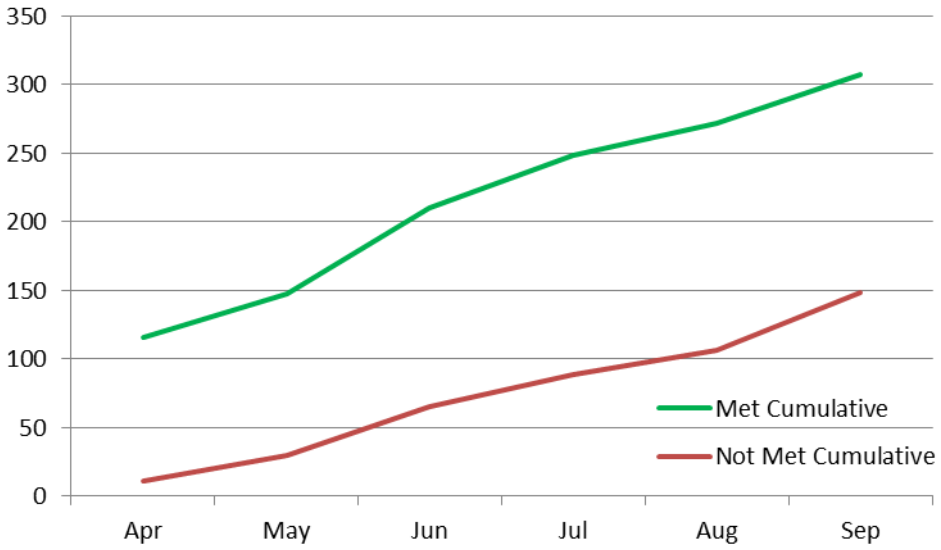
Quarter 2 Overview

Quarter 2 has seen the CPMO engage with Service Lines to obtain updates on 180 new Milestones across 116 Business Objectives. 97 were achieved and 83 missed their planned delivery date. In addition, there were 65 milestones not met in Quarter 1 and 14 of these were closed down in Quarter 2.





At the mid-point of the year, Solent NHS Trust has delivered 328 milestones on schedule or late, but still has 127 outstanding.

Common themes from service delivery for the delay or non-achievement of milestones have been critical dependencies on other stakeholders, both internal and external, ambitious business plans with conflicting demands of capacity and unrealistic planning of projects.

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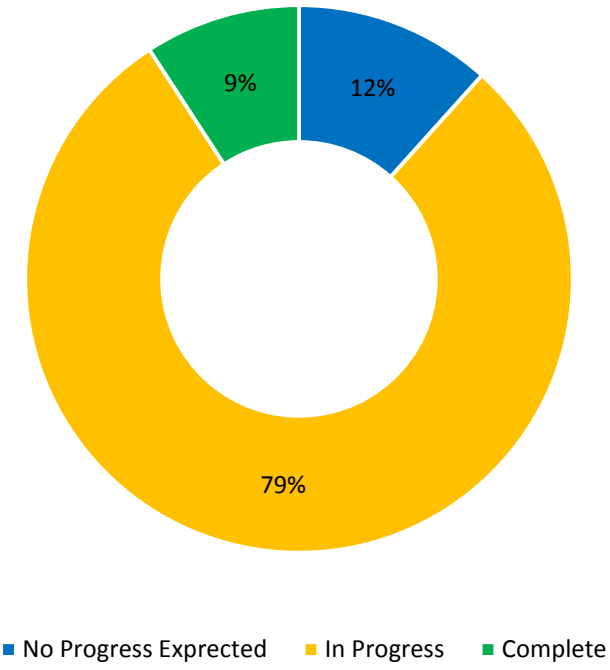
Current Breakdown of Business Objective status

No Progress Expected - 19	Business Objectives that are yet to have a milestone update. This figure only considers if a milestone has not been expected during Q1 or Q2. Work may have already begun on these objectives.
In Progress – 129	The first milestone date has been reached and an update given.
Complete – 15	All milestones have been met and completed.



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Objective RAG Status

As well as 'No Progress Expected', 'In Progress' and 'Completed' statuses, Business Objectives are also monitored by applying a Red, Amber, Green (RAG) status to each.

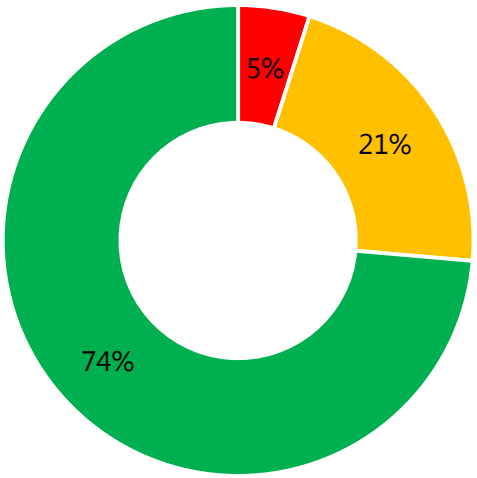
A RAG status denotes an assessment of progress.

RAG can therefore be outlined as:

> Red – Objective is experiencing major obstacles and/or current mitigation is failing or no mitigation is in place, resulting in the objective to likely not deliver.
>
> Amber – Objective is experiencing obstacles and mitigation is in place to guide the objective back to green.
>
> Green – Objective is on target to meet expectations and milestone dates assigned to it.

Below is the RAG status of Business Objectives across the Trust for the end of Quarter 2.

	Red	Amber	Green
Adults Portsmouth	0	0	8
Adults Southampton	0	5	19
Child & Family	1	3	16
Commercial	0	2	2
Dental	1	5	3
Estates & Facilities	0	2	5
Finance & Performance	0	2	14
HR	0	1	14
ICT	5	3	8
Mental Health	0	3	3
Primary Care Services	0	2	8
Quality	0	2	8
Research and Improvement	1	4	6
Sexual Health	0	1	6
	8	35	120



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Looking Ahead to Quarter 3 and 2018/19 Business Planning

Looking ahead to Quarter 3, the CPMO will continue to monitor and report on the milestones associated with Service Line Business Objectives. There are 192 milestones due during Quarter 3 with 95 planned for December alone.

The CPMO will provide an end of year report in April 2018 to document key successes and learning points for the year and give an overall statistical position for the Business Objectives.

The CPMO and Commercial Teams are currently engaging with Service lines to plan the upcoming business objectives for 2018-19. The processes will begin in October 2017 when all service lines will meet with corporate teams to discuss their proposed objectives and share ideas and guidance.

These meetings will then be followed up in November with presentations by service lines to executives on their objectives for the following year.

The last phase is for service lines to follow up on any exceptions from the presentations that the Trust executive team require further clarification on during December to finalise them.

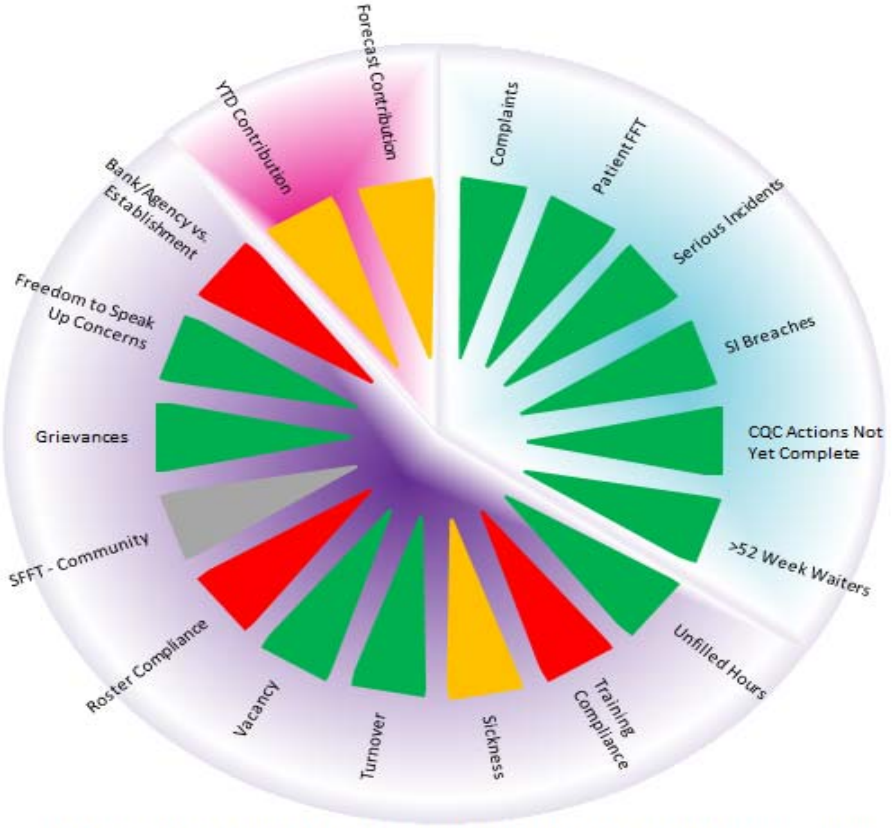
Key learning from this year has already been incorporated into the planning process for next year, such as service lines and corporate providing a maximum of 5 Business Objectives each for 2018-19 to ensure that objectives address the big changes and initiatives only and not business as usual tasks, to ensure inter-dependent stakeholders are not only aware of these dependencies and timeframes, but are included in their Business Plans also and to ensure that defined milestones are critical to the Business Objectives' delivery and not potentially inconsequential.

2.1 Performance Dashboard - October 2017/18

Solent NHS Trust - Trust Wide Report

Value	Metric	September	October
Great Care	Complaints	14	0
	Patient FFT	95%	96%
	Serious Incidents	3	0
	SI Breaches	3	0
	CQC Actions Not Yet Complete	39	0
	>52 Week Waiters	2960	0
Great Place to Work	Unfilled Hours	5%	2%
	Training Compliance	80%	80%
	Sickness	5%	5%
	Turnover	1%	1%
	Vacancy	5%	3%
	Roster Compliance	46%	41%
	SFFT - Community	64%	
	Grievances	2	0
	Freedom to Speak Up Concerns	0	0
	Bank/Agency vs. Establishment	6%	6%
Great Value for Money	YTD Contribution	94%	94%
	Forecast Contribution	93%	93%

Previous Month:



NB: Grey segments indicate data item not applicable or no data due to be reported

Metric	Definition	Green	Amber	Red
No of new Complaints in month	Number of new complaints raised with the Quality Team in month	0-20	21-22	23+
% Patient FFT recommending Solent Services	Percentage of patients that would recommend Solent as a place to receive care of those who have responded to the survey	95-100%	90-94.9%	0-90%
No of New SIs in month	Number of new Serious Incidents raised in month	0-17	18-19	20+
No of SIs breaches	Number of Serious Incidents breaching the recommended timescales for response in month	0	1	2+
No of CQC Actions Not Yet Complete	Number of CQC actions that are rated Red or Amber	0	1-42	42+
No of > 52 week waiters	Number of patients who have been waiting for a first appointment for more than 52 weeks	0	n/a	1+
% Unfilled hours (of temporary staff requested)	Percentage of hours requested from Bank Staffing Team which have NOT been filled by either Bank or Agency Staffing	0-4.9%	5-9.9%	10%+
% Training compliance	Percentage of staff that are compliant with their mandatory training as per ESR, of all eligible staff	85-100%	80-84.9%	0-79.9%
% Sickness	Percentage of time lost to sickness, of the total time worked in month	0-4%	4.1-5.9%	6%+
% Turnover in month	Percentage of staff leaving the organisation in a 1 month period. (Full time Equivalent % of Staff in Post)	0-12%	12.1-14.9%	15%+
% Vacancy	Percentage differential between Budgeted Establishment & Staff in Post measured as Full Time Equivalent.	0-5% 0- -5%	5.1-7.5% -5.1- -7.5%	7.6%+ -7.6%+
Roster Compliance	Percentage of rosters signed off 4-6 weeks prior to the start of the roster	0-1.24%	1.25-1.9%	2%+
% Staff FFT recommending as workplace	Percentage of staff that would recommend Solent as a place to work, of those who have responded to the survey	80-100%	70-79.9%	0-69.9%
No of new grievances in month	Number of new grievances raised with HR in month	0-3	4-5	6+
No of 'Freedom to Speak Up' concerns raised	Number of new Freedom to Speak Up Concerns raised in month	0-10	11-15	16+
% Utilisation of bank and agency vs. establishment	Percentage of bank and agency staff used, of the total workforce establishment in month	0-3.5%	3.6-5.9%	6%+
% YTD Contribution	Percentage contribution made year-to-date, of the total contribution plan (Service Lines only)	99.1%+	90.1-99%	0-90%
% Forecast Contribution	Forecast percentage contribution, of the total contribution plan (Service Lines only)	99.1%+	90.1-99%	0-90%

2.2 Solent NHS Trust Performance Report - Operations

October 2017/18

Activity

			Same Period 2016/17
16,052	New Referrals in month*		16,297
58,347	Attended Contacts in month*		50,654
3,353	DNA'd Appointments in month*	4.4%	4.8%
26	Delayed Patients in month (DTOCs)		31
380	Delayed Days in month		583
15,958	Discharges in month*		28,027

Key Performance Indicators

316	KPIs due in month
176	KPIs achieved in-month (as at 16/10)

CQUIN Schemes

15	CQUIN schemes
17	Milestones due YTD
15	Milestones** Achieved YTD

0	Contract Performance Notices (CPN) open

Hotspots

- Looked After Children Out of Area Placements
- Wheelchair provision delays
- Dental General Anaesthetic Waiting Lists
- Inpatient Temporary Staffing Spend
- Children's Community Nurse Vacancies
- Delivery of CQC Action Plan
- Community Nursing Recruitment (Southampton)
- Medically Fit For Discharge (MFFD) Backlog at PHT

* Data reported for Community and Mental Health Services only. IAPT, Substance Misuse and Specialised Services data not included **CQUIN current submissioins are awaiting comment from CCGs

2.3 Chief Operating Officer Commentaries - 2017/18 Month 7

Portsmouth System Developments

There have been no responses to the CCG's prior information notice (PIN) for Out of Hours services, the acute visiting service and extended primary care access services. There will therefore be a direct award to the Portsmouth Primary Care Alliance (PPCA), as an interim arrangement for 18 months to 2 years from June 2018. Solent and PPCA are working together to implement. The long term intention is for these services to be included in the scope of the MCP contract from 2020.

At the MCP Portsmouth programme board in October:

· It was reported that initial data from the MSK telephone triage pilot is hugely positive. To date the MSK GP Telephone Triage Service has saved 112 primary care on-the-day appointments by managing patients either with advice on self-referral or directly referring into the MSK Physiotherapy Service, avoiding unnecessary primary care contacts.

· The expanded and enhanced care home team data was similarly positive. The number of calls to SCAS from care homes involved in the pilot has reduced by 42% where a medical model has been implemented and by 28% with the clinical model. Over the same time period (01/07/17 to 30/09/17), calls from care homes not involved in the pilot have increased by 33.

· The team are progressing development of a new Portsmouth neighbourhood care model, in partnership with PCC.

Portsmouth Care Group Hotspots

- The Medically Fit for Discharge (MFFD) pilot has been hugely successful with patients now discharged between 0 and 3 days after being identified as MFFD. Discussions will take place looking ahead to a longer term model and provision.
- Statutory health assessments and reviews for Looked after Children when placed out of area are continuing to breach timescales. Although the responsibility to see the children are of those providers outside our areas, it is still a concern and the Children and Families service line are reviewing possible actions to help mitigate this issue.
- There are continuing high temporary staffing costs on the inpatients wards of our mental health services. This is due to both an increase in the general acuity of the conditions of our patients, requiring more staff to deliver safe care but also a number of nurse vacancies that nationally are difficult to recruit to due to a shortfall of available qualified nurses.
- There are continuing delays in the provision of wheelchairs for our patients, particularly our 0-19 service users, from the externally commissioned provider. The issue has been discussed at length with our commissioners and joint action plans are being implemented to help resolve the issue moving forwards.

Southampton System Developments

Local system partners are considering development of an evolved out of hospital operating model for the city. The model seeks to augment the established Southampton cluster model by wrapping integrated teams around a smaller population list size of approximately 15,000 to 20,000. The 'sub-clusters' would focus on case management of the top 10% of patients; the premise being that current clusters (with a population size of around 50,000) may be too big to proactively support the most vulnerable people.

At the Better Care Southampton meeting in October:

- It was agreed to progress a proposal to develop professional/clinical leadership roles within clusters, funded, for 12 months from vanguard monies.
- It was advised that NHSI have visited the recently established frailty service at the front door of UHS. The Geriatrician service supports people in ED and frailty scores them with a view to getting them home as soon as possible.
- It was advised that the ED streaming service, led by SPCL, has commenced at UHS. There have been a few teething problems but the service has started well.

Southampton & County Wide Care Groups Hotspots

- The Community Nursing Service has significantly reduced the number of vacancies with in the service over the last 6 months, after the implementation of credible induction programmes and recruitment drives. Not only will this reduce temporary staffing spend moving forwards but will offer continuity of service to our patients and career development opportunities for our valued workforce.
- Significant work is being undertaken for a full data quality cleanse of our dental patient record system currently, which is clearing a number of false long waiters for the service, that have actually already been seen. However, waits are still longer than desirable due to a shortage of available theatre space to undertake our procedures.
- Progress against the action plan, derived from the 2016 CQC Inspection, continues to make progress across the organisation and is monitored closely to ensure compliance. Further information can be read under the Quality section of the report.
- Our inpatient wards at RSH, similar to our mental health wards in Portsmouth, have a number of vacancies that are difficult to recruit to, leading to high temporary staffing use and are a cost pressure to the trust.
- Vacancies in both cities for our Children's Community Nursing services are proving difficult to recruit and are being covered by agency staff. The services are working hard to mitigate this cost pressure and deliver a safe service in the interim.

3.1 - Quality Performance

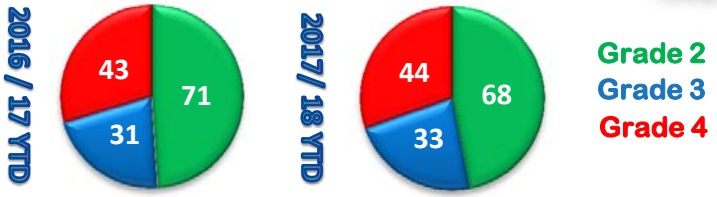
October 2017/18

Serious Incidents

5	Serious incidents occurred in month
67	less year to date than 16/17
1	Healthcare Infections / Cdiff / MRSA
0	Safety compliance breaches

Pressure Ulcers in Solent Care

23	Occurred in month
0	Equal than same month 16/17



Friends and Family Test

1914	Responses received
905	More than same month 16/17
96%	Positive ratings %
2%	Negative ratings %

Formal Complaints

11	Complaints received in month
15	Required response in month
3	Breaches in month

Care Quality Commission

2016 CQC inspection made 179 recommendations

MUST DO	SHOULD DO
86	93

Of these:

125	Have been completed
14	On target for delivery
32	At risk but mitigation in place
9	At risk requiring further mitigations

3.2 Chief Nurse Commentary - 2017/18 Month 7

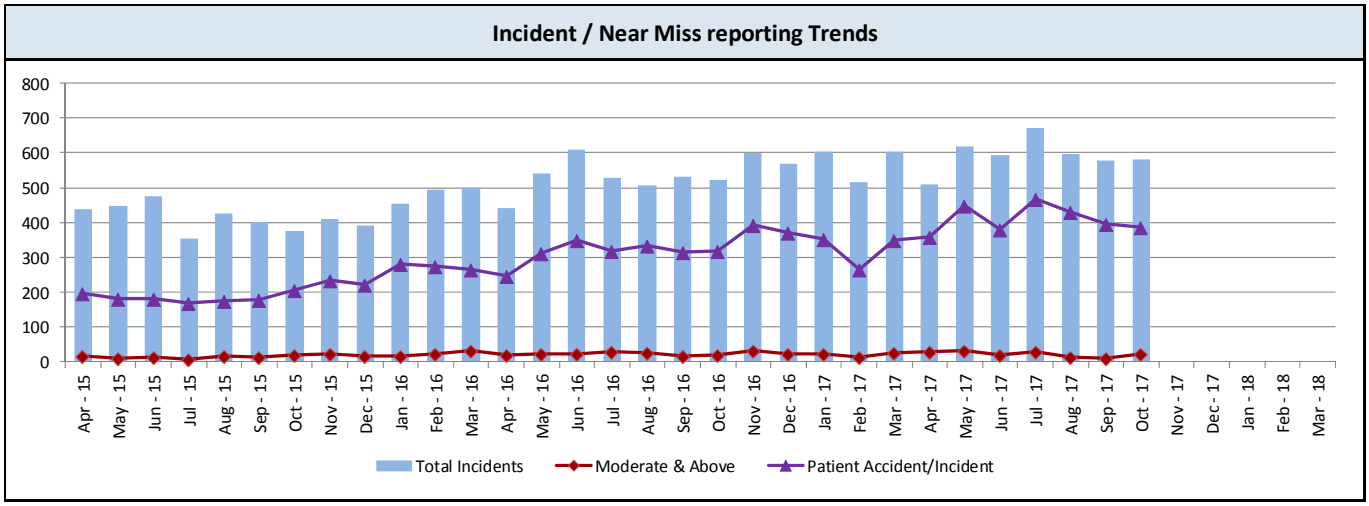
Highlights

- There continues to be a downward trend in the number of serious incidents reported. This is a positive position and incident reporting continues at a satisfactory level across the Trust, demonstrating that Solent continues to maintain an open and honest approach to incident reporting. This in turn enables learning and identifying how to avoid repetition of the incident or how to reduce the impact if not preventable. Learning is identified at every Serious Incident panel and is shared across all Service Lines. The number of reports that are not completed within 60 days is at 26 YTD compared to 70 which had breached at this time last year. Weekly monitoring of breaches continues to be in place.
- During October, we had one case of Clostridium Difficile which is the first in 18 months. The Infection Prevention and Control Team will conduct a full report, but have confirmed that there has been no onward transmission of infection.
- The collection of Friends & Family Test (FFT) data continues to be promoted across the Trust and responses are improved when compared to the 2016 data. There has been a specific increase in responses from Children & Family Services.

Exceptions

Number of Patient Incidents Reported

Reported patient incidents have remained static over the last two months, although remain at a higher level when compared to previous years. The Quality and Safety team and Service Lines continue to review and monitor incidents to identify any themes or trends that are reported on.



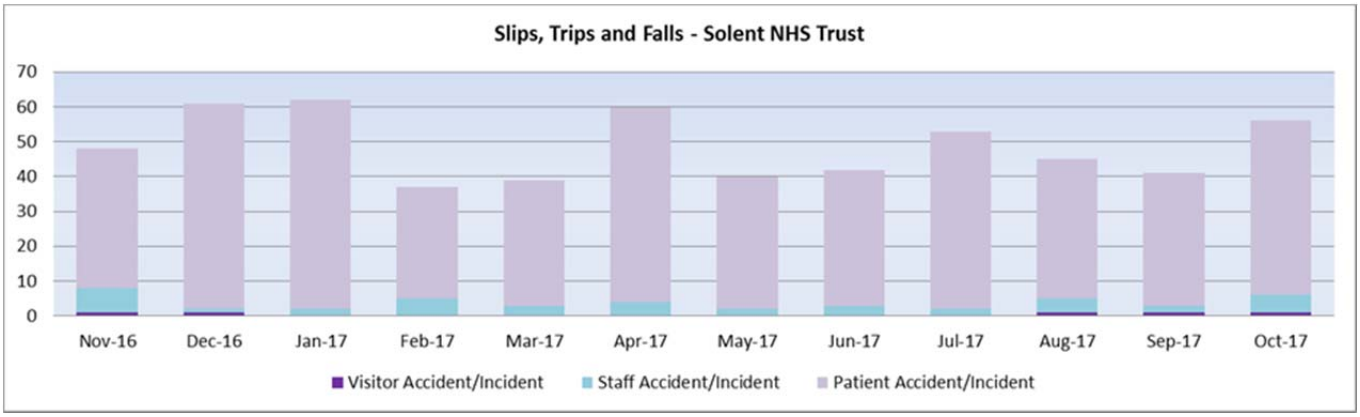
The percentage of patients suffering moderate harm or above has decreased for the third month in a row.

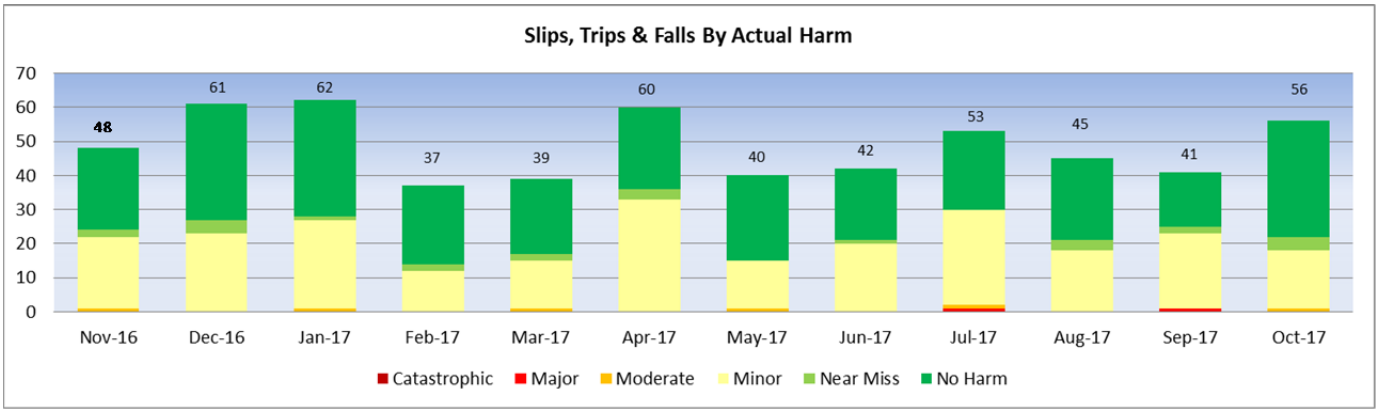
Number of Pressure Ulcers (PU) Acquired in Solent Care

Pressure Ulcers account for the majority of SIs reported each month and are scrutinised to ensure trends and themes are identified. There has been a reduction in grade 2 (3 PU), a small increase in grade 3 (2 PU) and a small increase in 4 (1 PU) on this time last year. This does not appear to be a deteriorating position and the variations are very small. However, it is not the improvement we had hoped for or referenced previously. Further work and examination is being carried out by the Professional Leads in Southampton and Portsmouth Adults services.

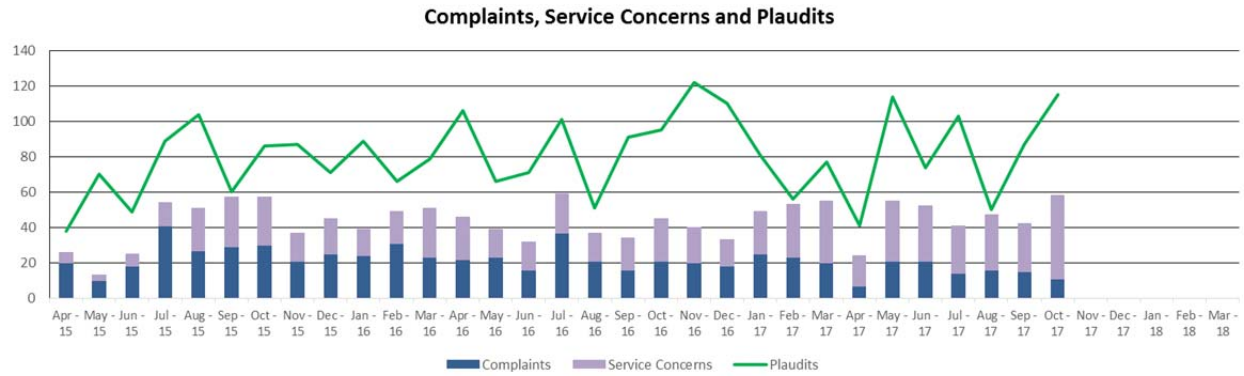
Falls

There have been three falls that have resulted in serious injuries (1 fractured Neck of Femur and 2 Head Injuries) within AMH. The number of falls as a whole (visitors, staff and patients) has increased but the majority of falls have resulted in no harm. The Thematic Lead for Falls will be providing additional support in Portsmouth.





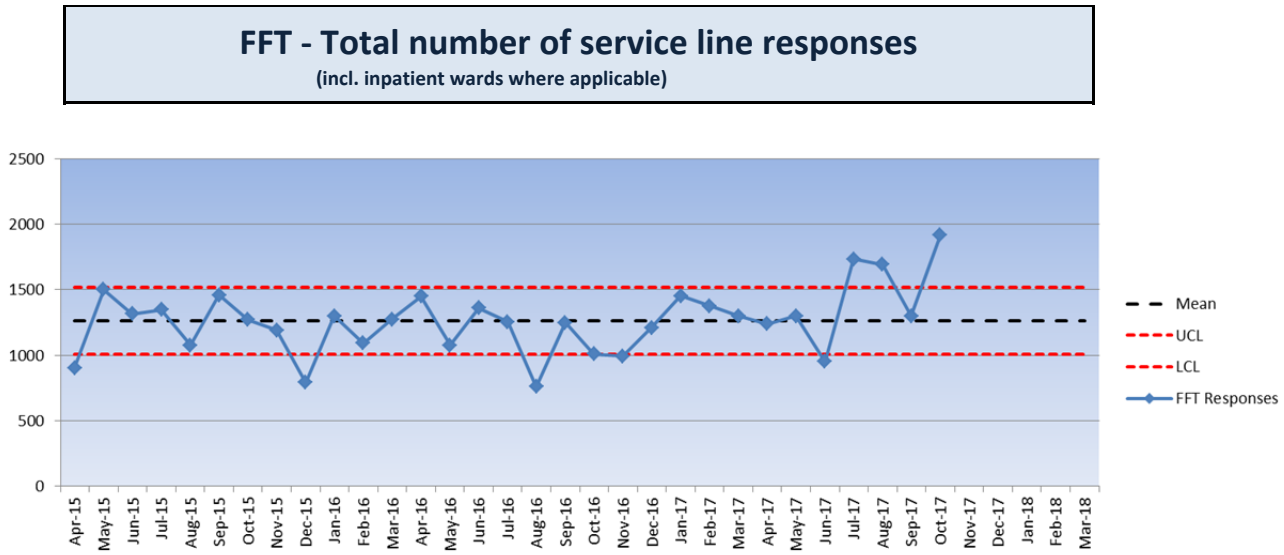
Complaints, Service Concerns and Plaudits



The number of plaudits received by the Organisation is the second highest in the last two years. Formal complaints continue to reduce as the Services respond to more Service Concerns, preventing them from escalating to formal concerns.

Friends and Family Tests

The total number of service line responses has improved with an upward trend since June, and is now the highest it has ever been. There have been a significant number of responses from Children & Family Services and particularly from School Nursing.



Risks Rated Register

The commissioned piece of work to review the strategic approach to risk, the risk register, training and use of the system has been completed and an action plan will be developed to incorporate all the learning from the review.

Quality Scorecard Narrative

Our Commissioners receive monthly information on quality via Scorecards. The following summarises the performance reported:

Portsmouth –

- No ward closures, infection control reportable infections or safety alert breaches reported.
- Four serious incidents (SI's) and three high risk incidents (HRI's) reported.
- Restraint episodes have decreased from last month. Although the number restraints are comparatively high to previous years, this is normally down to a small number of patients requiring repeated restraint for their own and staff safety. Consequently, we will report the number of patients receiving these moving forwards in our Quality Scorecards and Board Reports.
- Episodes of seclusion were six this month in adult mental health.
- Percentage of patients likely/extremely likely to recommend the service has improved slightly.

Southampton -

- No ward closures, or safety alert breaches reported.
- One infection control reportable infection – as detailed above.
- Three SI's and two HRI's reported.
- Percentage of patients receiving thromboprophylaxis (all community hospitals) has improved to be back at 100%.

- There has been an increase in medication reported incidents following last month's decrease. However, for the last three months none of these incidents have been rated moderate or above and the services continue to monitor the position.
- The number of patient responses to FFT has significantly improved.
- One grade 3 pressure ulcer was reported in Solent care and four pressure ulcers reported in Solent care were grade 4. In addition, a further four were reported as grade 2. These are within normal variation and no concerns are noted at this time.

4.1 - Financial Performance

October 2017/18

Performance

£146k Deficit in Month

£62k Adverse to plan

£1,076 Deficit YTD

£1,018k Favourable to plan

£1.5m Deficit Year End Forecast (adj)

£0 Achieving control target

Purchase Orders and Debts

Eligible invoices raised in month 999

953 Purchase orders raised in month

Purchase orders raised in month against eligible invoices 95%

£7,383,378 Total debt month end

£1,293,229 Total debt over 90 days month end 18%

Savings

£2,247,000 Savings Target YTD

£1,339,000 Savings Delivered YTD

0 QIA

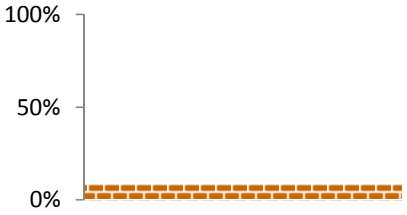
£394,000 Savings Delivered YTD

51% Savings Achieved

Capital Finance Summary

£1,674,000 YTD Spend

£18,782,000 Year end plan



8.9% Spend against year end plan

4.2 Finance Commentary

Month 7 Results

The Trust is reporting an in month deficit of £146k for month 7, £62k adverse to plan and a year to date deficit of £1076k, £118k favourable to plan.

Sexual Health have closed their gap slightly in month 7 and this is expected to continue due to increased visibility of their expenditure. Mental Health services have successfully sold beds to Southern Health on a 3 month trial period. There are ongoing concerns with Adults Southampton and Primary Care regarding the delivery of the closing the gap schemes.

CIPs

CIP delivery in month 7 was £308k, £301k adverse to plan. The main drivers of the adverse variance are:

- Underachievement in Sexual Health as online testing supplier savings have not materialised as expected.
- ICT under delivery on telephony.
- Income generation schemes are under delivering for both patient care and other operating income.

Capital and Cash

Month 7 year to date capital expenditure is low at £1.7m; this is due to awaiting approval for the loan application to start St Marys Phase 2 work. The Capital Resource Limit is £13.28m based on approval of the loan application. The cash balance at 31 October 2017 was £6.5m. The Trust is forecasting to draw down a Revolving Working Capital Facility Loan (RWCF) of £1.6m in February 2018 to fund its deficit.

Aged debt

Aged debt for significant customers has decreased slightly month on month. Debt over 90 days overdue as at 31 October is £1.29m compared with £1.33m at 30 September 2017.

Invoices processed via PO

The Trust continues to promote the use of purchase orders when ordering goods and services. In month 7 the percentage of eligible invoices processed via a PO (rather than via Non-PO) was 95%.

5.1 - Workforce Performance

October 2017/18

There were **2,895** FTE in post this month, which equates to **3,505** staff in post.

An increase of **19.2** since last month

80% YTD mandatory training compliance

83% YTD information governance training completed

79% YTD appraisals completed

77% medic appraisals completed,51% job plan completion rate

Bank and Agency

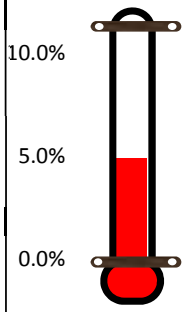
28,628 Hours requested in month

19,649 Hours filled by bank in month **£329,329**

8,312 Hours filled by agency in month **£439,474**

667 Hours requested not filled

In month, Solent are above agency ceiling by **£141,474**



4.9%

Sickness & absence in month

Last month, the rate was **4.6%**

97% *budgeted establishment (FTE) worked in month*

3% *vacancy factor*

FTE Posts **103.4**

12 month rolling turnover is **14.0%**

40 (35.2 FTE) new starters in month

47 (33.0 FTE) leavers in month

5.2 - Workforce Commentary

Sustainable Staffing

Month 7 shows an increase of 19.2 FTE from the previous month. This is due to the appointment of our new apprentices. The Trust's 12 month rolling staff turnover figure has fallen to 14%, however the in-month turnover within Portsmouth and Southampton Adult Services remains over 17% from the previous month. Our vacancy factor for Month 7 has dropped from 4% to 3% underpinned by a drop in the number of vacancies advertised (equivalent to 17 FTE).

For Month 7 our additional staffing has fallen from 201 to 197.2 FTE (broken down by agency at 30%, Bank at 60%, overtime at 3% and excess hours at 7%). Bank and agency usage for Month 7 has increased from the previous month. A reason for this may be due to a rise in sickness absence which increased from 4.6% to 4.9% in month. Whilst the Bank team was able to cover 69% of the total requested hours in Month 7, the proportion of off-framework agency usage has increased, most notably within our Southampton based inpatient wards. The average monthly agency expenditure across the Trust for this financial year is currently £448,346.

The Occupational Health and Wellbeing team have been administering the flu campaign which has been very successful this year with an uptake of 59% of front-line staff as of Month 7.

Education, Learning & Development

Mandatory training for Month 7 remains at 80% compliance, with the Learning and Development team continuing to run 'pop up' sessions across the Trust to meet statutory and mandatory training requirements. The Information Governance training completion rate continues to increase, rising from 75% to 85% in Month 7.

The yearly appraisal completion rate remains at 79% from the previous month. This in part is due to the beginning of the medical staff appraisal window (October to March). The medical staff appraisal completion rate as of Month 7 was 77%.

Leadership & Organisational Development

Workforce planning remains a key priority, with efforts focussed on developing new delivery models and skill mixes within our wards and inpatient units to deliver safe and sustainable care. This includes the development of a new Band 4 role in AMH.

The new approach to talent management has been implemented for senior leadership positions and a further 24 leaders attended the 'Leading with Heart' development centre. A revised programme for Releasing Potential has been developed which will be extended to middle management positions.

Our newly appointed L&D Manager has joined the team and will be focusing on medicine management training, statutory and mandatory learning and our CPPD strategy for next year.

We have also commenced our 'Core Essentials' People Management training, the first two workshops will focus on maximising attendance and performance.

6.1 NHS Improvement Single Oversight Framework

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

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

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

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

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

Current Month Performance

The Trust has continued to achieve a level 2 on the NHS Improvement scale, where level 1 is the best and level 4 the most challenged. This is a good position for the Trust.

The Finance and Use of Resources indicator has maintained it's position with a score of 2. The year-end financial plan remains on target at the end of quarter 2. Further information is provided in section 3.2.

During November, NHS Improvement have released a revised Single Oversight Framework for Trusts to be monitored against, which includes metrics such as out of area placements for metal health services and additional hospital acquired conditions. This will be incorporated into the Board Report moving forwards to provide assurances of performance.

Quality of Care Indicators

Organisational Health

Internal aspirational thresholds are highlighted in grey

Indicator Description	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Staff sickness (in month)	4%	4.3%	4.0%	3.8%	4.4%	4.9%	4.8%	4.8%	4.4%	4.2%	4.0%	4.1%	4.1%	4.3%	4.8%	4.6%	4.9%
Staff turnover (rolling 12 months)	12%	17.6%	18.1%	16.9%	15.9%	16.6%	16.3%	15.5%	15.9%	16.1%	15.2%	15.3%	15.1%	14.8%	14.8%	14.5%	14.2%
Executive team turnover (rolling 12 months)	12%	17.4%	8.7%	8.8%	8.7%	0.0%	8.5%	8.5%	8.7%	18.2%	15.4%	15.4%	24.0%	23.1%	23.1%	23.1%	23.1%
NHS Staff Survey	40%			56.7%						61.5%			64.4%			64.1%	
Proportion of Temporary Staff (in month)	6%	5.2%	5.8%	5.8%	5.5%	6.5%	6.5%	6.5%	6.2%	6.5%	6.9%	5.9%	6.1%	6.1%	6.4%	5.8%	5.7%
Aggressive Cost Reduction Plans (YTD delivery)	100%			71.9%			73.4%			75.8%			55.0%			53.2%	

Caring

Indicator Description	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Written Complaints		37	21	16	21	20	18	25	23	20	7	21	21	14	16	15	11
Staff Friends and Family Test Percentage Recommended - Care	80%			79.5%						81.8%			83.0%			82.3%	
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Scores from Friends and Family Test - % positive	95%	95.6%	95.5%	95.8%	95.7%	97.0%	95.5%	95.6%	96.3%	96.4%	96.8%	95.7%	95.0%	97.6%	95.3%	95.0%	96.0%
Mental Health Scores from Friends and Family Test - % positive	95%	92.4%	89.7%	92.3%	86.8%	93.3%	89.7%	95.7%	89.9%	90.7%	97.2%	88.1%	87.1%	100.0%	90.5%	83.3%	85.4%

Effective

Indicator Description	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	95%	100%	100%	100%	97%	100%	97%	96%	94%	100%	100%	100%	100%	100%	100%	100%	92%
% clients in settled accommodation		72%	73%	76%	72%	71%	71%	73%	71%	70%	69%	69%	68%	69%	70%	72%	72%
% clients in employment	5.0%	6.6%	5.0%	4.0%	3.1%	4.0%	3.1%	6.4%	5.9%	10.0%	5.6%	6.6%	6.0%	6.0%	5.0%	5.0%	6.0%

Safe

Indicator Description	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Occurrence of any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHS England/ NHS Improvement Patient Safety Alerts outstanding	0	2	0	1	1	1	2	0	0	0	0	1	0	0	0	0	0
VTE Risk Assessment	95%	94%	97%	95%	89%	100%	100%	100%	97%	100%	91%	100.0%	97.0%	99.0%	98.0%	97.0%	88.0%
Clostridium Difficile - variance from plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile - infection rate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MRSA bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Admissions to adult facilities of patients who are under 16 years of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Operational Performance Indicators

Indicator Description	Threshold	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	99.9%	99.5%	99.2%	99.9%	100.0%	100.0%	99.7%	100.0%	99.5%	99.3%	100.0%	100.0%	99.9%	99.8%	99.5%	99.7%
Maximum 6-week wait for diagnostic procedures	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	50.0%	50.0%	NIL	88.0%	67.0%	71.0%	75.0%	100.0%	71.0%	30.0%	71.0%	50.0%	86.0%	67.0%	83.0%	80.0%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set submissions to the HSCIC		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Identifier metrics	95%	95.6%	95.3%	95.3%	95.2%	95.0%	94.9%	94.8%	94.7%	94.5%	95.5%	95.4%	95.2%	95.2%	95.1%	95.1%	94.9%
- Priority metrics	85%	86.1%	85.8%	86.6%	86.5%	83.7%	83.6%	84.5%	82.6%	82.3%	80.0%	78.7%	78.3%	78.8%	79.0%	80.7%	81.0%
Improving Access to Psychological Therapies (IAPT) / Talking Therapies		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
- Proportion of people completing treatment who move to recovery	50%	52.9%	52.4%	52.9%	50.0%	51.2%	53.9%	56.7%	51.9%	50.0%	62.1%	57.7%	54.0%	58.8%	54.2%	54.5%	59.8%
- Waiting time to begin treatment - within 6 weeks	75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	99.0%	100.0%	100.0%	100.0%	100.0%
- Waiting time to begin treatment - within 18 weeks	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Finance and Use of Resources Indicators

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

Indicator Description		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Capital service capacity	Financial Sustainability		1.1	1.4	1.2	1.2	1.3	1.2	0.5	0.7	0.0	1.1	1.5	1.4	1.6	1.7	1.7
Score			*4*	*3*	*4*	*4*	*3*	*4*	*4*	*4*	*4*	*4*	*3*	*3*	*3*	*3*	*3*
Liquidity (days)	Financial Sustainability		-4.0	0.9	-4.0	-4.2	-1.0	-4.4	-4.9	-12.1	-13.0	-12.9	-12.5	-13.0	-12.9	-13.3	-12.7
Score			*2*	*1*	*2*	*2*	*2*	*2*	*2*	*3*	*3*	*3*	*3*	*3*	*3*	*3*	*3*
I&E Margin	Financial Efficiency		-2.3%	-1.7%	-1.8%	-1.9%	-1.8%	-1.8%	-1.8%	-1.2%	-0.02%	-1.9%	1.3%	1.4%	1.1%	0.9%	1.0%
Score			*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*3*	*4*	*2*	*2*	*2*	*2*	*2*
Distance from financial plan	Financial Efficiency		0.8%	54.2%	1.5%	1.0%	0.7%	0.5%	0.3%	0.8%	-0.02%	-0.5%	0.0%	0.1%	0.2%	0.3%	0.1%
Score			*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*2*	*2*	*1*	*1*	*1*	*1*	*1*
Agency spend	Financial Controls		-3%	-12%	-9%	3%	4%	4%	4%	4%	0.3%	25.0%	24.3%	25%	47%	40%	38%
Score			*1*	*1*	*1*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*3*	*3*	*3*
Use of Resources Score			3	3	3	3	3	3	3	3	3	3	2	2	2	2	2
RAG			R	R	R	R	R	R	R	R	R	R	G	G	G	G	G

6.2 NHS Provider Licence - Self Certification 2017/18

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.	

No.	Requirement	Response (Confirmed /not confirmed)	Assurance (or in the case of non-compliance, the reasons why)	Risk and mitigating actions to ensure full compliance
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed*	External Auditors have issued a Section 30 letter to the Secretary of State in relation to the Trusts deficit position, which shows a cumulative deficit for the three year period to 31 March 2017. However, for the financial years ended 31 March 2015/16 and 2016/17, the Trust has recorded deficits smaller than the amounts agreed with NHS Improvement. The Board is not aware of any other 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. External Auditors concluded an unqualified VFM opinion. ** The Trust was given a deficit control total by NHS Improvement of £3.5m for 2016/17 against which it delivered a deficit of £2.1m. For 2017/18 the Trust has agreed a deficit control total of£1.5m with NHS Improvement.*	Concerning CQC compliance: A comprehensive action plan is in place and being monitored in response to the CQC comprehensive inspection during 2016.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board is not aware of any departures from the requirements of this condition. The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do. The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors. There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer. Concerning Board level capability- recent appointments have been made to the Chief Nurse position and COO Southampton and County. A new NED colleague joined the Board from 1 September 2017. Established escalation processes allow staff to raise concerns as appropriate.	

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.	

Item 10

Presentation to	[x] In Public Board Meeting	[ ] Confidential Board Meeting	
Title of Paper	**Equality and Diversity Report**		
Author(s)	Sarah Martin, AD for People & OD Kathryn Smith, Diversity & Inclusion Lead	**Executive Sponsor**	Helen Ives Chief People Officer
Date of Paper	17/11/17	**Committees presented**	
Link to CQC Key Lines of Enquiry (KLoE)	[ ] Safe [ ] Effective [ ] Caring [ ] Responsive [x] Well Led		
Action requested of the Board	[x] **To receive** [ ] **For decision**		

The purpose of this paper is to annually update the Board on the Trust's Equality and Diversity role and requirements.

This paper primarily deals with our duties under the Workforce Racial Equality Standards (WRES), the NHS Equality Delivery System (EDS2). The paper does not contain detailed input from the Quality & Patient Experience team and we propose that a follow-up paper is brought to Board for 2018/19, which provides an integrated perspective on Equality & Diversity, Patient & Public Involvement and the procurement/ commissioning of services under the Social Values Act (2012).

The EDS2 Summary Report will be made available on the Solent NHS Trust website and copies will be circulated to Board. In particular, this Summary Report provides additional information on the actions the Trust is taking to embed Better health outcomes, Improved patient access and experience.

The document includes:

- Introduction to our requirement to prioritise and promote equality, diversity and human rights
- The standards we are monitored on – including the Equality Act 2010 and the Public Sector Equality Duty
- Update on implementation of the NHS Equality Delivery System (EDS2)
- Report on Workforce Racial Equality Standard (WRES)
- Analysis of our workforce monitoring data including our Workforce Diversity Scorecard
- Recommended actions for 2018-19

Recommendation

The Board are asked to receive the Equality and Diversity Report.

1. Introduction

The needs and circumstances for patients, carers, communities and staff from protected groups can be distinct and specific. In providing quality services and workforce environments that are appropriate and effective for all, Solent NHS Trust prioritises and promotes equality, diversity and human rights.

The NHS Equality Delivery System (EDS2) framework was published to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. We follow the implementation of EDS2 in accordance with the 9 Steps through the 'Equality Standards toolkit' and all of our clinical services have now achieved the Silver standard, which is verified through peer review of submitted evidence.

We also report on the Workforce Racial Equality Standard (WRES), which requires us to demonstrate through the nine-point WRES metric how we are addressing race equality issues in a range of staffing areas. In the NHS Workforce Race Equality Standard 2016 data analysis report for NHS Trusts, Solent was listed in the section for: Trusts where data suggest practice may be better for WRES 3.

We steer implementation through the Equality Impact Group, which meets quarterly and is well attended from Clinical Services, in particular by the Professional Leads. The focus is on embedding Equality & Diversity in our workforce and patient experience. This Group will now form part of the sub-committee structure of the People & OD Committee.

The established good work within Solent on Equality & Diversity was recognised when we were chosen by NHS Employers as one of their Diversity and Inclusion Partners for 2017/18. As a partner we have joined NHS Employers and other national organisations including NHS England and NHS Improvement and Health Education England, on the NHS Employers Diversity and Inclusion Programme.

The Equality & Diversity Lead for Solent has until recently been a shared role with Southern Health and Portsmouth Hospital. This role was hosted by Southern Health and provided great value by sharing specialist expertise across the local system. This role is no longer available and we are therefore training a new Diversity & Inclusion Lead within the People & OD Team in Solent. This transition has revealed an opportunity to coordinate our approach more closely across Quality, Improvement and Communications in to deeply embed the role of Equality & Diversity in providing better health outcomes for all and improved patient access and experience.

2. About this report

This report is published under the Equality Act 2010, as our duty to "publish information relating to persons who share a relevant protected characteristic who are its employees".

The Public Sector Equality Duty, which came into force on 5 April 2011, was created by the Equality Act 2010 in order to harmonise the race, disability and gender equality duties and

extend protection to the new protected characteristics of age, sex, gender re-assignment, pregnancy and maternity, religion or belief and sexual orientation. This has led to a requirement for public bodies to publish both equality objectives at least every four years and equality information to demonstrate compliance with the equality duty annually.

The workforce data in this report forms part of the required equality information. We have collated, monitored and published this information to help our organisation meet our responsibilities under the duty and to ensure equality considerations are reflected in our employment practices and policies.

3. Analysis of our workforce monitoring data

Equality and Diversity is embedded within our values and culture in our organisation. Progress is measured through our Diversity Scorecard (see section 4). This was developed to track both quantitative and qualitative metrics and ensure we are recruiting, developing and retaining a highly skilled, diverse workforce that can best serve the needs of the diverse communities that we serve.

Our workforce reporting for the year 2017 is structured across the following key aims:

(i) Inclusive leadership at all levels
(ii) A representative and diverse workforce across all levels
(iii) An inclusive workplace culture and environment

(i) Inclusive leadership at all levels

As a Trust we view leadership as key in taking forward the diversity agenda as to gain value from diversity it requires leadership and a sustained, systematic approach with long-term commitment.

Leaders and managers are all responsible for being able to manage a diverse workforce, work alongside members of diverse teams and create an inclusive culture. As a Trust we are committed to continuing to build the capabilities of our managers so that they can champion our leadership commitment to diversity.

Our commitment to this aim is to ensure that:

- Equality and Diversity training is in place for all staff (this includes our online mandatory training package plus a session on corporate induction)
- Engage and communicate with staff so that the workforce is kept up to date with equality and diversity information and updates
- Governance will be strengthened to ensure equality and diversity considerations are embedded in our decision-making processes
- Implement the Equality Standards Toolkit (our bronze, silver and gold standards)

(ii) Representative workforce across all levels

Our diverse workforce enables us to benefit from the creativity and skills of all our staff and it is important that this diversity is present across all levels of the organisation. It enables us to tap into a broad spectrum of experience and ideas that comes as being part of a diverse team.

Our commitment to this aim is to ensure that:

- Staff at all levels continue to have access to appropriate learning and development opportunities and continuing professional development
- Continue to monitor the diversity of our workforce through the Diversity Scorecard

(iii) An inclusive workplace culture and environment

We want to enable all our staff to be fully involved in the Trust's work, to protect them from unfair treatment and ensure each individual can reach their potential. We have developed a set of Equality Standards that will aim to embed equality and diversity throughout the organisation and continue to identify innovative ways to promote an inclusive workplace culture for all our staff

Our commitment to this aim is to ensure that:

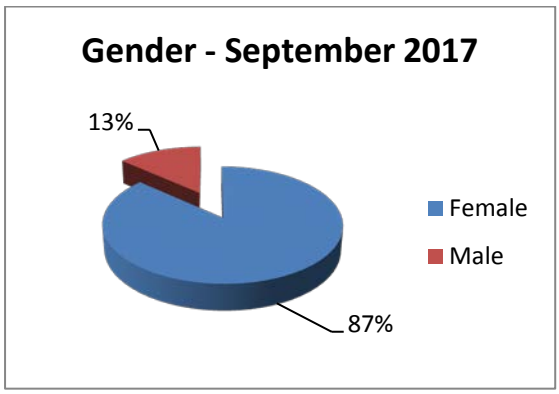
- We promote our values and associated behaviours through training, development and communications to progress and encourage an appreciation of an inclusive workplace
- Continue to develop our engagement and communication with our people

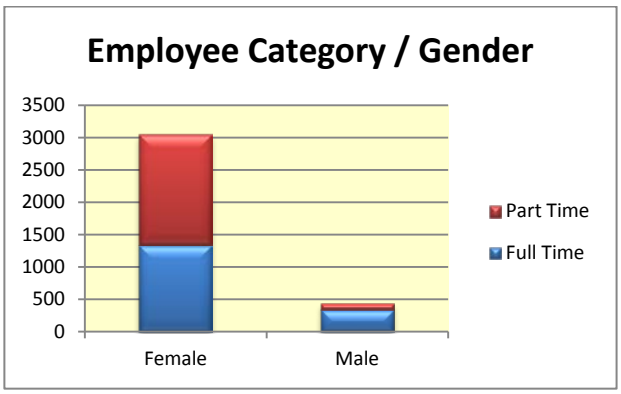
4. Workforce Diversity Scorecard

The Workforce Diversity Scorecard will provide a breakdown of the workforce by protected characteristics: Gender; Race; Religion; Age; Marital Status; Disability; Sexuality; Pay Bands; Retention.

4.1 Gender

Solent had a headcount of 3492 at September 2017, and the gender split was 87% female to 13% male, with a female bias being typical of the caring professions. The bar chart on the right indicates that approximately half females are part-time, vs a far smaller proportion of part-time males.

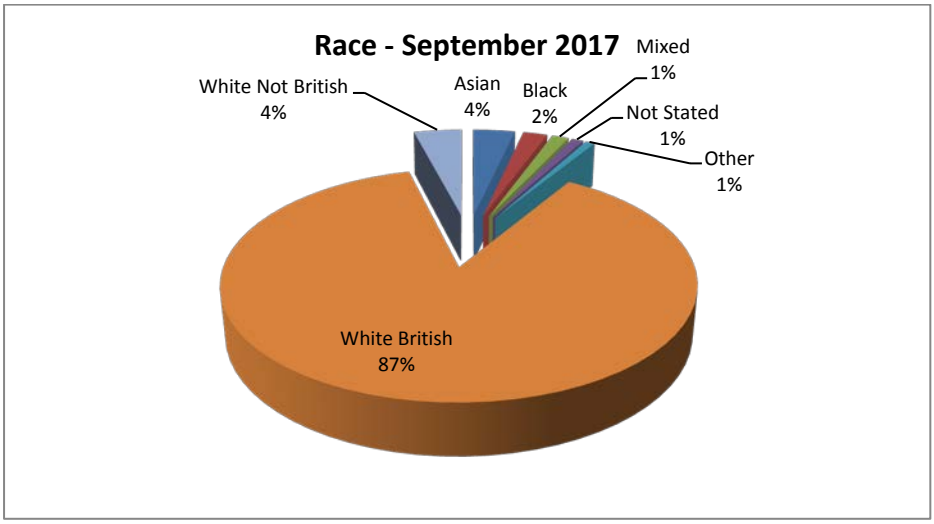




Whilst many flexible working patterns exist within Solent, we know from the data collected through Employee Engagement that we can do more to include all staff members and ensure that there is clarity and fairness. This will be a key deliverable in the 2018/19 business plan.

4.2 Race

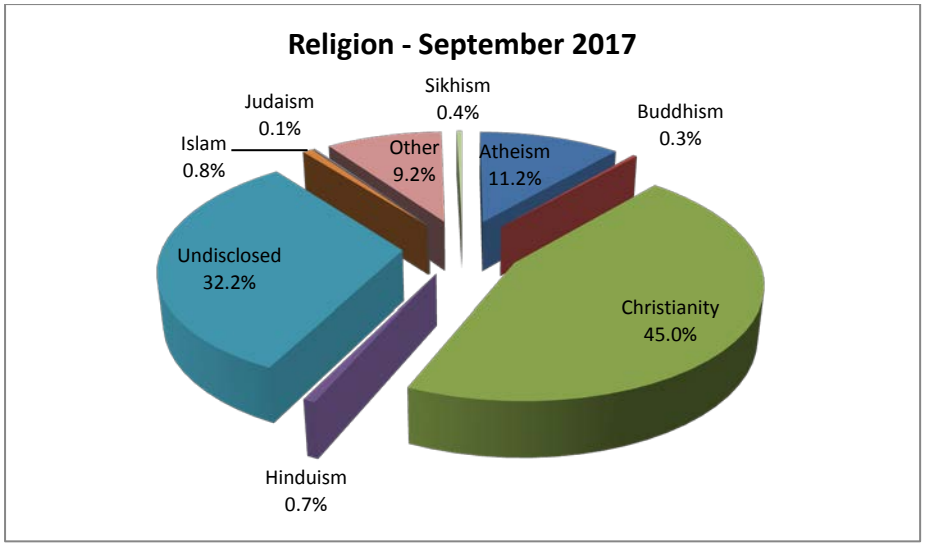
The chart suggests that Solent is under-represented in the White Not British, Asian and Mixed categories and over-represented in the White British and Other categories when compared to local averges which indicate a White British population of 81%, White Not British at 6%, Asian at 7% and Mixed at 3%. From early 2014 to early 2016, Asian group increased by 1%, with a decrease in White British by the same amount. Since March 2016, figures have remained stable.



We recognise that there we can do more to proactively and positively reach out to diverse communities when we advertise roles. We plan to incorporate a range of new communications tactics into our Recruitment campaigns for 2018/19 and to use more diverse marketing. In addition, we will do more to provide targeted development opportunities for employees within the different race categories and to ensure effective representation across our internal forums and groups.

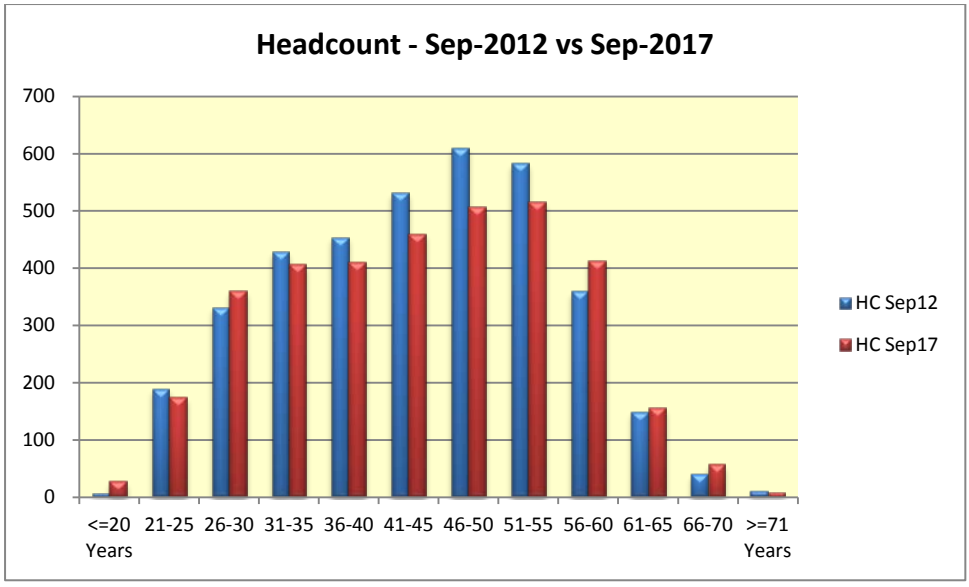
4.3 Religion

Religious Beliefs recorded presently show a high proportion of 'Undisclosed' records, hence a good comparison cannot accurately be made against local information. The Not Disclosed category enables employees to opt out of providing this information. Since March 2016, Atheism has increased by 2% while Christianity has reduced by the same amount.



4.4 Age

In 2012 the highest proportion of staff was in the 46-50 age band – in 2017 it is 51-55. In 2012, the drops in the 56-60 and 61-65 age bands were marked; in 2017 it is less pronounced, indicating that fewer people in those age bands are leaving (e.g., for retirement, etc). Comparing the September 2012 position with September 2017 reveals that overall, we have reduced in headcount by nearly 200 staff, and notably, staff numbers were reduced from the age bands under 55, whereas the age groups over 56 all experienced growth, demonstrating the effect of changes to pensionable age.

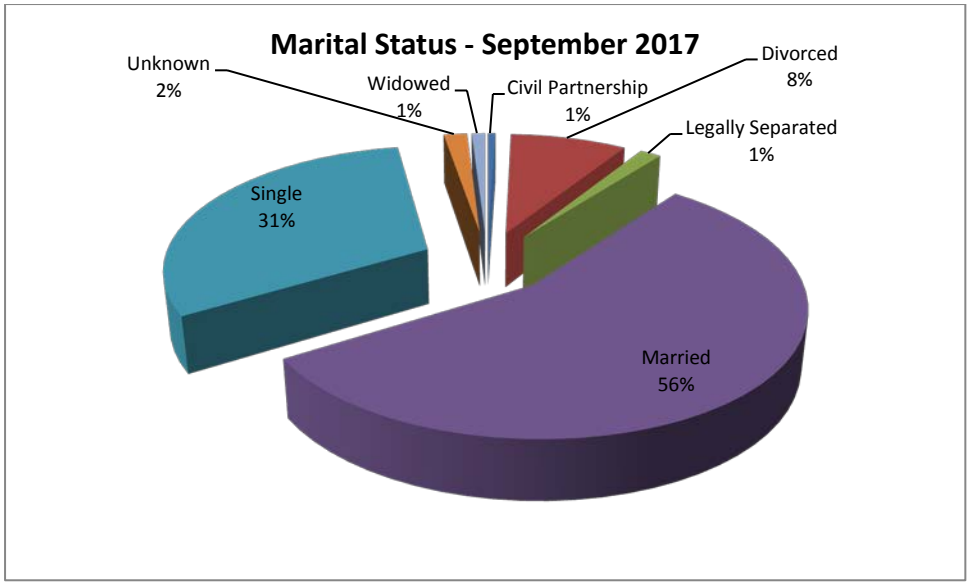


As this demographic continues to shift, our workforce will continue to 'age' and this provides a number of challenges and opportunities. Care needs are becoming more complex due to the ageing population and thus the work carried out by our employees is more demanding. Health and Wellbeing remains a key consideration for us and the top reasons for sickness absence are MSK and Stress, which continues to rise. With national shortages of registered professionals entering the workforce, there is a very significant risk to sustainability.

In Solent, we continue to develop a number of new and innovative approaches to Health & Wellbeing such as the OWLES Group and Mindfulness resources. Together with the work we will do on Flexible Working in 2018/19, we will need to target communications at the segments of our workforce so that we can better understand, respond and adapt to differing needs.

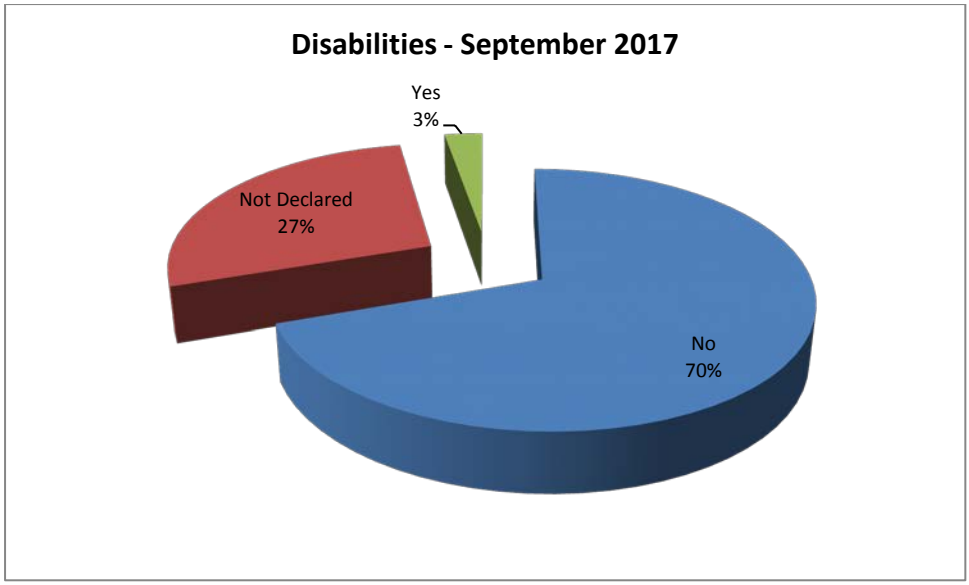
4.5 Marital Status

Solent continues to have a higher proportion of married couples than is reported in local Census data (55% vs 37%) mainly due to the fact that all ages of the local population are being compared with the working age group that Solent's staff fall into. The other marital statuses are represented similarly between Solent and local averages. The married group has reduced by 1% in the past year, while legal separations have increased by 1%.



4.6 Disability

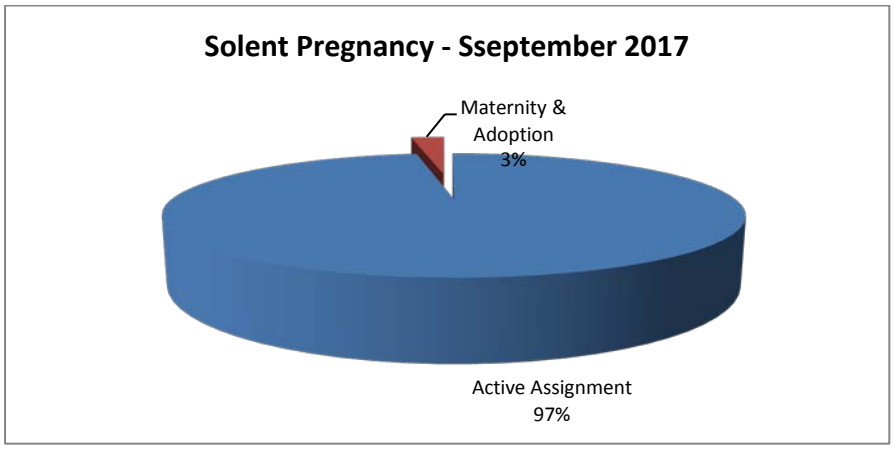
Solent reports a 3% disability rate, with 27% being undeclared (which was reduced from 37% in March 2016 by data cleansing).



In our plans for 2018/19, we will engage with local and national organisations to expand our existing good practices in this area. This will include increasing the visibility of disability within the organisation, building the skills and confidence of line managers and providing targeted development opportunities for employees with disabilities.

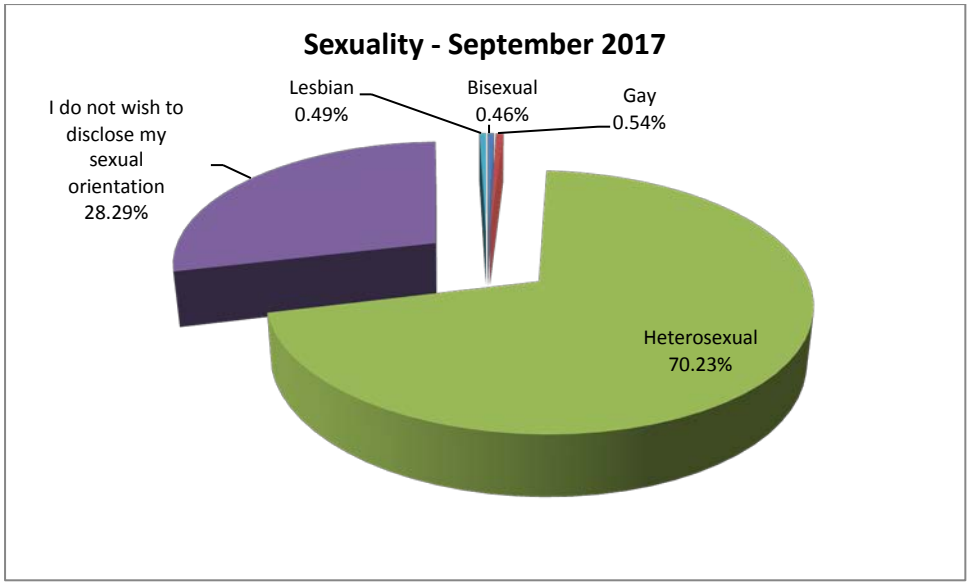
4.7 Pregnancy

Solent's pregnancy, ie, maternity/paternity and adoption rate remains stable at 3%.



4.8 Sexuality

A large number of staff records show that sexuality is not disclosed. Employees can update this data directly themselves in ESR. There is a very small proportion of records where Bisexual/Gay/Lesbian have been recorded (1.5% for all three categories combined).



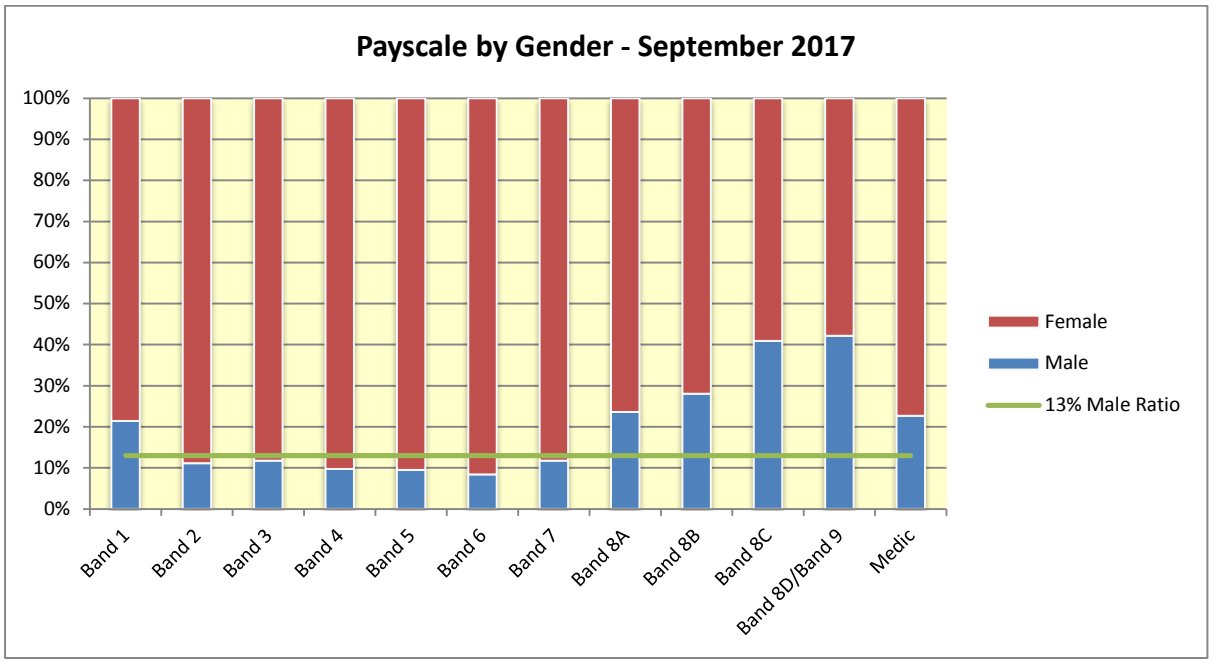
This is an area where we can enable a more inclusive and supporting workplace environment by supporting employee-led networking and communication. The Owles Group for mental wellbeing is an example of a successful employee action model, which we can can develop for other areas.

4.9 Gender Re-assignment

There remains no information available in this area; it is not presently recorded via ESR.

4.10 Information by Pay bands

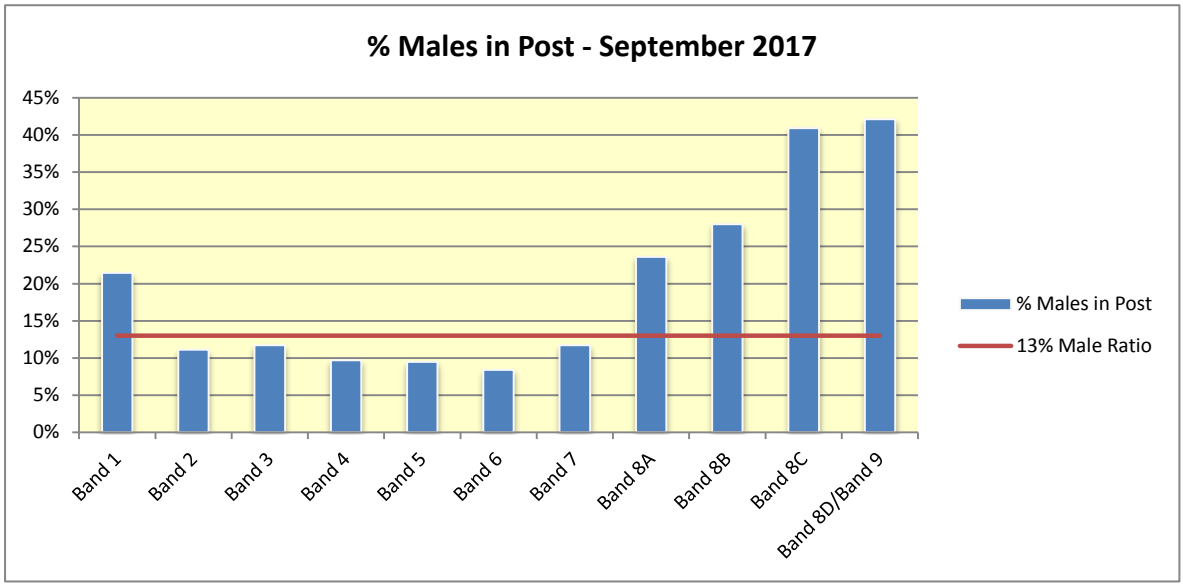
The chart shows paybands and the proportions of males to females, and indicates that there are proportionately more males in the higher bands than some of themiddle/lower bands.



The Agenda for Change pay system was introduced in October 2004 to ensure that pay in the NHS was consistent with the requirements of equal pay law. Following government consultation, it became

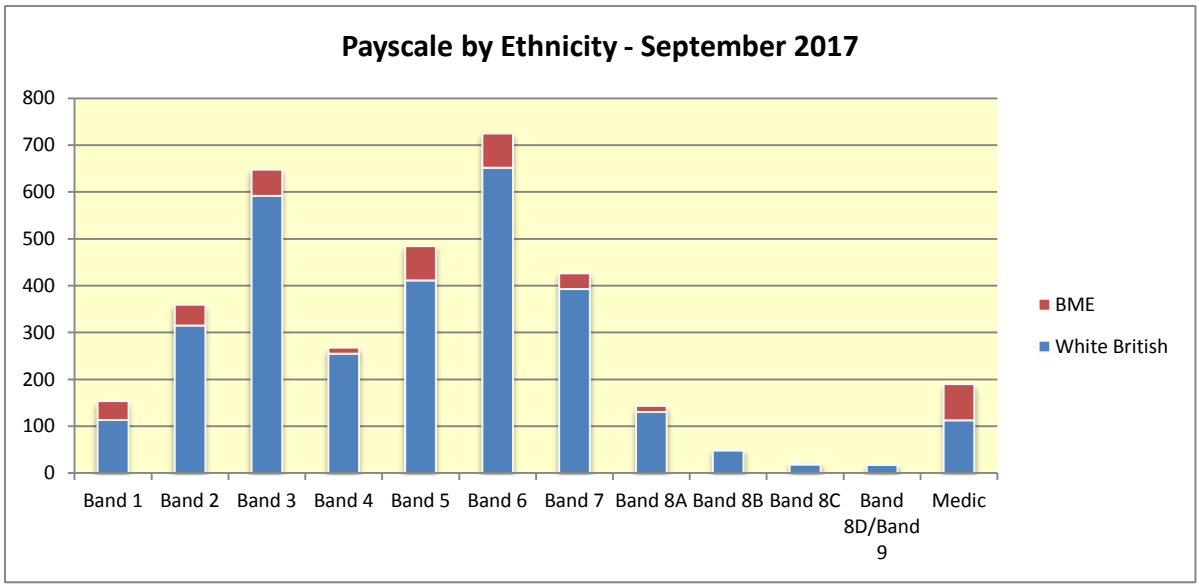
mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG). The deadline for complying is March 2018 and work is currently underway to analyse our data fully.

This chart shows that males are under-represented in bands 2 through 7, yet are over-represented in all other bands.

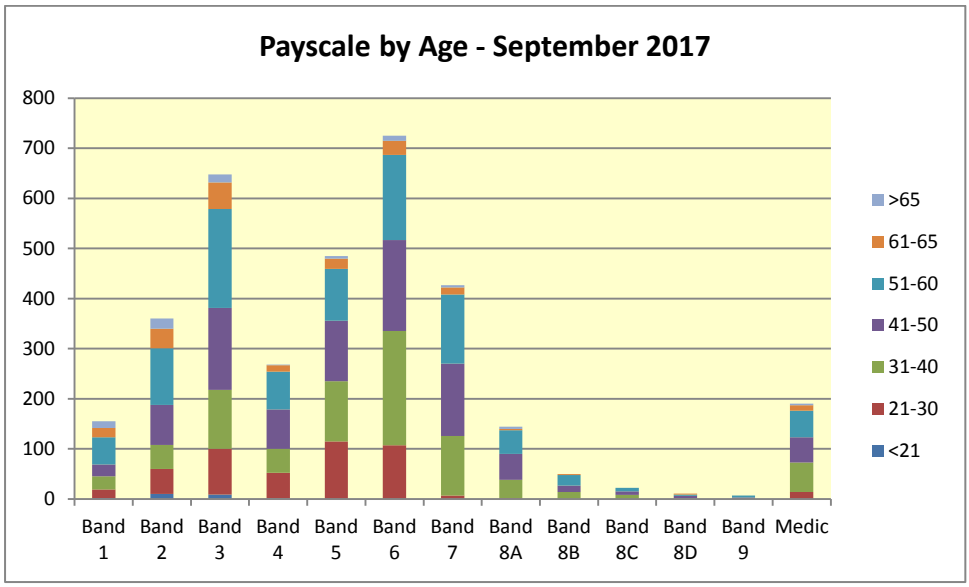


There is an under-representation of females in senior positions and again this is an area that we can target in 2018/19 by providing targeted development opportunities for female employees and ensuring that we fully participate in national programmes.

The below chart shows that medics and band 5 staff are the most ethnically diverse, with bands 2, 3 and 6 showing broad diversity too.

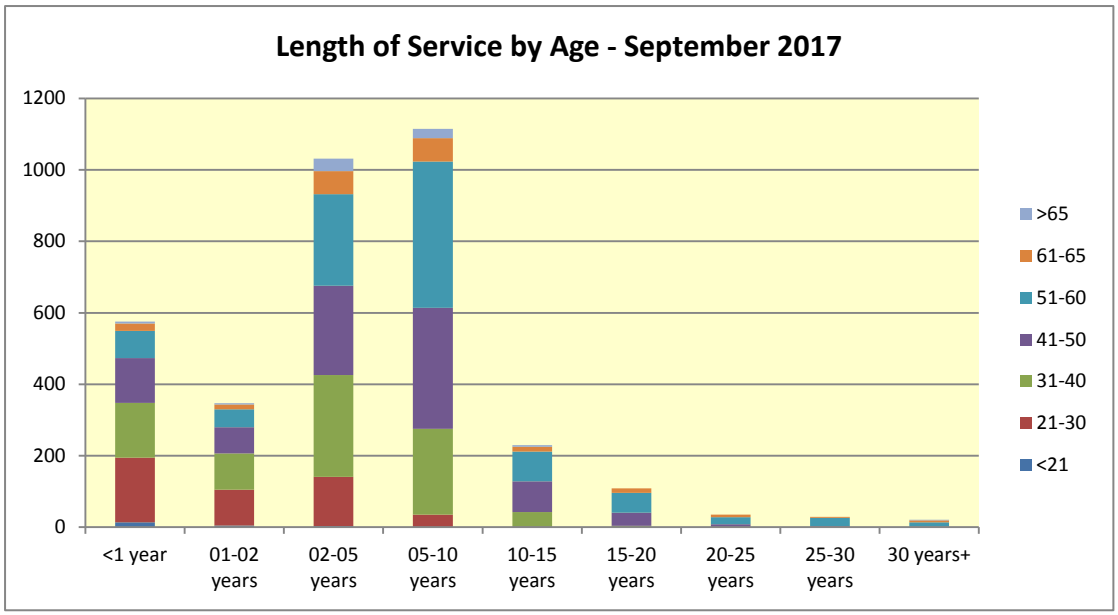


This chart demonstrates subtle differences in how staff are distributed by age and band, for example, under 30s have a proportionately higher representation in bands 5 and 6 and are proportionately fewer in bands 7 and 8. This could indicate a natural career progression as staff age and gain experience. In the higher payscales it is possible to see how progression and representation tails off as staff age. The high proportion of 21-30 year olds in band 5 roles would most likely be graduating nurses.



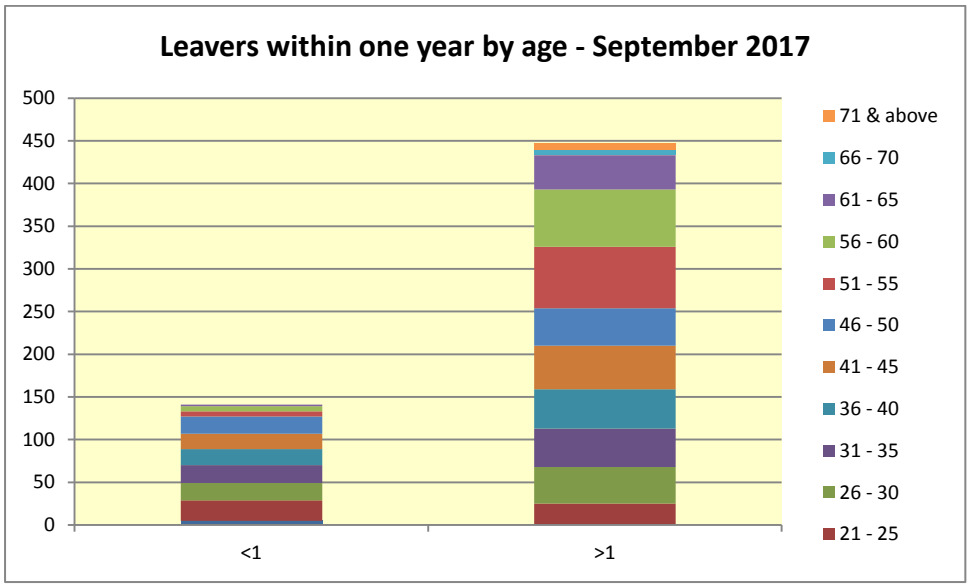
4.11 Length of Service

Length of service is reasonably proportionately distributed, except younger employees are more prevalent in the 0-10 years' service as might be expected. 61+ year olds have a slightly higher representation on the 2-10 year categories, possibly due to TUPE in of Estates in that period, and also, flexi-retirees would show in that category since their contracts are reset; estates typically carry an older staff ratio. Most employees have served 1-10 years.



4.12 Retention Rates

It can be seen that staff under 40 are most likely to leave within one year of employment. This may be expected due to career stage and a natural desire to pursue different career paths. Retention increases with age and this is to be expected in line with needs around job security.



5. Workforce Race Equality Standard (WRES)

The aim of WRES is to improve the experience of Black, Asian, Minority & Ethnic (BAME) staff in the workplace. This includes recruitment, employment, promotion and training opportunities. It also applies to BAME staff experience of the employee relations process and is achieved through positive action to eliminate discrimination, harassment and unfair treatment of BAME staff in the workplace.

The implementation of WRES has enabled us as a Trust to drive race equality and focus on:

- BAME representation at leadership level
- The experience of BAME staff in the employee relations process and NHS Staff survey
- Ensure that non mandatory training and development opportunities are made available to BAME members of staff

WRES data in Solent 2017

Within Solent we have a WRES Strategy (15-18) and WRES Programme plan. The data below has been extracted from the overall Staff survey 2016 report. WRES reporting takes place annually in August.

The national NHS Staff Survey select four indicators to compare outcomes of the responses for White and BAME staff:

National NHS Survey	2016	2017	Action for 17/18
KF25 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**White** 23% **BAME** 25%	**White** 20% **BAME** 31%	Increase in BAME staff experiencing harassment from public. Action to promote campaign and increase signage of zero tolerance of abuse to our staff from patients
KF 26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months	**White** 19% **BAME** 26%	**White** 16% **BAME** 24%	Despite reduction, action is to deliver bullying and harassment workshops with on-going monitoring of complaints and grievances and incidents in service groups. FTSU guardians in place to further support issues raised
KF21 - % believing that trust provides equal opportunities for career progression or promotion	**White** 86% **BAME** 73%	**White** 91% **BAME** 82%	Positive increase in staff groups understanding equal opportunities within Solent and career progression has increased. Despite increase, work on talent management must continue so that career development and promotion is available to all.
Q17. In the last 12 months have you personally experienced discrimination at work from Manager/team leader or other colleagues	**White** 5% **BAME** 10%	**White** 4% **BAME** 8%	Slight decrease on last year however on-going monitoring required to remove and eliminate discrimination.

11. Recommended Actions for 2018/19

As a Trust we have made good progress on the Equality Diversity Standard objectives and have launched a number of Equality and Diversity initiatives in the last 18 months such as 'Diversity moments' at the Equality Impact Group and bespoke Positive Psychology workshops. We will continue to build on this progress and the Equality Impact Group will be the driving force of the Equality Standard as we move towards completion of the Equality Standard.

Our recommended actions for 2017/18 are:-

(i) Collaborate with our Quality Improvement and Patient Experience teams to join up our workforce and patient equality and diversity data and provide a clearer picture of how we are serving our local communities.

(ii) Fully utilise the Joint Strategic Needs Assessment (JSNA) as an assessment of the current and future health and social care needs of local populations. Broaden the scope of our Equality & Diversity aims for 2018/19 to include Better health outcomes for all and Improved patient access and experience.

(iii) Work with system partners to ensure that we contribute to consistent communications across the local delivery systems and increase Equality & Diversity messaging within our own service access communications.

(iv) The Equality Impact Group (EIG) to discuss and implement plan to reduce the not-declared rate for Disability, Religion or Belief and Sexual Orientation. The key issues are visibility and acceptance in the context of inclusive culture.

(v) Following the published results of our Workforce Race Equality Standard (WRES) a change of focus is required to identifying appropriate and responsive measures/ methods to improve the career progression of BAME staff.

(vi) Continue programme of delivery of our Equality Toolkit Standard with the aim to achieve the Gold Standard by the end of 2018.

(vii) Ensure that the Equality Toolkit Standards are equally applied to corporate services.

(viii) As a Trust we will contribute to the national consultation of the proposed Sexual Orientation and Disability Standard (NHS England).

(ix) Ensuring our staff, and in particular our senior leadership team, understand the responsibilities of EDS2/WRES in light of the CQC well led domain standards.

(x) Embed action from the analysis of WRES, EDS2 and Workforce Diversity Scorecard into our integrated People & OD Plan for 2018/19.

(xi) Gender pay gap report (GPG). The deadline for complying is March 2018 and work is currently underway to fully analyse our data.

Item 12

Board Report – In Public Meeting

Title of Paper	Smoke Free Report to Board – November 2017		
Author(s)	Andrew Smith Katie Arthur	**Executive Sponsor**	David Noyes
Link to strategic Objective(s)	X Improving outcomes ☐ Working in partnership ☐ Ensuring sustainability		
Link to CQC Key Lines of Enquiry (KLoE)	X Safe X Effective X Caring X Responsive ☐ Well Led		
Date of Paper	November 2017	**Committees presented**	N/A
Action requested of the Board	X To receive ☐ For decision		
References	Solent Smoke Free Protocol October 2016 NICE Guidance PH48 Solent "Creating a Smoke Free workplace" Policy April 2015 Solent NHS Trust Smoke (Tobacco) free Mental Health In patient services Standard Operating Procedure (SOP) August 2017		

Executive Summary

This paper outlines the trust's progress towards delivery of the Solent Smoke Free Protocol of October 2016, which supports the delivery of the NICE Guidance PH48 (Smoking: acute, maternity and mental health services) as it pertains to Solent NHS Trust.

The board is asked to note the progress made; to note the estates risk around Smokefree compliance that the organisation is tolerating; to agree the review of the Smokefree protol; and to agree the on-going compliance and assurance monitoring process through the existing operational and performance route.

Situation and Background

The Smoke Free Solent initiative had an overall aim of preparing Solent NHS Trust for compliance with NICE guidance PH48 (Smoking: acute, maternity and mental health services).

The development of a range of policy, protocol and guidance has been delivered within Solent since June 2016. This provides supportive measures for the delivery of a Smoke Free Solent.

A voluntary scheme of E-Learning has been developed and provided for Trust staff which develops brief intervention skills in smoking cessation and is available through the E-Learning portal. The E-learning module will help with on-going compliance. Staff are encouraged to take up this opportunity through service lines.

One of the successes of the Smokefree programme has been the direction and drive from the Executive team. Whilst there have been difficult conversations about the move to Smokefree for some of the more complex elements of services, including mental health in-patient services, as well as challenging discussions regarding E-cigarettes; the executive steer has been to make sure that the development of Smokefree Solent supports staff and patients and treats smokers with respect and dignity whilst providing pharmacotherapy and support to engage with nicotine addiction.

The table below identifies progress to date.

Date	Development
May-16	Trust commences it's Smokefree Process, including the creation of a Smokefree Steering Group
Aug-16	Smokefree Media Campaign commences: - press releases, - website based patient information and - leaflets and organisation wide posters.
Sep-16	Smokefree champions identified and trained (Trust wide); Online training module for staff to deliver Brief Interventions (supporting smoking cessation) goes live; Solent E-Cigarette Guidance developed.
Oct-16	Solent formally goes Smokefree: - outpatients and RSH inpatients go Smokefree - further media campaign including press releases - ratification of the Solent Smokefree Protocol at the Medicines Committee - Adult Mental Health wards reviewed, plan to progress to Smokefree status in 2017
Jan-17	Trust signs up to the NHS Statement of support for tobacco control Adult Mental Health (AMH) Smokefree project commences led by the service and monitored through the QIR process
Sep-17	Solent goes Smokefree for AMH inpatient services at St James' Hospital
Oct-17	Solent Estates and Communication teams agree new signage for the St James' Site in order to comply with the Smokefree policy: - signage ordered and installed Occupational Health commence review of the "Creating a Smokefree Workplace" policy AMH investigating use of eburn/ecigarette options to support inpatients in line with other mental health units

Following the move of Adult Mental Health to Smokefree, demonstrating completion of the last project in the trusts' Smokefree programme, it is opportune to confirm the on-going monitoring and assurance of the trust's Smokefree Protocol: It is proposed that monitoring of our commitments be managed through the existing care group performance management structures which all Service Lines and corporate services participate in, providing oversight and assurance of trust on-going progress and compliance.

The board is asked to consider the following risk, in relation to Solent's Smokefree protocol and workplace policy:

- Solent NHS Trusts trust delivers services from a significant number of multi-user sites, some of which we own; in others we are a tenant or licenced occupier. Whilst we actively advocate for our staff, patients and the public who access our services, to refrain from smoking, and continue to offer support for them to do so, the trust acknowledges the

difficulties enforcing our Smokefree protocol across other organisations and tenants sharing these site. This may mean that smoking shelters are accessible on some sites where we are a tenant.

Board Recommendation

Solent NHS Trust has made significant progress to achieve the current level of compliance with Smokefree and has developed policy and protocol to support this; on-going monitoring is required to maintain the focus.

The board is asked to agree a review of the trusts Smokefree protocol, with a recommendation that this is undertaken by the Medicines Management Committee.

The board is asked to agree the recommendation of moving the monitoring and assurance of compliance with Smokefree to the existing Performance Management Structures within the organisation.

The board is also asked to tolerate the risk identified around estate compliance with Smokefree for those premises where we are operating out of multi-use sites or are a tenant/licensed occupier.

Item 13

Presentation to	X In Public Board Meeting	☐ Confidential Board Meeting	
Title of Paper	Professional Leadership Report		
Author(s)	Ann Rice & Dr Clare Mander Head of Patient experience & AHP Professional Lead (job share) Angela Anderson, Head of Professional Standards and Regulation	**Executive Sponsor**	Lesley Munro, Chief Nurse & Lead AHPs
Date of Paper	November 2017	**Committees presented**	
Link to CQC Key Lines of Enquiry (KLoE)	X Safe X Effective X Caring X Responsive X Well Led		
Action requested of the Board	X **To receive** ☐ **For decision**		

The purpose of this paper is to provide an update on the current position with regards to professional leadership activity across the nursing and allied professions including the implementation and monitoring of Solent NHS Trust's Allied Health Profession (AHP) and Nursing strategies.

Board Recommendation

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

Executive Summary

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

The areas of focus in this report are summarised as follows:

Changes to professional Leadership Structure: new job share arrangements to provide Head of Patient Experience and Professional Lead for AHP's commenced on 1st November 2017

Workforce development initiatives: A summary of a range of initiatives that the Trust is engaging in with HEE/Wessex and the NHSI. In addition a summary of the work streams developed internally to improve retention and reduce turnover in key staff groups

Delivery of Nursing & AHP Strategies: On going initiatives to deliver the professional strategies including work within the AHP forum and the support worker forums

Revalidation: Systems continue to be refined to ensure support for staff to complete revalidation and re-registration in a timely way to avoid lapse of registration

External Visits: A summary highlighting the visits the Trust has had from external organisations as part of the professional leadership agenda

Celebration of Success: A review of those staff that have been recognised for their work within their professional area of practice.

Current Position

Changes to Trust AHP Leadership structure:
From the 1st November, Ann Rice and Dr Clare Mander have started a job share as the Head of Patient Experience and AHP Professional Lead. The job title has changed from 'Head of AHPs' to 'AHP Professional Lead' to align with the service line Professional Lead posts and to provide greater clarity of the role. The change in leadership will also provide an opportunity to refresh the AHP forum and map profession specific leadership and representation across service lines.

Workforce Developments/Issues
In line with the national picture the Trust continues to face challenges with the recruitment of both nursing and Allied Health Professionals across a number of areas. There is a programme of work within the Trust being led by the People and OD team to support individuals and teams make Solent a great place to work. In addition the Trust is engaging in the NHSI programme to reduce turnover, the NHSI focus being on nursing but the Trust taking a whole professions approach. This work has helped the Trust to interrogate the data in detail which has helped to develop a better understanding of the challenges and where improvement can be focussed.

In August a survey was sent out to staff across the Trust in order to gather information about why people joined Solent, what made them stay and what would make them leave. In September a very successful workplace improvement event was held and approximately 40 staff from across a range of services and roles in the Trust attended. The information from the survey was presented and using this and information from activities during the morning led to the development of a number of staff led project groups to develop specific areas of work. The topics being covered are:

- Recruitment - Attraction & brand: Employer Value Proposition & Distinctive Brand
- Flexible working arrangements
- Training for our managers in People development
- Reward and recognition
- Career Progression: defined progression routes
- Induction – the root into Solent

Progress on these areas of work will be monitored through the people and OD group.

AHP Workforce Issues:
Health Education England (HEE) is rolling out a national project to support AHPs to Return to Practice. The AHP Professional Lead will be working with the Learning and Development team to explore opportunities within Solent, aligned where possible to areas where there are specific AHP recruitment issues.

In October HEE hosted its first South AHP Workforce Event. Information was provided on the national AHP workforce position and innovation around new models of care. There was the opportunity to network with senior AHP leads from across the South and discuss influencing the local STPs/ACS. Results from a pre-meeting workforce survey were shared, providing soft intelligence on the current AHP pressures. There are recruitment and retention issues across all AHP professions. Specific difficulty with Band 5 Occupational Therapy and Physiotherapy (small numbers applying), retaining Band 5's more than 2 years, recruiting senior therapists (especially within acute)

and recruiting within children's and young people pathway. Early indicators of this year's undergraduate numbers were also shared, although the formal position will not be known until later this year. Both Podiatry and Occupational Therapy numbers are lower.

HEE is funding the development of paramedic rotations within community settings. Early expressions of interest are being sought and a briefing document will be circulated by the end of November. HEE are looking for pilot sites that can provide a system-wide approach to community care, an evaluation of the rotation and interest in the development of future business proposals. The AHP Professional Lead will liaise with Portsmouth and Southampton service lines to explore further.

Nursing Workforce:
Since the last report the Trust has contributed to the NMC consultation in relation to proposed changes to the education and standards of proficiency for nursing students in the future. The changes will come into effect from 2020. There will be significant changes to the way in which students will be trained and how they will be supervised and signed off in terms of competence to practice. The Trust is currently considering the implications of these changes in order to put systems in place to ensure we can meet the requirements.

In previous reports the new nursing associate roles were described and there are now a number of test sites training nursing associates. While Solent is not a test site we are currently hosting 6 Trainee Nursing Associates (TNA) for their community placements. The placements commenced on 2nd October and last either 5 or 6 weeks depending on whether the TNA works full time or 30 hours a week. The TNA continue to attend study days at Southampton Solent University once a week during placements. The TNA's are working in the following areas of the Trust:

Trainee	Placement area
1	Snowdon
2	Nicholstown Solent GP practice
3	Snowden at home
4	Portswood Solent GP practice
5	Portsmouth Rapid Response Team
6	Learning disability team/ Kestrel

The NMC are currently consulting on the proposals for the regulation of Nursing Associates and Solent will be developing its response through the Professional Advisory Group. In addition there will be a consultation in early 2018 regarding the standards of proficiency for this group of staff. These consultations will be helpful in considering how we as a Trust incorporate these new roles in our future workforce planning.

Progress on Implementation of the AHP Strategy and Nursing Strategy:

AHP Strategy:
Through Solent's AHP Forum, information is being collated evidencing progress on the AHP Strategy; examples are provided as appendices to this report.

Nursing Strategy:
Through the Quality Improvement and Risk group service lines have been asked to consider the progress being made locally to deliver the nursing strategy. The Head of professional Standards has been using opportunities when on clinical visits to discuss the strategy with front line staff. It is planned to develop a clinical matrons group who will support the delivery of the strategy.

The Head of Professional Standards & Regulation has delivered a number of sessions to staff across the Trust in relation to understanding the NMC Code of Conduct and their accountability in relation to this. The sessions have been well received and future sessions are being planned. The second round of Support Worker forums are planned to take place at the end of November 2017.

The monitoring of the delivery of both the AHP and Nursing strategies will be formally done through the Professional Advisory group. Plans are underway to develop informal professional discussion groups in the style of 'An Audience with….' and it is hoped the first of these will take place in January 2018. In addition it is planned to hold a joint event in June 2018 to celebrate the progress made to date and to develop thinking for the review of the strategies both of which take the organisation up to 2019.

AHP SharePoint and communication:
To facilitate the joint leadership a new AHP email account AHPs@solent.nhs.uk is being set up. This forms one part of a communication strategy that is being developed to support shared learning across our AHP professions and specialities.
A SharePoint page will be developed to share key documents, examples of Solent AHPs in Action, opportunities for CPD, forum meeting minutes, details of our AHP Fellowships/Awards, links to social media etc. Promotional messages that highlight examples of how our AHPs prevent ill health and mental distress across care pathways and professions will also be collated.

Revalidation
The Nursing and Midwifery Council (NMC) introduced revalidation for nurses and midwives from April 2016. To support compliance with the requirement of revalidation for the nursing workforce the Trust continues to monitor and provide support to staff to ensure they revalidate within timescales. In Q2 of 2017/18 189 nurses re-registered and all staff that were required to revalidate, did so successfully, however 3 staff failed to re-register resulting in lapsed registration for a short period of time. In the case of one of the individuals there was no impact as NMC registration was not a requirement of their role. However in the case of the remaining two individuals the impact was that they were unable to perform as a registered nurse meaning throe clinical work was covered by others until such time as they were reinstated on the register.

The Trust has reviewed the process for monitoring and supporting staff to ensure they do not lapse and additional communications will be provided to staff on a more regular basis and managers are being encouraged to use the roster system to identify staff whose registration is due as well as discussing it at staff management supervision sessions.

The NMC will be providing a workshop for senior clinical staff on 23rd November to provide an update on accountability, revalidation and professional accountability. It is hoped that with NMC support it will be possible to deliver similar sessions on a regular basis.

External Visits:
Colleagues from NHSI attended the Improving the workplace summit held in September and members of the wider NHSI team attended a follow up meeting in October to discuss the work being taken forward as a result of this event. A number of colleagues from across the Trust are working together on key actions in response to the feedback reecived at the summit.

The Deputy Chief Nurse, South, NHSE met with the Chief Nurse on 10th November and as part of the visit had the opportunity to go to our inpatient wards at the Royal South Hants Hospital, our central community nursing team , inpatient therapies and sexual health services. Feedback from NHSE was positiove noting the professionalism and honesty from the staff seen.

Celebrations:
Congratulations to Dr Lynn Dangerfield (Speech and Language Therapist who leads the Community East Adult SLT Team) who was awarded her Professional Doctorate from the University of Portsmouth. Her research was an in-depth exploration of an aphasia care pathway.

Esther Clift (Consultant Practitioner Trainee in Frailty) has had an abstract accepted for the CAHPR Health Research Awards 2017 for her study entitled 'Who users exercise in later life? A critical ethnographic study'

Toni King (Thematic Lead for Recovery and Peer Support) was co-author on a case study publication entitled 'Co-production – Sharing our experiences, reflecting on our learning', see https://imroc.org/resources/13-co-production-sharing-experiences-reflecting-learning/

One of our Podiatrists, Charlie Dando, has received an HEE Wessex Clinical Academic Transition Award to support the final stages of her PhD and application for the HEE/NIHR ICA Clinical Lectureship in 2018.

Sally Griffiths, Community Children's Asthma Nurse received a commendation at the National Paediatric Respiratory Nursing Conference for her poster presentation and for an abstract she submitted.

Recommendation
There is significant work taking place within the Trust to develop the nursing and AHP professional workforce and ensure that it is fit for purpose and ready to meet the challenges of the changing healthcare environment. This report has provided a summary of the key activities being undertaken since the last report.

The Board is therefore asked to note the progress being made

Appendix: A Vlog from Esther Clift, Consultant Practitioner Trainee in Frailty
https://vimeo.com/217177561

Wessex AHPs into Action

Template for local examples

NHS Trust	**Solent NHS Trust**
Title	A randomised controlled trial of the effectiveness of parent-based models of speech and language therapy intervention for 2 to 3 year old children with primary language delay in areas of social disadvantage.
Lead AHP	**Name: Dr Deborah Gibbard** **E: Deborah.gibbard@solent.nhs.uk** **T:** 07713 089 623
New initiative □x **OR** **Stealing with pride*** □ (*Please reference case study number from AHPs into Action…)	
Which impact does it relate to? (Please tick)	**X Impact 1:** Improve the health and well-being of individuals and populations **Impact 2:** Support and provide solutions to general practice and urgent and emergency services to address demand. **x Impact 3:** Support integration, addressing historical service boundaries to reduce duplication and fragmentation **x Impact 4:** Deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.
Summary (250 words)	(Comment on the problem, aims/objectives, method/approach, results/evaluation, learning & plans for spread) Early treatment for language problems is important to help prevent low educational achievement and poorer outcomes later in life. Early intervention and parental involvement in treatment has proven beneficial for pre-school children experiencing language development difficulties. In areas where there is social disadvantage, however, engagement with treatment can be a challenge. We have developed a new, joint-working, service in Portsmouth, UK, Enhanced Parent Based Intervention (EPBI), which has helped families to engage. A pilot project showed Enhanced intervention is viable in a community setting. This project will compare the Enhanced service with the existing one in areas of social disadvantage and will look at the effects on parental skills, attitude, confidence and engagement with treatment, in addition to outcomes for children. Parents' views and feedback have shaped this proposal from the outset. For the standard care and intervention groups, we will measure child language abilities, parent language, the home communication environment and parent's knowledge, skills and confidence in managing the intervention. These will be measured at the beginning of the intervention, at the end of the intervention period (short-term change) and 6 months post-intervention (longer-term change). If EPBI groups prove beneficial then their implementation will be valuable for this population given the long lasting effects of children's language delay on education, personality, employment and wider society. More importantly, this population will benefit from a reduction in health and social inequalities that impact on the individual, family and wider communities, ensuring children have the best possible start in life.

Wessex AHPs into Action

Template for local examples

NHS Trust	Solent NHS Trust
Title	Supporting the communication and information needs for all: a Trust-wide approach to clinical leadership
Lead AHP	**Name:** Dr Clare Mander **E:** clare.mander@solent.nhs.uk
New initiative √	
Which impact does it relate to? (Please tick)	√ **Impact 3:** Support integration, addressing historical service boundaries to reduce duplication and fragmentation √ **Impact 4:** Deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.
Summary (250 words)	The health determinants of patients with communication and information needs remain largely understood by healthcare providers. The Accessible Information Standards addresses the needs of these individuals and aims to reduce health inequalities through the provision of information in accessible formats and communication support. To embed accessible information practice and improve quality of communication and information support, a new Trust-wide leadership role was created. This thematic leadership eliminated traditional service boundaries and allowed for a cross-service networked approach. Co-designed methodology was utilised to design and develop an evidence based tiered-model of accessible information training aimed at raising awareness and promoting behavioural change in healthcare staff. This training was piloted with 10 community and mental health services. Pre and post questionnaires highlighted a significant improvement in staffs confidence and knowledge about supporting accessible information for all. The only element that required further development was onward referral to specialist support. Following the training, a champion network was developed to support the translation of learning into service and ongoing peer-to-peer learning. Numerous examples of quality improvement initiatives were developed within the first 6 months including patient and public involvement in the review of patient reports and recommendations for future resources within a community therapy team, new Easy Read goal setting resources within acute rehabilitation setting, an Easy Read resource pack developed and rolled across a specialist dentistry service etc. Over the next year the focus will be on further development of the network, expansion of the use of technology and an economic impact evaluation of specific accessible information support.
Preferred method for sharing? (Please tick)	√ Short video clip √ Annotated PowerPoint √ Poster □ Written report with images

Item 14

PATIENT FEEDBACK MAKING A DIFFERENCE

QUARTERLY PATIENT EXPERIENCE REPORT

QUARTER 2

(July – Sept 2017)

SOLENT NHS TRUST VALUES

CONTENTS

1. EXECUTIVE SUMMARY - HOW PATIENT FEEDBACK MAKES A DIFFERENCE

This is the quarter two (Q2) patient experience report for Solent NHS Trust for the period 01 July 2017 to 30 September2017. Patient experience is one of the 3 domains of quality together with patient safety and clinical effectiveness.

This paper provides an overview from a combination of sources of patient and carer feedback giving insight on what matters to our patients. Insight from patient feedback enables learning for improvement, enabling us to make changes, where indicated, and do things differently to achieve better patient experience and outcomes. This paper provides examples and evidence of the learning that has taken place in Q2.

In this paper the term patient is used to encompass the alternative terms of client or service user and also, for the context of the document, carers and families. The key highlights from the report are as follows:

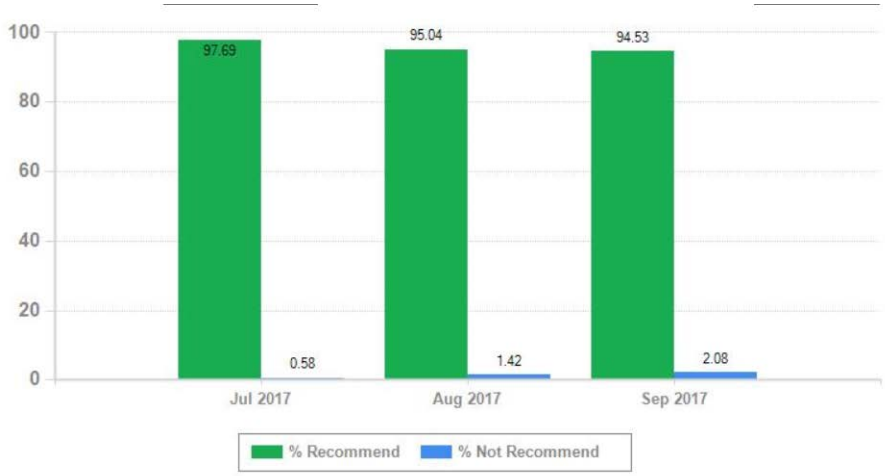
- The FFT results show a continued positive level of satisfaction for the organisation overall with the Trust internal targets being met apart from a very minor variance in September.
- Solent has introduced a web link provided by email as a new method for offering FFT with promising results seen in one service line.
- Comparing the national results for August 2017 to Solent's Q2 results the Trust's community and mental health services compare favourably with the national results on both measures
- Q2 has seen an increase in responses for the Trust overall and an increase in responses across each service line.
- Quarter 2 Staff FFT (2017/18) was open to all staff in September and it ran as an online survey. Solent received 1239 responses in comparison to 1204 responses in Q1.
- SFFT is showing a relatively stable position and there has been the highest result over the past one year for those who ***would*** recommend Solent as a **place to work**,
- Between July and the end of September 2017, the Patient Advice and Liaison Service (PALS) and Complaints Team received a total of 42 new complaints. In addition 81 service concerns were recorded in Q2.
- In Q2, there were 59 categories recorded against the 42 complaints. There were 30 concerns raised in relation to Clinical Care.
- In Q2 the PHSO advised that they wished to review four complaints and the associated paperwork was sent to them. The PHSO has subsequently advised that they would be investigating three of these complaints further and the final reports are pending.
- During Q2, 240 plaudits were received and registered by the Solent PALS and Complaints Service, compared to 226 plaudits being registered the previous quarter.
- During Q2 linked actions have been generated from the patient experience technology platform direct to the clinical enabling near real time feedback to the service and the opportunity to address the issues raised promptly and record outcomes.
- The complaints review panel met in September 2017 the purpose of which is to drive quality improvement in relation to managing complaints and to provide a mechanism for cross organisational learning from complaints.

- In response to staff feedback from the National Staff survey and quarterly SFFT a number of initiatives have been put in place.

2. QUARTER 2 PATIENT FEEDBACK DATA

2.1 Friends and Family Test (FFT) - The FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely likely to extremely unlikely, they are to recommend the service to their friends and family if they needed similar care or treatment. The FFT is intended as a service improvement tool, measuring performance continually and enabling increased responsiveness to near real time feedback. It is also a mechanism to encourage and motivate staff and reinforce good practice.

Bar Chart 1: Trust Overall Percentage of Patients who would and would not recommend Solent services (July – September 2017 responses)



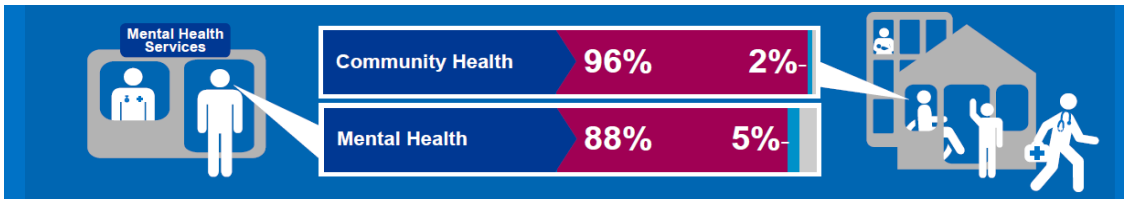
The FFT results show a continued positive level of satisfaction throughout the quarter for the organisation overall with the Trust internal targets of 95% and above to recommend Solent services and below 5% not recommending being met apart from a very minor variance in September.

In Q2 Solent received a total of 4724 responses compared to 3487 responses in Q1 (2017/8) which is an encouraging increase in response rates overall. Offering a variety of methods for gaining feedback is cited as an important factor to improve response rates. Solent has introduced a web link provided by email as a new method for offering FFT with promising results in one service line. In addition, in Q2 additional training to services has been provided after a relaunch of the web based technology platform suggesting this has also contributed to an increase in responses.

In Q2 4529 people responded they would be extremely likely or likely to recommend Solent services, 61 responded they would not recommend Solent services and 134 responded either they did not know or would be neither likely nor unlikely to recommend.

Solent results in comparison to national FFT results: At the time of writing this report national FFT results for August 2017 are the most recent national results available to compare with Solent's Q2 results. National results are presented for community services and mental health services separately.

Info graphic data for National FFT Results for Community and Mental Health Services for August 2017 N.B National Mental Health data results include Child and Mental Health Services (CAMHS).



Comparing the national results for August 2017 to Solent's Q2 results (Bar chart 1) shows that Solent's community and mental health services overall compare favourably with the national results on both measures (although it should be need that aggregating data in this way masks variances at a granular team level).

2.2 Service Line Level FFT Results for Q2

The FFT feedback is reviewed at service level to provide more detailed understanding of patient experience and the results are accessible to services direct from the technology platform used enabling as near real time feedback as possible, action planning and learning.

Table1: FFT Results by Service Line for Quarter 2 (aggregated July - September results)

Results

Area	SMS/Text/ Smartphone App	Electronic tablet/kiosk at point of discharge	Paper/Postcard given at point of contact	Paper survey, sent to the patients home	Telephone survey once patient is home	Online survey once patient is home	Other
Overall	1	11	4401	0	0	311	0

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Adults Portsmouth Services	96.83%	0.63%	315	250	55	6	2	0	2
Adults Southampton Services	96.53%	0.89%	1009	784	190	26	4	5	0
Childrens Services	97.63%	0.64%	1098	895	177	10	4	3	9
Dental Services	97.07%	0.21%	478	348	116	6	0	1	7
Mental Health Services	90.69%	2.45%	204	137	48	9	4	1	5
Primary Care Services	95.59%	1.47%	885	711	135	23	7	6	3
Sexual Health Services	92.93%	3.27%	735	526	157	22	10	14	6
Summary	**95.87%**	**1.29%**	**4724**	**3651**	**878**	**102**	**31**	**30**	**32**

Comparing Q2 and Q1 results, there has been an increase in responses for the Trust overall and an increase in responses across each service line.

2.3. THEMES FROM FREE TEXT COMMENTS AND IMPROVEMENT PLANS

Although the quantitative FFT and survey results are encouraging, and the overwhelming flavour of the feedback the trust receives is positive, it is the free text comments from patients that provide the richest source of information. All free text comments are examined as, even when quantitative results are positive and complimentary, the comments may include suggestions of small changes that can be implemented to improve the experience of our patients.

Word cloud of most frequently used words to describe Solent services in September (aggregated for trust overall)

2.4. Examples of Complimentary comments received in Q2 by each service line:

How can you improve on the care and professional excellence of such competent and reliable people.

Adults Southampton

Comments & Compliments

This display contains positive comments received from service users during Q2 July - September 2017.

The whole process was handled really well & the information given was clear.

Children and Families

Couldn't have wished for a better team of people amazing!

Specialist Dental Services

Thank you all for the support and help you've all given me and the knowing I have a safe place to return if my positive turns to negative again is helped me feel safe again.

Adult Mental Health

Very friendly felt listened to and helped. Extremely helpful and very understanding explaining everything along the way.

Sexual Health

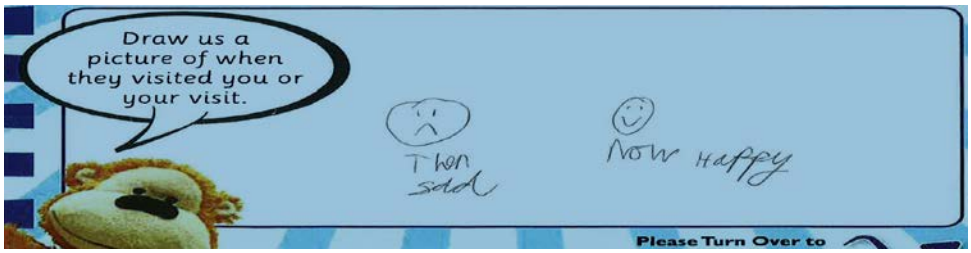
Friendly professional service clean well maintained building giving me confidence in my care.

Primary Care

The nurses are all caring angels doing a wonderful job. They are very much needed to get us back on our feet again.

Adults Portsmouth

E… …g in Children'



3. QUARTER 2 STAFF FRIENDS AND FAMILY TEST (SFFT)

Overwhelming evidence shows that there is a clear relationship between staff satisfaction and patient satisfaction - the highest quality of care for patients is delivered through a high quality and engaged workforce where staff feel empowered to really make a difference.

The Staff Friends and Family Test for staff (SFFT) is a feedback tool which allows staff to give feedback on NHS Services based on recent experience. SFFT is conducted quarterly, with the exception of quarter 3 when the national staff survey is open. SFFT is intended as a 'pulse check' between the national staff survey to support local improvement work.

Staff are asked to respond to two questions. The **Care** question asks how likely staff are to recommend Solent services to friends and family who need treatment or care. The **Work** question asks how likely staff would be to recommend Solent to friends and family as a place to work.

The results are published by NHS England at organisational level. These scores relate to the percentage of respondents who would recommend (Extremely Likely or Likely) and the percentage of respondents who would not recommend (Unlikely or Extremely Unlikely), NHSE 2015.

Quarter 2 SFFT (2017/18) was open to all staff in September and it ran as an online survey. Solent received 1239 responses in comparison to 1204 responses in Q1.

Table 2: SFFT Trust Level Results - Recommend Responses Questions in Q2 (Higher scores are better)

Question	Base	Picker Average	% score	Target	Target met	Change vs. last quarter	Lowest (to date)	Highest (to date)	
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	1230	0%	82%	N/A		-1%	79%	83%	Edit
How likely are you to recommend this organisation to friends and family as a place to work?	1232	0%	64%	N/A		0%	56%	64%	Edit

Table 3: SFFT Trust Level Results - Not Recommend Responses in Q2 (Lower scores are better)

Question	Base	Picker Average	% score	Target	Target met	Change vs. last quarter	Lowest (to date)	Highest (to date)	
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	1230	0%	4%	N/A		0%	4%	6%	Edit
How likely are you to recommend this organisation to friends and family as a place to work?	1232	0%	17%	N/A		2%	15%	23%	Edit

Allowing for a small degree of variability between quarterly results, SFFT is showing a relatively stable position on the **care** question. Q2 results show a small percentage decrease in those who ***would*** recommend Solent services for **care** but no change in the percentage of those who ***would not*** recommend Solent for **care**. There has been the highest result over the past one year for those who ***would*** recommend Solent as a **place to work**, although the percentage of those who ***would not*** recommend Solent services as a **place to work** has also increased slightly (by 2% of respondents). This reflects more staff moving from a middle ground response (*neither likely nor unlikely* or *don't know*) to a definitive response. Allowing for a small degree of variability (below 5%) the SFFT results have remained stable between Q1 and Q2 on the work question.

As in Q1, a 36% response rate was achieved which is considered extremely good particularly for a recurring survey.

A deeper analysis of the results at service line level reveals a variance across the service lines. The results from clinical services for Q2 on the recommend care question range from 89% to 70% (compared to 89% to 65% in Q1) and 75% to 49% on the recommend as a place to work question (compared to 78% to 50% in Q1).

There are over 492 free text comments against the care / treatment question and 514 comments against the work question. Although there is a range of sentiments expressed the positive comments outweigh the negative. However, there are some comments of concern that require further attention and discussion and these will be reviewed with the Director of People.

Examples of positive and negative comments:

Great culture, innovative and flexible, lots of opportunities if you want to take them

Although staff are stressed and working over their paid hours, teams look after each other, there is a robust Health and Wellbeing team and patient care is of prime importance

waiting list and short term interventions with no relapse plan within their own service.

Lack of support from management. Bank staff given payment incentives to do hours yet nothing for substantive staff working extra hours and going above and beyond

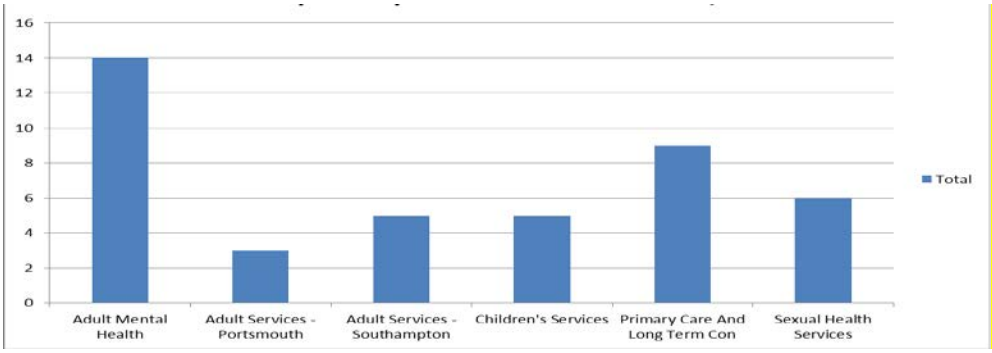
4. CONCERN

Everyone counts. We take all negative feedback very seriously. Our Chief Executive is notified of all complaints when they arrive in the Trust. Complaints handling and any trends or themes identified

from them are shared and discussed regularly by the Executive Team and the Board. Concerns and complaints are also reviewed within each of the service lines at their monthly governance meetings.

Between July and the end of September 2017, the Patient Advice and Liaison Service (PALS) and Complaints Team received a total of 42 new complaints (this figure includes 4 instances of professional feedback and 4 MP queries). In addition 81 service concerns were recorded in Q2. This compares to 51 new complaints, and 76 service concerns in Quarter 1 (April – June 2017).

Bar chart 2: Number of complaints received in Q2 by Service



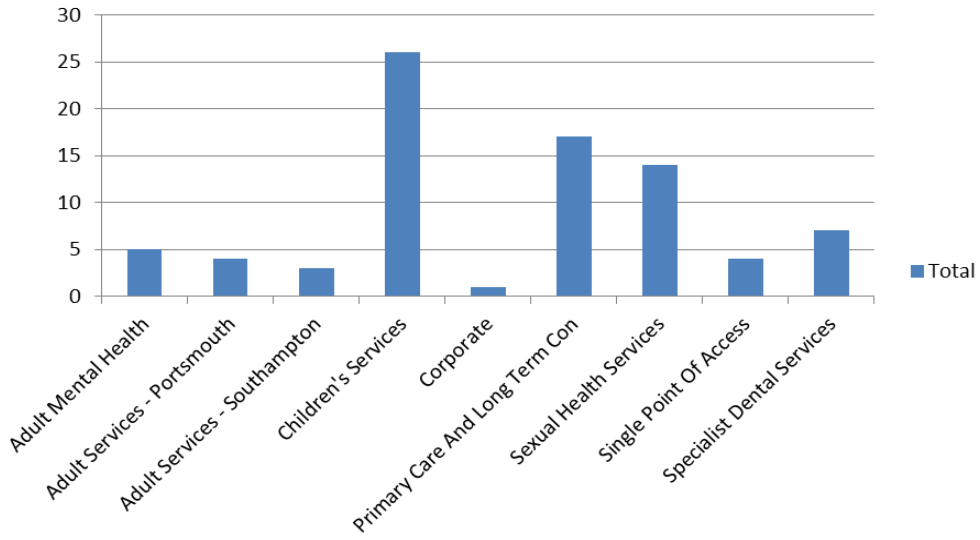
Complaints received within the Adult Mental Health service line remain consistent with the levels for the same period last year but there has been a reduction in the level of complaints within Adults Portsmouth and Children's service lines.

During Q2, 26 of the 42 complaints received have since been closed. Following completion of investigation into the concerns raised, 8 were found to be 'Not Upheld', 5 were 'Partially Upheld' and 8 were found to be 'Upheld'. 5 complaints were closed as 'N/A' for a range of different reasons. For example, one case was merged with another open complaint which was for the same patient; however, the concerns were raised by another family member and are currently being investigated as a Serious Incident. Two of the five raised in Q2 were withdrawn as the patient did not wish to pursue their formal complaint.

4.1 Service Concerns

Services are required to advise the PALs and Complaints team of all concerns they receive and the outcomes so that they are recorded and can be monitored centrally. Although some service concerns are later escalated to formal complaints, either because the person who has complained is not satisfied with the response provided at the local level or because the issue is complex and cannot be resolved in the service concern timeframe (72 hours for resolution). One service level concern was escalated to a formal complaint in Q2 which related to the Adult Mental Health Service.

Bar Chart 3: Q2 Concerns by Service Line



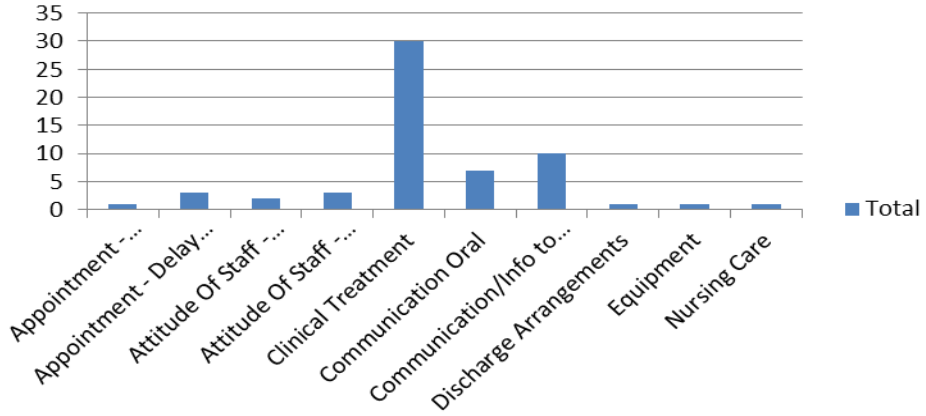
Although there has been a general decrease in the number of the complaints received there has been an increase in the number of service concerns. In Quarter 2 (2017/18), 81 concerns were received, in the corresponding period 2016/17 there were 55. During Q2 there has been an on-going emphasis placed on making early contact with people who raise concerns or complaints to achieve early resolution for the person concerned. It is encouraging that the local resolution process is becoming embedded; however, the number of expressions of dissatisfaction (complaints and concerns) within the organisation has remained at a relatively constant level, 123 in Q2 2017/18 compared to 126 2016/17.

4.2 Complaints by Theme for Q2

The PALS and Complaints Service break complaints down into categories, to enable recurring themes and trends to be identified and areas where improvements are indicated. Some complaints include more than one theme, for example a complaint may concern a patient's discharge from the service, and the way in which this was communicated.

In Q2, there were 59 categories recorded against the 42 complaints. There were 30 concerns raised in relation to Clinical Care.

Bar Chart 4: Q2 Complaint Categories



A monthly complaints report and weekly complaints tracker is produced by the Complaints Team, to enable the services and Trust overall to monitor the categories of complaints and concerns, so that issues can be addressed at both Trust wide level, and service level in a timely way.

4.3 Outstanding Complaints

The PALs and Complaints Team work with the services to reduce the number of outstanding complaints and those that have breached their response target dates. At the conclusion of Q2, 30 complaints remained open. This figure includes reopened complaints where a local resolution meeting or second response was required, and those referred to the Parliamentary and Health Service Ombudsman (PHSO).

4.4 PHSO

In Q2 the PHSO advised that they wished to review four complaints and the associated paperwork was sent to them. The PHSO has subsequently advised that they would be investigating three of these complaints further and the final reports are pending. Two complaints from Q1 were closed, one of these was partially upheld, and the PHSO felt that although the outcome for the patient would have remained the same an earlier referral could have been made which would have resulted in an earlier diagnosis. The other complaint was closed without further investigation.

5. PLAUDITS

Plaudits may be received from patients, their family, or members of public, expressing their thanks and appreciation for the care provided.

During Q2, 240 plaudits were received and registered by the Solent PALS and Complaints Service, compared to 226 plaudits being registered the previous quarter.

Examples of plaudits received in quarter 2:

Children's Services: A box of chocolates was received by a member of staff from a patient's mother as a thank you gift. Patient's mother thanked the service for everything they have done for them, and for suggesting the resourced provision placement.

Adults Portsmouth: Service received an email from a service user; *'I really wanted to say thank you for taking the time out of what I'm sure is your busy day to call. It is heartening to know that there remains a sense of compassion within our NHS'.*

Adults Southampton: The service received a thank you email from a patient's family member to thank staff for being so caring towards them. Email explained that the patient has recently passed away, and they would like to thank the team with heartfelt gratitude for the attention they gave to the patient. Family cannot fault the care they received; staff were always receptive to calls, concerns, and conversations regarding the patient's care and condition. Service always attended to the patient in a timely manner, escalated any concerns when required, and always fed back to the family. Family said that all staff were lovely, caring and professional.

Specialist Dental Services: The service received an email from a parent praising them for the care provided to her daughter *'The service we have received has been exemplary; she has been treated with dignity and superb care. A huge thanks to everyone involved in Madeleines care, you should all be proud of the professional and friendly service you offer. I can highly recommend this service'*.

Sexual Health Service: Verbal compliment received by consultant from a service user who was very grateful for the care they received and the clear and concise advise given to them by the member of staff involved who was very understanding and made the patient feel at ease.

Adult Mental Health: Thank you card received from a patient thanking staff for *'Always being there for the patient, always smiling, always understanding and going above and beyond their call of duty to be an amazing support worker'.*

Primary Care: A service user sent a cheque for £50 and a letter of thanks to the team to express their appreciation of the work put into each session. Patient said they certainly increased their balance and stamina over the weeks, something they would not have been able to do by themselves.

6. LEARNING - HOW FEEDBACK HAS MADE A DIFFERENCE IN Q2

Learning from FFT

During Q2 linked actions have been generated from the patient experience technology platform direct to the clinical team concerned when an unlikely or extremely unlikely response is received via the FFT. This enables near real time feedback to the service and the opportunity to address the issues raised promptly and record outcomes. During Q2, 53 linked actions were generated and examples of the learning include:

6.1 Examples of 'YOU SAID - WE DID' learning/ actions from FFT for Q2

You said, we did

This display shows improvements that have been in response to patient feedback received during Q2 July - September 2017.

You said: can never get appointments, change the way they accept calls.

We did: The surgery is working hard to release more capacity and have reviewed the impact on the growing surgery list. This is an ongoing project and will keep the patients informed via the PPG Group.

You said: I have found it very difficult to make an appointment by phoning up - Being repeatedly told to phone on the day for a 'chance' of being fitted in, which with my work isn't a particularly feasible option. However now appointments can be made online this worked really well for me and is a big improvement!

We did: On the *lets talk about it* website it is encouraged that patients book online first, if this process fails they are able to contact SPA and try and book an appointment with them. Patients, if an appointment is unavailable for that day but are deemed as urgent by SPA, will be put on a telephone triage where a clinician from that clinic will contact the patient and discuss the issue and determine if the patient is appropriate to be seen as an emergency.

You said: The process is timely and very frustrating I feel that it's a shame that it feels like a postcode lottery for different services and care that can be provided. The staff despite these pressures have been fantastic & we cannot fault their commitment.

We did: The service is currently undergoing a transformation plan which aims to reduce the wait times for assessment and therapy. We are actively implementing wait list initiatives to reduce wait times and looking at staffing levels to help reduce wait times.

You Said: Appointments made in one month advance. Even telephone triage. No doctors in the weekends. Never see the same doctor twice, most of the time even nurses not available.

We did: Our patient participation group have identified that we need to give better information to our patients. Patients can receive a triage appointment and are able to request to see the same doctor again and can book in with nurses direct. We are hoping to get the television screen in the waiting room working so we can put these messages up as there is limited space in the waiting area for posters. We do currently have a one month wait for a routine GP appointment and are reviewing ways of addressing this including direct booking for Advanced Nurse Practitioner appointments.

You said: Too difficult to try and get an appointment. Too difficult to try and get in as the times are all in the day time obviously for people who don't work! I lose money if I don't work/work in …..

We did: Day time and evening appointments are available across different clinics. Some offer as early as 08:00 am appointments and the latest being 19:00pm in some clinic. These can be found on our website. Some clinics are open on a Saturday but travel to these maybe required.

The Trust recognises the opportunity complaints bring to l
organisation to effect improvement for the benefit of our service users and staff. We strive to demonstrate the changes that have been made as a result of learning from complaints and to

sustain the changes for long term improvement. The table below provides examples of themes that have arisen in complaints and the action and learning that has taken place as a consequence:

Table 4: Examples of Complaint themes and actions /learning in Q2

Complaint category	Actions taken
Appointments cancelled	**Sexual Health Service** - an apology has been offered for the cancellation of an appointment. The importance of notifying patients' as early as possible when an appointment has been cancelled has been re-emphasised to the team.
General procedures	**Adult Mental Health –** Following a complaint related to a patient's lost personal possession a new procedure has been introduced to ensure a record of patient's possessions when transferred between wards**.**
Making an appointment with the service	**The Sexual Health Service** experienced an increase in demand for appointments when a neighbouring trust closed their clinic. The service therefore implemented changes to the appointments system and recruited additional staff to allow for this increase in demand to be met.
Clinical- catheter care	**Adults Southampton-** The team have reflected on the issues raised in this complaint and recognise that clinical decisions should not be made in isolation and that staff should take into account the views of patients and their families when prescribing equipment. As a result of this the team have now implemented a process where patients with a new catheter are visited 2 weeks after initial contact to ensure all equipment is in place and to review how the patient and their family/carers are managing with the team seeking to take action to address any issues including any concerns specifically raised by the family and/or carers.
Communication	Within **Adults Southampton** improved communication pathways are being developed with GP Surgeries in order to keep them informed of changes to the service. A new referral pathway, where all referrals can be sent via email, is to be introduced to improve access to Services. **Adults Portsmouth** Community Nursing Team have worked with patients to understand how they want to be communicated with following a theme in complaints related to rearranged visits resulting in patients not feeling their needs are being prioritised. Welfare checks and phone calls to ensure timely communication with patients are now taking place if it is necessary to reschedule an appointment. This has resulted in a reduction in concerns being raised due to more effective communication processes. The service has also implemented the standard that all people who have made contact with the PALS and Complaints team receive an immediate phone call from the relevant clinician within the service, usually within one hour offering an apology and seeking to resolve the issue as early as possible.
Attitude of staff	**Sexual Health Service-** Apologies offered as part of the complaint response for the lack of information and support received from a member of staff. The learning from this complaint was that the patient could have been referred to another clinic to be seen sooner.

Clinical –Managing Patient expectations	**Childrens Services** - Information to be provided to patients about potential clinic wait times at the time of referral, so that patients do not worry unduly.
Clinical-Lack of follow up appointment	**Adults Southampton**- Patient should have had a follow up appointment arranged and this will be raised with the member of staff.
Clinical - Follow up appointments	**Primary Care -** A new procedure has also been put in place with regards to routine double appointments being booked as soon as a form arrives. Staff training has also been undertaken by reception staff with regards to their interactions with patients.

6.3 Complaints Review Panel Learning

The complaints review panel met in September 2017. This panel is chaired by one of our Non-Executive Directors together with our Chief Nurse. Membership includes a Healthwatch colleague and senior clinical representatives from each of our service lines. The purpose of the panel is to drive quality improvement in relation to managing complaints and to provide a mechanism for cross organisational learning from complaints.

Three complaints were reviewed at the panel. Learning was shared across all service lines from each complaint:

1. **Clinical complaint**- the service concerned had not followed the correct process for responding to complaints and had attempted to resolve the issues raised within the concerns process, resulting in missed deadlines for responding and a poor experience for the person making the complaint. The Professional Standards, Governance and Quality Lead for the service will review the clinical pathway with the service and also ensure the team concerned follow correct processes for managing complaints in future. Review of the complaint response letter identified that the response was inadequate and the consensus of the review panel was that the tone of the letter lacked compassion and empathy. It was agreed that a telephone conversation by the service manager would have been best practice after the first complaint letter was received.

2. **Complaint made by a Carer concerning discharge from a ward** - Since this complaint, all carers who contact the complaints team are offered signposting to carer support. In addition a new process has been introduced to ensure any safeguarding issues identified by the Complaints team are discussed directly with the Safeguarding team.

3. **Complaint received from an MP on behalf of the constituent**- A review of MP queries and the process for responding to these will be undertaken.

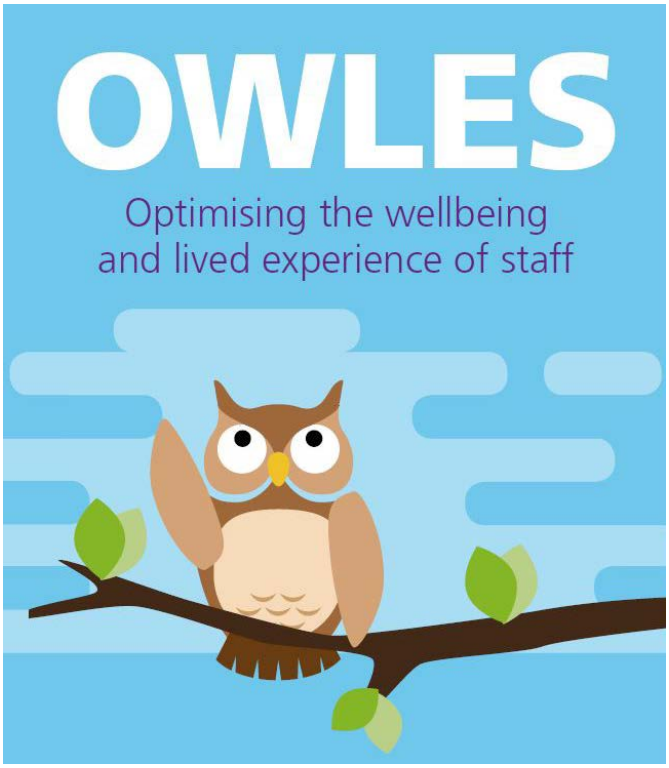
Local Resolution Meetings (LRMs) are being encouraged at an early stage in the complaints process and although offered across all services, Adults Portsmouth are ensuring that all people raising concerns are offered a LRM and have received comments from families about how personal the experience is for them and how they have felt listened to. However, following feedback from one person who attended a LRM which they found unsatisfactory, the service has identified learning that each LRM needs to be more effectively tailored for each individual. To ensure we fully understand the factors that enable an effective LRM from the perspectives of the person who has complained, a Quality Improvement Project has commenced with members of the project group from the clinical

team in Adults Portsmouth, the Complaints team, and a Healthwatch Portsmouth representative. Staff and people who have complained and attended a LRM will also be invited to take part in the project.

6.4 Learning and Outcomes from Staff Feedback

In response to staff feedback from the National Staff survey and quarterly SFFT a number of initiatives have been put in place including:

Professional forums: Supporting staff to share and learn from best practice
Power Hours: Providing staff with more learning opportunities



We really believe in creating a space where people can safely share their experiences, learn from one another and provide support to each other.
As part of our employee health and wellbeing programme, we have worked with people who have experience of mental health problems to develop
the OWLES (Optimising the Wellbeing and Lived Experience of Staff) group. The role of the group is to help create a culture where we all feel comfortable
and inspired to talk about mental health, and to encourage everyone to support one another. The group has worked together to design and develop a whole week of activities for us to think about mental wellbeing as a Trust.

Yoga and Pilates: Classes provided to help staff have some 'me time'
Freedom to Speak Up: Creating a place where to ensure staff are listened to

7. SUMMARY

The patient experience report aims to bring together a range of sources of feedback to give us insight to better understand what matters to our patients. It provides a snapshot of what our patients have told us in Q2 and our actions and learning as a consequence. However, inevitably a report cannot capture, nor do justice to, all the ways in which staff strive, on a daily basis, **to provide great care**.

Ann Rice

Head of Patient Experience and Profession Lead for Allied Health Professionals

31/10/2017

Item 15.1

Board Report – In Public Meeting

Title of Paper	**Information Governance Briefing Paper & Information Governance Strategy**		
Author(s)	Sadie Bell, Data Protection Officer and Head of Information Governance & Security	**Executive Sponsor**	Report issued by Data Protection Officer David Noyes - SIRO
Link to strategic Objective(s)	X Improving outcomes ☐ Working in partnership ☐ Ensuring sustainability		
Date of Paper	8th November 2017	**Committees presented**	N/A
Action requested of the Board	X To receive ☐ For decision		
References			

Please Note: It is a requirement of the General Data Protection Regulations 2016 that the Board have oversight of and take accountability for Information Governance (IG). This was outlined in the IG Accountability & Reporting Paper that went to Board in July 2017. It was agreed at Board that that IG would report three times a year (March, July and November).

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

Information Governance Briefing Paper

The purpose of this paper is to update the Board on the Trust's current Information Governance compliance with the Data Protection Act 1998, Freedom of Information Act 2000 and IG Toolkit Requirements 2017/18.

It will also outline the Trust's current status with regards to its General Data Protection Regulations 2016 (GDPR) readiness plan, to ensure compliance for when the law changes in May 2018.

The report identifies the current compliance in detail;

- Compliance with Data Subject Access Requests (requests for records – a requirement under the Data Protection Act 1998 and GDPR 2016) has increased rapidly since centralising the process within the Information Governance Team.
- Compliance with the Freedom of Information Act 2000 has increased to between 92% - 100% since identifying a dedicated resource to monitor and support such requests.
- The number of IG incidents remains the same as the previous year, however the number of High Risk and Serious Incidents has decreased, and therefore the impact of such incidents have decreased.
- The Trust has currently achieved Level 2 or above compliance with 78% of the forty-five IG Toolkit requirements and is on track to achieve Level 3 compliance in forty-two of the requirements by the end of the financial year, making the Trust GDPR compliant. The remaining three requirements will achieve Level 2 compliance and reasons for not meeting Level 3 compliance are identified in the report. Not achieving Level 3 compliance in these areas does not directly impact upon the Trust's ability to achieve GDPR compliance, but would strengthen compliance. Further work is to take place in the next financial year to strengthen compliance. Please see page 6 of the report for further details. Compliance is to be audited in January 2018.
- The Trust is on schedule with its GDPR Readiness plan, which is to be audited in December 2017
- Data breach preventative work has been identified and partially implemented.

Information Governance Strategy

It is an Information Governance Toolkit Requirement that the Board is sighted on, feels assured and approves the Trust's Information Governance Strategy, which is reviewed annually and outlines how the Trust intends to achieve IG Toolkit compliance. The IG Strategy has been approved by the Trust's ICT Group.

Item 15.2

Solent NHS Trust

Information Governance Accountability and Reporting Review

1. Introduction: This report has been complied to update the Board on the Trust's current Information Governance compliance with the Data Protection Act 1998, Freedom of Information Act 2000 and IG Toolkit Requirements 2017/18.

It will also outline the Trust's current status with regards to its General Data Protection Regulations 2016 (GDPR) readiness plan, to ensure compliance for when the law changes in May 2018.

2. Summary of current compliance

2.1. Subject Access Requests

In accordance with the Data Protection Act 1998 the Trust has 40 days in which to respond to requests for copies of records.

	Q3, 2016/17	Q4, 2016/17	Q1, 2017/18 **TBC	Q2, 2017/18 **TBC
Number of requests received	171	188	198	240
Number of requests responded to within 21 days (best practice)	106 (62%)	131 (70%)	104 (53%)	116 (48%)
Number of requests responded to within 40 days	42 (25%)	25 (13%)	43 (22%)	36 (15%)
Number of breaches (in excess of 40 days)	23 (13%)	32 (17%)	45 (23%)	43 (18%)
Not Due	0 (0%)	0 (0%)	6 (3%)	45 (19%)

* Data as of 08/11/2017

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

Reviewing the last quarter in detail;

Q2, 2017/18

- To date Q2's compliance level is 78% (with forty-five requests not due; therefore figures are subject to change)
- 59% (minus those note due) of all requests released, have been responded to within 21days (best practice)
- The IG Team centralised all Subject Access Requests from the 1st August 2017. Since this time, compliance has increased;

Month	Total No. Requests	Total No. Not Due	Total No. Responded to within 21 days*	Total No. Responded to within 40 days*	Total No. Breach*
Aug	92	20	35 (51%)	12 (19%)	25 (30%)
Sept	86	18	51 (75%)	12 (18%)	5 (7%)
Oct	77	40	36 (97%)	1 (3%)	0 (0%)

* % compliance = requests minus those not due.

Summary:

Compliance levels continue to improve, despite the increase in the number of requests. Compliance levels since centralising the process have rapidly increased and lessened the burden on clinical services lines. It has also allowed for greater support for Health Care Professional in signing off requests prior to release.

2.2. Freedom of Information Act 2000
Compliance Overview:

Quarter	Q1			Q2			Q3
Month	April	May	June	July	Aug	Sep	Oct**
No. Requests	20	21	29	24	33	24	24
No. Breaches	3	6	7	2	2	2	0
No. Not Due	0	0	0	0	0	0	9
% Compliance	85%	71%	76%	92%	94%	92%	100%

* Data as of 08/11/2017

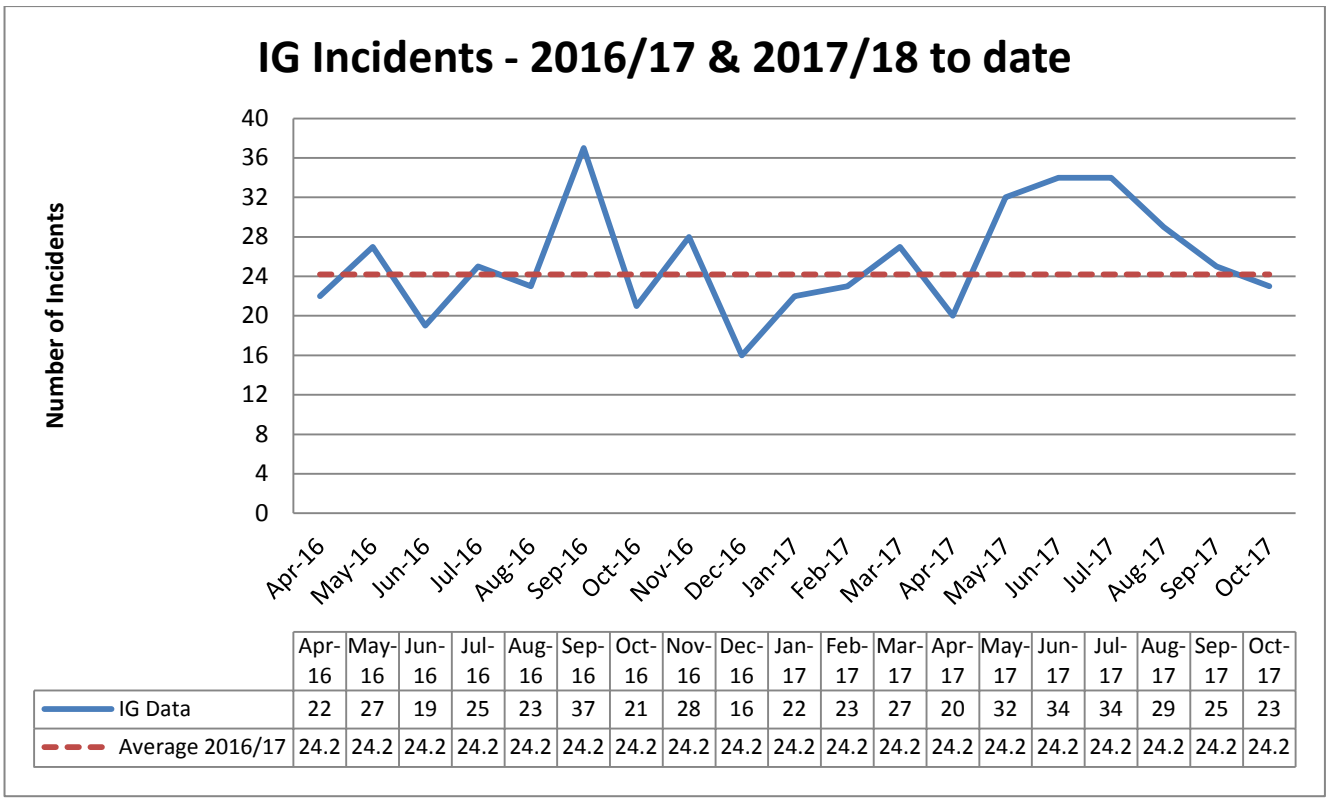
** Final figures are subject to change, as some requests are currently not due to date.

Summary:

The ICO have stated that compliance on FOI's should not full below 90%.
Overall compliance for Q1 was 77% and Q2 was 92.5%.

There is now a dedicated resource within the IG Team to oversee Freedom of Information requests and allow for the enforcing of weekly reminders and escalating as appropriate to increase compliance. This has led to the increase in compliance, with 100% compliance in October (to date).

2.3. Incidents



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
IG Data	22	27	19	25	23	37	21	28	16	22	23	27	20	32	34	34	29	25	23
Average 2016/17	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2	24.2

Information Governance incidents saw a spike in reporting in May – July 2017, but this has since declined and continues to decline. It is thought that the spike in report was linked to the increase in IG training in these months and the identification in the training that staff should be reporting Records Errors and PID in wrong records as IG incidents, which spiked in Q1 and Q2 of this financial year.

Trends*:

IG Incidents – Main Issues					
	2016/17		2017/18		
	Q3	Q4	Q1	Q2	Total
PID sent to wrong address / person	21	16	26	24	**87**
PID in wrong record	9	5	16	19	**49**
Records Error	6	6	8	12	**32**
PID Saved / Stored Insecurely	8	9	9	6	**32**
Other	8	11	7	5	**31**
Lost Notes/PID	4	6	3	8	**21**
Breach by staff - Unintentional	2	6	4	1	**13**
Printing Issues (left on printer / wrong printer)	4	1	4	4	**13**
Post Issues (way in sent/received)	1	6	3	2	**12**
NHSMail not used for PID	0	5	1	4	**10**
PID found in public place	2	0	1	3	**6**
Breach by staff - Deliberate	0	1	3	0	**4**
Cyber Security	0	0	1	0	**1**
Stolen Notes/PID	0	0	0	0	**0**
Total	**65**	**72**	**86**	**88**	**311**

*** Minus low level incidents**

The highest reporting category remains PID sent to wrong address / person, however the impact of these incidents are becoming more minimal due to the changes in processes being made.

The next highest reporting categories are PID in wrong record and record errors, which are reported above have featured heavily in the IG Training and staff are more aware of reporting such incidents now, then previously. This is also the same for PID Saved / Stored insecurely.

Incident categories such as Breaches by staff, Post issues and Stolen notes have declined in the last two quarters.

Serious Incidents (SI) and High Risk Incidents (HRI):

All IG incidents within Solent NHS Trust meeting the High Risk (+1) or Serious Incident (2+) categories in accordance with the HSCIC (NHS Digital) guidance for scoring IG incidents are to be measured against a checklist to determine if a formal or informal investigation will be carried out. It has been agreed that;

- Formal investigations of High Risk or Serious IG incidents will be presented individually to SI panel.
- Informal investigations of High Risk IG incidents will be collated and presented by the IG team within one report to SI panel on a monthly basis where incidents have occurred.

Informal HRI Investigations

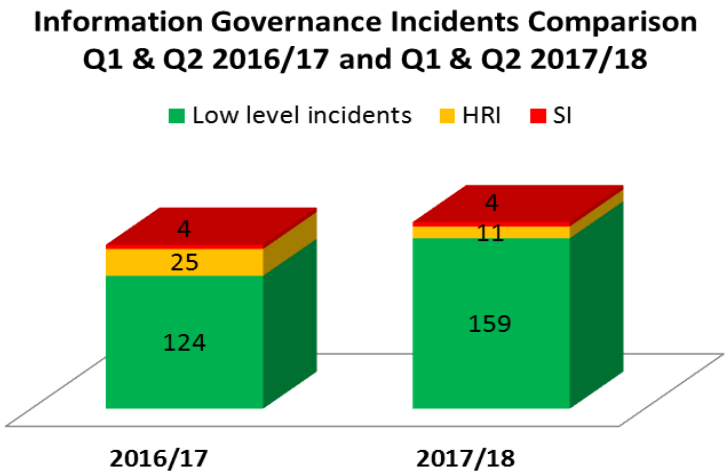
It may be agreed and determined at the incident review meeting that no additional learning will be identified as a result of a formal investigation, due to a number of factors, e.g. the incident was the result of an unintentional human error, the incident was a result of failure to follow process, this is an isolated event specific to a service and all actions were taken immediately, etc…. Under these circumstances no formal investigation report will be required to be undertaken by services. The IG team will monitor these incidents within a consolidated report to SI panel to highlight incidents ensuring awareness of data breaches and allow preventative work to be undertaken within the Trust.

Comparison: The IG Team have compared Q1 & Q2 2016/17 to Q1 & Q2 2017/18 incidents to highlight good IG practices and IG awareness of staff. Overall there has been a slight increase in the number of incidents reported (twenty-one), but the number of High Risk and Serious Incidents has decreased from twenty-nine to fifteen.

- The number of ***SI's*** has not changed, when compared to the last financial year, however it is important to note that one of the SI's for this financial year relates to a national major cyber-attack that affected the whole of the NHS, which was outside of our control and did not impact upon the loss of or access to any data. Therefore looking at the number of IG incidents, within the Trust's controller, the number of SI's has slightly decreased. It is also important to note that no SI's have been reported in Q2 of 2017/18.

- There have been 11 ***HRI's*** reported so far this financial year, which is a 56% decrease when compared to the same time last year. It is also important to note that there have only been two High Risk Incidents reported in Q2, with one incident not requiring a formal investigation as the incident was due to failure to follow process, rather than no process being in place.

The above demonstrates that although the Trust continues to report IG incidents, the impact these incidents are having, due to the mitigations we have put in place, is decreasing.



*The above incidents exclude IG categories associated with low risk (lost smart card, system error and out of our control)

Summary: In summary the number of incidents reported on average has increased slightly when compared to the last financial year, but the most commonly reported incident categories have changed, with the exception of PID sent to the wrong person / address; however the impact has reduced. The number of HRI's and SI's are also decreasing, which supports that the impact of IG incidents is reducing.

Shared Learning:

- The Information Governance Team continue to quarterly assess any incident trends in IG incidents and identified shared learning for the Trust to disseminate amongst Service Lines to their staff.
- The Information Governance Team continue to assess the best way to prevent reoccurrence of incidents.
- IG incident scenario's continue to be cascaded fortnightly in Staff News.
- IG newsletters continue to be cascaded to all staff on monthly basis.

The IG Team will undertake spot check audits within service lines to raise awareness of IG working practices. Services will be audited if;

- Highlighted as a concern by staff member or member of the public
- Reported a level 2 or above (SIRI) IG incident
- Reported a high number of incidents
- Selected at random

2.4. IG Toolkit Requirements

On the 31st October 2017 the Trust submitted its first baseline assessment for the 2017/18 IG Toolkit. The Trust's current compliance status is shown below (please refer to Appendix A for a full breakdown);

The Trust is mandated to achieve Level 2 or above compliance in all 45 requirements, by the end of March 2018. As of the 31st October 2017 the Trust has achieved Level 1 compliance in all 45 requirements. It is on track to achieve the minimum Level 2 compliance by the 31st March 2018; there are currently only 10 areas of work that need to be completed in order to achieve Level 2 compliance, as detailed below;

- 112 – Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained; **Current training compliance is 85% and the mandated target is 95%. The Trust is ahead of schedule and compliance is expected to be reached in December 2017**
- 202 – Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected; **Audits and reviews are currently taking place**
- 209 – All personally identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines. **Annual Reviews are currently taking place**
- 307 – An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy; **Information Asset Owner Training is to be undertaken and the annual Information Asset Review is being undertaken**
- 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; **Audits and reviews are currently taking place**
- 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; **Previous returns and documentation are currently being reviewed**
- 310 – Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error; **SIRO Annual Report will take place in January / February 2018**
- 323 – All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures; **The annual Information Asset Review is being undertaken**
- 404 – A multi-professional audit of clinical records across all specialties has been undertaken; **Annual Audit is currently taking place**
- 506 – A documented procedure and a regular audit cycle for accuracy checks on service user data is in place; **Audit is scheduled**

Level 3 Compliance:

Although the Trust is currently only mandated to achieve Level 2 compliance this financial year, the Level 3 requirements are directly linked to the Trust's need to be compliant with GDPR Requirements by May 2018, at which time Level 3 requirements, will be considered compliance with law. The implications of not being Level 3 compliant this financial year will mean that the Trust will have less than six weeks to become GDPR compliant, failing to do so will result in large financial fines. The Trust has therefore made the business decision to ensure that the IG Team are appropriately resourced to achieve level 3 compliance this financial year and therefore achieve GDPR readiness in time for the change in law.

Although the Trust is currently only mandated to achieve Level 2 compliance this financial year, the subsequent achievement of Level 3 directly links to the Trust's need to be compliant with GDPR

Requirements by May 2018, and failure to achieve GDPR would risk a fine. The Trust has therefore made the business decision to ensure that the IG Team are appropriately resourced to achieve Level 3 compliance this financial year and therefore achieve GDPR readiness in time for the change in law.

While the Trust is on track to achieve Level 3 compliance, it should be noted that there are three areas where further work will be required, but our current status and plans mean that we are still able to achieve GDPR legal compliance. The further work will serve to strengthen compliance. Further work is to take place in the next financial year to strengthen compliance.

- Req 205 - There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data; Service users are provided with online access to their electronic care records without charge.
  - Although online access will not be available this financial year, the requirement under GDPR is to make records available on a portable format and in electronic medium if requested. This will be achievable. On online portal is part of the Trust's ICT Strategy and will strengthen the Trust's compliance in meeting the requirement of Data Portability.

- Req 313 - Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely; Penetration Testing on Network Security provided by CGI
  - There is currently no funding for external penetration testing, however the Trust's ICT provider does undertake internal security checks on our systems. Funding is to be identified for external Penetration testing in the 2018/19 IT Business Plan, to strengthen the Trust's assurance on security.

- Req 516 - Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards; There is active promotion of the clinical coding training programme and support for clinical coders to gain Accredited Clinical Coder (ACC) status by passing the National Clinical Coding Qualification (UK).
  - Level 3 compliance in this requirement does not impact upon the Trust's ability to achieve Level 3 compliance.

The Trust also a minimum need to achieve Level 3 compliance with the 12 requirements linked to the Caldicott 2 Report.

101	203	300
200	205	302
201	206	307
202	207	400

Compliance is being monitored through the Trust's ICT Group and the latest highlight report can be found in Appendix B.

The Trust's IG Toolkit compliance is to be audited by the Trust's Auditors in January 2018.

3. General Data Protection Regulations 2016 (GDPR) Readiness

The Trust is currently on track with its GDPR Readiness Plan; a full detailed version of the Trust's Readiness Plan, can be found in Appendix C. The Trust's Readiness Plan is to be audited by the Trust's Auditors in December 2017.

It is important to note that the ICO have stated that **Directors and CEO's could be held personally liable** and fined for Data Breaches, where they have knowingly failed to provide adequate security and resources to prevent such breaches and comply with requirements of the GDPR, including that of the Data Protection Officer and ensuring they are fully resourced in order to carry out their duties.

Report written by: Sadie Bell, Data Protection Officer and Head of Information Governance & Security

Report Date: 8th November 2017

Appendix A – October 2017 IG Toolkit Baseline Submission

Information Governance Management		
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	2
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	2
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	2
14-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	2
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	1
Confidentiality and Data Protection Assurance		
14-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	2
14-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	2
14-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	1
14-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	2
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	2
14-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	2
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	1
14-210	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	2
Information Security Assurance		
14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	2
14-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	2
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	3
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	2
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	2

14-305	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	2
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	1
14-308	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	1
14-309	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	1
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	1
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	2
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	2
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	2
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	1
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	2
Clinical Information Assurance		
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	2
14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2
14-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	2
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	1
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	2
Secondary Use Assurance		
14-501	National data definitions, standards, values and data quality checks are incorporated within key systems and local documentation is updated as standards develop	2
14-502	External data quality reports are used for monitoring and improving data quality	2
14-504	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	2
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	1
14-507	The secondary uses data quality assurance checks have been completed	3
14-508	Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity	2
14-514	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	2
14-516	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	2

Corporate Information Assurance		
14-601	Documented and implemented procedures are in place for the effective management of corporate records	2
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	3
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2

Appendix B – IG Toolkit Highlight Report October 2017

Project Name	**IG Toolkit Submission 2017/18**		
Start Date	01/07/2017	End Date	31/03/2018
Project Value	N/A	Project RAG rating	

Brief Project Summary
The Information Governance Toolkit is a performance Tool produced by NHS Digital. It draws together the legal rules and central guidance set out and presents them in one place as a set of information governance requirements. 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 (2016). 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.

Actions completed between 22nd September 2017 and 16th October 2017
Level 2 compliance with all requirements is at approximately 75% completed; All requirements (except ten) have achieved Level 2 compliance. Although level 2 compliant, due to existing evidence, more in-depth reviews are required with regards to requirements linked to the wider General Data Protection Regulations review. These include; • Information Sharing Review • IG Audits • Review of Contractors compliance, including those outside the EU • IG Policies and Records Management Strategy Reviews (existing ones are in place)

Actions due to be completed 17th October 2017 and 13th November 2017
• Outstanding Level 1 & Level 2 requirements to be completed by end of December 2017;. Update to be sort prior to next report • Submission of the IG Toolkit October 2017 Baseline Assessment • Review of Level 3 requirements, to ensure appropriate resources have been allocated to ensure compliance

Project Risks	Safe Guard Ref (if relevant)	Current RAG	Mitigation
Overall compliance is 75% for level 1; this meets the initial target of all requirements being between 75%-100% as of 21st September 2017. The wider requirement is to be 100% compliant by the end of			Completed

September; there is still an outstanding number of evidence that is required in order to achieve level 1			
Secondary Use Assurance – Level 1 Although assurance of compliance has been received verbally, to date no evidence has been provided			Completed
Completion of Corporate Record Inventory Trust-wide. This initially was to be completed, by utilising the outcome of the Sharepoint Document Management project.			A new process for completion now needs to be identified

Key milestone:		
Milestone	Deadline	Current Status
All requirements are to be level 1 compliant – not including agreed exceptions	September 2017	Completed
All requirements are to be level 2 compliant – not including agreed exceptions	October 2017	75% compliant
Baseline Assessment is to be submitted	October 2017	On track
All requirements are to be level 3 compliant – excluding the three requirements where this level is not expected to be achieved	February 2018	On track
IG Toolkit Related Audits	February 2018	On track
Final Assessment is to be submitted	March 2018	On track

Document	Location
Project Initiation Document	IG Toolkit Project Initiation Document
Action Plan	1. Action Plan.xlsm
Project Plan	2. Project Plan.xlsx

Appendix C – GDPR Readiness Plan

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
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	**Completed**
Assess Subject Access Request processes, and the suspected increase in demand, to ensure the Trust can comply and has adequate resources	**Individuals Rights** **Subject Access Requests**	Subject Access Request processes already in place, but need to be amended to reflect	Jul 17 – Aug 17	Data Protection Officer	**Completed –** appropriate resources have been allocated, allowing for processes for GDPR to be implemented from August 2017, allowing for the culture of the new process to be embedded within the Trust,

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
Ensure that all our patients and staff are aware they can access their records for free from May 18		changes, such as demand, time to process requests reduced, cost removed, etc…			ahead of the new law in May 2018
Implement new Subject Access Request Processes and Resources required to ensure compliance	**Individuals Rights** **Subject Access Requests**		Aug 17 – Sept 17	Data Protection Officer	**Completed –** appropriate resources have been allocated, allowing for processes for GDPR to be implemented from August 2017, allowing for the culture of the new process to be embedded within the Trust, ahead of the new law in May 2018
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	September 17	Data Protection Officer	**Completed –** IG Risk Policy revisions and new processes for reviewing, monitoring and handling IG Serious Incidents have been implemented
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 ensure it meets the new requirement of "vital interest". Revised agreements to be put in place and signed off by all parties	**Legal Basis for Processing Personal Data**	Information Sharing Agreement and Privacy Notices already in place	Aug 17 – Dec 17	Data Protection Officer	**Partially completed –** a new Information Sharing Agreement and Privacy Impact Assessment Template has been implemented, identifying clear legal basis, compatible with both the Data Protection Act and GDPR. All new Information Sharing processes are being mapped against this new template and existing agreements are being reviewed.

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
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**		Sept 17 – Dec 17	Data Protection Officer	**Commenced –** A Data Sharing Agreement Template has been produced, which identifies clear data processing standards, agreements and security checks and incorporates IG compliance checks for all contractors and identifies IG Policies that contractors must abide by. A list of contracts has been provided to the Trust's Data Protection Officer, who will now implement Data Sharing Agreements within all contracts.
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 needs to consider terminating the contracts	Sept 17 – Nov 17	Data Protection Officer	**Commenced –** This has been incorporated into the Data Sharing Agreement Template which will be associated with all contracts retrospectively and going forward.
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 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	**Completed –** New PIA Template has been produced and a clear procedure has been implemented to support this.

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
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.					**Partially completed –** the Data Protection Officer has become a member of most service line governance and/or innovation meeting and appropriate corporate meetings. Further work is continuing with regards to this. The aim of this is to ensure the implementation of Privacy by Design, meaning that the Trust's compliance with GDPR can be embedded seamlessly and with minimal impact to services. This is done by allowing the Data Protection Officer to become aware of, input into, advise on and complete certain actives, where service changes, innovation, integration etc… is taking place.
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	Sept 17 – Mar 18	Data Protection Officer	**Commenced –** Audit plan has been identified and work to undertake the audits commenced in November 2017.
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	Nov 17 – Mar 18	Data Protection Officer	**Delayed –** This piece of work was being undertaken as part of the Trust's Sharpoint project. This aspect of the project is no longer going forward and the IG Team are currently reassessing how to undertake this work. It is believed however that alternative arrangements can be made to undertake this piece of work.

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
		preparation for SharePoint, but retention dates have not been assigned to archived data			
Assess processes in place regards perceived "inaccuracies of data" and how these can be "corrected"	**Individuals Rights**		Jan 18 – Mar 18	Data Protection Officer	**Work is to commence**
Implement processes to comply with the "Right to be forgotten – erased"	**Individuals Rights**		Jan 18 – Mar 18	Data Protection Officer	**Work is to commence**
Review all IG policies in line with the GDPR	**Data Protection by Design**		Jan 18 – Apr 18	Data Protection Officer	**Partially completed –** all IG Policies have been reviewed with GDPR in mind, so this work has been undertaken ahead of schedule. However near the commencement of GDPR certain terminology will need to be changed within the polices and reference to Data Protection Act replaced with GDPR.
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 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	May 18	Data Protection Officer	**Commenced –** Work on updating the Trust's Privacy Notice has commenced. The creation of a "Your Information, Your Rights" internet page has also already commenced and plans to go live are imminent. This page will be a "work in progress" page until May 2018. The aim is to have all Information Sharing Agreements, Data Sharing Agreements (contract summaries), Privacy Impact Assessments and certain IG Compliance Audits / Documents, published publically.

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
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**		Sept 17 – May 18	Data Protection Officer	**Partially completed –** refer to Appendix D
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**		Nov 17 – May 18	Data Protection Officer Head of Information Systems	**Work is to commence**
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 Head of Information Systems	**Work is to commence**
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.	**Data Protection by Design**		Mar 18 – May 18	Data Protection Officer	**Partially completed –** the Data Protection Officer has become a member of most service line governance and/or innovation meeting and appropriate corporate meetings. Further work is continuing with regards to this. The aim of this is to ensure the implementation of Privacy by

Action Required	Linked to ICO's 12 Steps	Supporting Information	Time Frame	Person Accountable	Compliance / Status Update
• Contract Review • Information Sharing Agreements • Privacy Impact Assessments • IG Audits • IG Training					Design, meaning that the Trust's compliance with GDPR can be embedded seamlessly and with minimal impact to services. This is done by allowing the Data Protection Officer to become aware of, input into, advise on and complete certain actives, where service changes, innovation, integration etc… is taking place. IG Audits are now undertaken by the IG Team IG Training for 2018/19 has been DRAFTED and will be cascaded throughout the Trust, to be completed between April 18 – December 18

Appendix D – Information Governance Report of the preventative work for the management and reduction of data incidents within Solent NHS Trust 2017/18 and 2018/19

1. **Introduction:**
   This report has been written to detail the preventative work, both undertaken and planned by the Information Governance Team (IG Team) for the management and reduction of data incidents within Solent NHS Trust in line with the Data Protection Act 1998 (DPA) and the General Data Protection Regulations 2016 (GDPR).

2. **Scope:**
   The scope of this report will detail the work that the IG Team have implemented, undertaken and planned for the changes proposed by the introduction of the GDPR in May 2018. The Information Commissioner's Office (ICO) have issued guidance 'Preparing for the GDPR – 12 steps' which details main areas of focus and actions required in order to ensure compliance by the implementation in May 2018.

3. **What has already *been* implemented:**
   Bespoke training: During the financial year 2017/18, due to the large amount of positive feedback received from the previous year and the closure of the IG training tool, the IG Team created bespoke online modules and questionnaires for both clinical and corporate service lines with the addition of an estates & facilities service line module. There has been a dedicated resource within the IG team who has been able to dedicate time to delivering IG face to face training. Staff were advised that IG training should be completed within the first three quarters regardless of when training was last undertaken. This allows staff to be up to date with the most current law, practices and Trust issues. To date (6th November 2017), the Trust's staff IG compliance is 85%.

   It has been clear in delivering this bespoke training that staff are more aware of;
   - How to contact the IG team should they have any queries
   - What to report as an IG incident (increase in reporting noticeable in service lines who receive training)
   - Staff awareness of IG (queries and assistance sought prior to an incident occurring)

   Resource Review:
   Data Protection Officer (DPO): Within the 'Preparing for the GDPR – 12 steps' guidelines, organisations are required to appoint DPO with professional qualities and expert knowledge of data protection law and practices with the ability to fulfil the tasks referred to in Article 39 of the GDPR.

   This role was appointed in June and was included within the current role of the Head of Information Governance and Security's. The position has since undertaken and completed a Practitioners Course in Data Protection.

   The DPO has initiated attendance within service line meetings and other key meetings within the organisation, allowing for further work to be completed in embedding a change in organisational culture and the implementation of "Privacy by Design". Privacy by Design means that Information Governance and requirements of GDPR become part of everyday practice, as the DPO becomes aware of changes and uses of Personally Identifiable Data and implements/completes the necessary GDPR Requirements, to make the practice lawful, it also shifts the organisations culture of Information Governance from being a blocker to an enabler.

The DPO oversees all of the '12 steps' and reviews the Trust's compliance with current and planned changes within data protection laws.

Information Governance structure: As part of the DPO's role, they were required to review the current data protection resources for the Trust.

Within the new structure of the IG Team (implemented August 2017), there has been a noticeable increase in staff awareness of the Information Governance and greater compliance. The following tasks have since been undertaken and actioned by the IG Team:

- Data protection and information requests are completed centrally relieving the administration burden on clinical services
- The High Risk and Serious Incident reviews of data breaches are conducted by the IG Team who liaise with the Quality & Risk team for reporting. This has allowed for the response time in reporting to the ICO to be improved and meet GDPR Requirements.
- IG involvement has been implemented within service line projects
- All new Privacy Impact Assessments and Information Sharing Agreements have been implemented using the new GDPR standards. This allows for risks and areas of concerns to be addressed ahead of a project, innovation, integration, sharing of data, etc… reducing the risk of a data breach in the future.
- Dedicated resource for the project plan of the annual IG Toolkit, ensure compliance with law
- Services are being provided with further support on 'deep dive' audits to ensure IG Toolkit and GDPR compliance and identifying risks / areas of concern.
- Spot check audits have been undertaken allowing an increase in IG awareness of services practices and services awareness of IG
- Communications between all levels of staff has increased; this shows a shift in the culture and ideas previously thought around IG, allowing privacy by design, an open and honest culture for reporting incidents with adequate and appropriate actions implemented to reduce impact of data breaches or issues.

Staff communications

Newsletters: The IG Team continue to quarterly assess any incident trends in IG incidents and identify shared learning for the Trust to disseminate amongst service lines to their staff.

The IG Team create a and cascade a monthly IG newsletter to Information Asset Custodians, Information Asset Owners and Governance leads via email and all staff via Staff News. The newsletter details hot topics and issues occurring within the Trust, covering good practices, key updates, monthly incidents, shared learning and staff scenarios.

IG Scenarios: The IG Team periodically create scenarios for staff that are disseminated via staff news and the IG newsletter. The scenarios are based on Trust incidents and key issues and assist in ensuring that staff see IG as part of their relatable working life rather than policies and procedures.

Communications Plan: Each year the IG Team create a communications plan that details mandated communications that are required by the IG Toolkit. This is updated as completed, ongoing/planned and not undertaken/risk. This plan covers all aspects of preventative work and communications such as scenarios, spot check audits, staff awareness, training, staff and patient literature.

Incident review processes: All incidents are monitored by the IG Team to ensure that key messages are cascaded to staff where similar incidents are reported throughout the Trust. The IG Team will continue to;

- Quarterly assess incident IG trends and identify shared learning for the Trust to disseminate amongst services lines
- Assess the best way to prevent the reoccurrence of incidents
- Create IG scenarios to be cascaded via staff news
- Create IG newsletters to be cascaded to staff on a monthly basis

Prevention of Data Breaches: All of the above actions have allowed for increased awareness of Information Governance practices, the commencement of implementing GDPR and changes to practices. This in itself allows the organisation to identify risks/issues, prior to a breach occurring and therefore is preventative.

4. Preventative work to be undertaken

The new IG structure and the change in organisational culture is still in its early stages of development and there is further work required to embed practices and "Privacy by Design", allowing for the Trust to achieve its full potential and allow for greater proactive data awareness, preventative work and compliance with legal requirements.

- Strengthen staff awareness
- Completion of IG deep dive audits – identify and addressing potential / actual IG risks
- Review of existing Information Sharing Arrangements against the new template, design to identify risks / issues in sharing arrangements
- Review of all contracts, where personally identifiable data is effected and the implementation of Data Processing Agreements (setting out clear directions on the use of, storing, transferring, etc.. of data) and Information Governance compliancy checks of our Data Processors / Contractors.
- Strengthening existing practices for preventing data breaches

Training plan 2018/19: With the introduction of GDPR in May 2018, the IG Team have created a training plan that allows staff to undertake their IG mandatory training with the additional aspects/ topics that are required for the change in law. There are specific questions within the staff assessment that focus on the changes from the DPA to the GDPR. It has been agreed that face to face training will not be offered during this financial year as staff are required to complete the more in depth training modules to ensure compliance and understanding with any changes that may be required to their role under new legislation and that further time to read the information provided in the training is required.

There will be sessions offered by the Trust's DPO specifically focused on the changes of the GDPR that will be available for senior and middle managers to feedback through to staff groups and team meetings on the main changes that are required to practices and procedures under GDPR legislation.

Training plan 2019/20: Face to face training will be offered to staff within 2019/20 to allow focus on relatable Trust issues and build on knowledge that staff have from the implementation of legislation and sessions received previously.

5. Summary

The above outlined actions; undertaken, commenced and planned will be monitored by the IG Team and reported on and escalated as appropriate by the DPO. Further work and continued in line with the

'12 steps' and ensuring Trust readiness for the implementation of the GDPR and working towards improved preventative work for the management and reduction of data incidents within the Trust.

The DPO will continue to assess the needs of the Trust to ensure that there are adequate resources dedicated to the implementation and management of data protection within the Trust.

Further Reading

DPO Business Case and Job Description

DPO_BusinessCase

DPO_JobDescription

IG and GDPR Resource paper and Summary

IG&GDPRResourceSummary

IG Communications plan

CommunicationAwarenessRaisingActionPl

Item 15.3

Solent NHS Trust

Information Governance Management Framework & Strategy 2017/2018

Purpose of Agreement	This strategy sets out the three year plan and the approach to be taken within The Trust to provide a robust Information Governance Management Framework for the future management of information. Using the Information Governance Toolkit as its foundation the strategy focuses on setting standards and implementing these through the Information Governance Improvement plan for both Clinical and Corporate areas and associated identified business units. IG requirements change over time and priorities for improvement may also change so it is important that IG documentation is reviewed annually and aligned with the latest Department of Health guidelines.
Document Type	Strategy & Framework
Reference Number	IGS_V4
Version	4
Name of Approving Committees/Groups	ICT Committee
Initial Operational Date	September 2017
Document Review Date	September 2020
Document Sponsor (Name & Job Title)	SIRO & Caldicott Guardian
Document Manager (Name & Job Title)	Danielle Reddy, Senior IG Officer
Document developed in consultation with	ICT Committee
Intranet Location	http://solent/corp/igov/Training/Forms/AllItems
Website Location	Insert the location of the document on the FOI Publication Scheme TBC
Keywords (for website/intranet uploading)	Information Governance Strategy, Governance Strategy, Strategy, Information, Toolkit, IG, IG document, Framework

Review Log

Include details of when the document was last reviewed:

Version Number	Review Date	Name of Reviewer	Ratification Process	Notes
Prior to October 2010		S. Brown	The Trust was established on 1st April 2010 through the integration of Southampton Community Healthcare (West) and Portsmouth Community & Mental Health Services (East). The Trust is the Provider arm of NHS Southampton City. As such this is largely a new Information Governance strategy document, encompassing the Information Governance Management Framework requirement 8-101 and the Information Governance Improvement Plan in alignment with V8 of the IG toolkit requirements. Acknowledgment is given to some areas of the NHS Southampton City IG Strategy.	Refer to; • NHS Southampton City's IG Strategy, Data Protection, Caldicott & Confidentiality Policy
	Oct 2011	S. Brown	IGSC	Change of organisation name Dashboard presented to IM&T&IGSC Monthly
	Jan2012	S. Brown	Assurance Committee	
	FEB 2012	S. Brown	TMT	JH to Attend
	July 2013	S.Brown	To include framework in title of document	
	August 2013	S.Brown	ToR Updated	
	October 2013	S.Brown	Reporting Structure Updated	
	October 2013	S.Brown	Policy descriptor & approval dates included	
	October 2013	S.Brown	Incident Reporting amended guidance	Changed June 2013
1.6	November 2014	Sadie Bell	Information Governance Steering sub-Committee and Trust Board	Annual review – minor changes Approved IGSC October 2014
	February 2017	Head of IG	ICT Committee	Review – minor changes
V4	September 2017	Senior IG Officer	ICT Group	Review – multiple changes

Table of Content

1. Introduction & Purpose

1.1 General Background

This strategy sets out the approach to be taken by the organisation to ensure compliance with the Data Protection Act 1998. It is vital that the organisation is fit for purpose and has a robust Information Governance Management Framework, which extends throughout the organisation and aligns succinctly with the approach to service line management

The strategy and associated framework identifies how The Trust will deliver its corresponding Information Governance Policy, by identifying the accountability structure, processes, interrelated policies, procedures, improvement plans and training within the Trust for the future management and protection of organisational information in compliance with legislative and Government process and procedures.

This Information Governance Management Framework & Strategy document is in aligned with the Solent objectives to support their delivery

1.2 Using the Information Governance Toolkit and associated Information Governance guidance as its foundation, this document focuses on setting a framework and strategy to achieve overarching standards.

'Information Governance' describes the approach taken within which standards, are developed implemented and maintained within The Trust and ensures best practice applies in particular to all personal and sensitive information relating to organisations and individuals. Information Governance ensures that these are sourced, held and used legally, securely, efficiently and effectively, in order to deliver the best possible care In compliance with legislation and advice received from the Department of Health. Information is a vital asset to the organisation supporting both daily clinical activities and the effective management of services and resources. Therefore it is essential that all organisational information be managed effectively within a robust information governance management framework.

The organisation requires accurate, timely and relevant information to enable it to deliver the highest quality healthcare and to operate effectively and meet its objectives. It is the responsibility of all staff to ensure that information is accurate and current and is used proactively in the conduct of its business. Accurate information that is dependable plays a key role in both corporate & clinical governance, strategic risk, performance management and service planning.

1.3 Responsibilities

As a business and healthcare provider The Trust carries clear responsibilities for handling and protecting information of many types in many differing formats.

Confidential Information - Some information is confidential because it contains personal details of patients, their families or staff or is of a sensitive nature. The Trust must comply with legislation, which regulates the holding and sharing of confidential personal information. The Data Protection Act 1998 has eight principles which govern all areas relating to the use of personal information and supports organisations in the sharing of information where it is appropriate to do so e.g. "*in the detection or prevention of a crime"*. It is important that relevant timely and accurate information is available to those who are involved in patient care, but it is also important that personal information is not shared more widely than is necessary except where national policy on accountability and openness requires otherwise (e.g. Freedom of Information Act 2000).

Non-Confidential information - Some information is non-confidential and is for the benefit of the general public. Examples include information about the organisations provision of services. The Trust and those employed directly or indirectly by the organisation share responsibility for ensuring that this type of information is accurate, up to date and easily accessible to the public. Solent NHS Trust utilises its publication scheme to ensure this information is readily available to the general public.

Publication Scheme -The majority of information about the Trust and its business should be held on the Publication Scheme which is required to be maintained through the 2005 development & maintenance initiative from the Information Commissioners office. Information should be open for public scrutiny although some, which is commercially sensitive, may need to be safeguarded.

2. Scope & Definitions

2.1 To develop Information quality assurance standards in alignment with the content of this Strategy and IG Management Framework and in conjunction with;

- Clinical Governance (ensuring continuous improvements in the quality of healthcare),
- Corporate Governance (which ensures organisations achieve their business objectives and meet integrity and accountability standards)
- Research Governance (which ensures compliance with ethical standards)

2.2 **Employee's responsibilities -** This document applies to all The Trust staff/employees; this document applies to all directly and indirectly employed staff within The Trust and other persons working within the organisation in line with the Equal Opportunities Document. Disciplinary procedures may be taken against any employee who is proven to have acted in breach of the terms of their contract, acts of gross misconduct will lead to dismissal. This document applies to all third party contractors or the like through their contractual agreement

with this organisation.

3. The Standards & Requirements of Information Governance

3.1 Implementation of robust Information Governance arrangements will deliver improvements in information handling by following the Department of Health standards (known as the 'HORUS' model), these standards require that information will be:

Held securely and confidentially
Obtained fairly and efficiently
Recorded accurately and reliably
Used effectively and ethically
Shared appropriately and lawfully

3.2 Information Governance is a framework to providing consistency and best practice for the many different information handling requests and associated guidance. These principles are equally supported by the Caldicott Principles which have been subsumed into the NHS Code of confidentiality.

3.3 There are five interlinked principles, which serve to guide this information governance strategy:

- Openness
- Legal compliance
- Information Security
- Quality assurance
- Proactive use of information

4. Objective of Implementation

4.1 The strategic implementation of this Information Governance strategy will lead to improvements in information handling underpinned by clear standards which will ultimately benefit the Trust in enabling proactive privacy protection.

4.2 The Trust will be able to ensure that all employees manage personal information for the benefit of the Patient/Client and staff.

4.3 Patients, clients and staff will be aware that their records will not be disclosed inappropriately, which will lead to greater confidence in NHS working practices, ensuring that patients and clients receive the best quality care and encouraging them to be more open when sharing important medical information.

4.4 The information governance framework should be seen as a tool that will aid The Trust in preparation for improvements with the organisational plan for Information Technology, which includes;

- Information Quality Assurance Programme (IQAP) requirements
- NHS Care Records Service (CRS) implementation
- Electronic Booking
- Information Governance contributes to the implementation of the

Care Quality Commission (CQC) Standards in respect to records requirements.
- Service Line Management/reporting
- Robust Governance

4.5 Information Governance contributes to other standards by ensuring that data required supporting decisions, processes and procedures are accurate, available and endures.

5. The Information Governance Management Framework of Accountability and Reporting Mechanisms

5.1 Accounting Officer - Chief Executive

The Chief Executive/Chief Officer as the Accountable Officer has overall responsibility for compliance with Information Governance and the requirements within the Information Governance Toolkit. The accounting officer is responsible for the overall management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Information Governance is key to supporting this within the organisation.

5.2 Senior Information Risk Owner (SIRO)

The SIRO is a member of the Board or Senior Manager who is accountable to the board for the use of information and will ensure that the organisation conducts its business in an open honest and secure manner, updating the board in respect to the annual report, the statement of internal controls and any changes in Law or potential risks. The SIRO is supported by the Head of Information Governance and the Trust's Information Asset Owners (IAO's).

5.3 The Caldicott Guardian

The Caldicott guardian is, in order of priority:
- an existing member of the senior management team
- a senior health or social care professional
- The person with responsibility for promoting clinical governance or equivalent functions.

The Guardian acting as the conscience of the organisation plays a key role in ensuring that The Trust satisfies the highest practical standards for handling patient identifiable information. The Caldicott Guardian serves as part of a broader Caldicott Function and is supported by the Information Governance team.

5.4 Information Asset Owners (IAO's)

Within The Trust an Information Asset Owner (IAO) is a senior member of staff who is the owner for one or more identified information assets of the organisation. There are IAO's working in a variety of senior roles to support the SIRO by risk assessing the assets for which they are accountable IAO's
- provide assurance to the SIRO on the security and use of these assets through contribution to an annual report (a template for

which is provided by the IG Team)
- Understand and address risks to the information assets they 'own'.

5.5 **Information Asset Custodians (IAC's)**

The Trust IAC's serve as local records managers (IAC's) are responsible for assisting in the co-ordination of all aspects of Information Governance requests in the execution of their duties to :

- provide support to their IAO
- ensure that policies and procedures are followed locally;
- recognise potential or actual IG security incidents;
- undertake relevant IG audit tasks
- consult their IAO on incident management;
- ensure that information asset registers are accurate and maintained up to date

5.6 **The Information Governance Team (IGT)**

The Senior Information Governance Officer & IG Toolkit Officer is the Trust's dedicated resource responsible for coordination and monitoring of the IG work plan.

The Data Protection Officer, Head of Information Governance & Security has the overall sign off and will undertake a final assessment of work co-ordinated by the Senior Information Governance Officer & IG Toolkit Officer, assessing the IG Toolkit prior to all baseline assessment submissions, as well as the final submission on 31st March.

The IGT are responsible for supporting the Accounting officer, SIRO and the Caldicott Guardian in the execution of their duties and responsibilities. The IGT also serve to support the IAO's, IAC's and all members of staff in respect to all matters of Information Governance and any associated Information risk and all relevant training. The IGT are tasked with the completion of the Information Governance Toolkit and associated baselines and monitoring any resulting action plans. The IGT will advise in respect to new system deployments, matters of clinical safety affected by IG and changes to existing systems both paper and electronic. The IG team will additionally advise The Trust in respect to the IG elements within contractual and research requirements.

5.7 **Reporting, strategy ownership and approval;**

Trust Board

The Data Protection Officer, will report to Board three times a year, including March; prior to the annual submission of the IG Toolkit. This is in support of both the recommendations made by NHS Digital and the legal requirement under GDPR for the Data Protection Officer to report to Board.

The detailed report outlines the following but is not limited to:

- Compliance with GDPR

- Compliance of Information Requests
- Escalations of Incident Management and Risks

Data Protection Officer & SIRO
In addition to this the Data Protection Officer and Senior Information Risk Owner (SIRO) will meet monthly to discuss key issues and where applicable the SIRO will escalate to Board.

The SIRO will be accountable for highlighting to the DPO a summary report on all Trust / Governance issues, that effect Privacy and Data Protection e.g. integration, innovation, organisational redesign, etc., so that the Data Protection Officer can ensure the following in accordance with GDPR Requirements;

- They are consulted as a matter of routine on the need for data protection impact assessment and other governance matters
- Assurance of compliance is addressed by default in design and implementation
- Review and revision of fair processing information; to provide full disclosure of what personal data is used, for what purpose, who it is shared with and the legal basis for doing so and how long it will be retained.

ICT Group
Detailed Information Security and Data Protection Impact Assessments are reported through the new ICT Committee which occur monthly

Quality, Improvement and Risk Group
Detailed Information Request compliance, Audit outcomes and Incident Management is reported through Quality, Improvement and Risk Group monthly

Resource Implications
The Trust's Data Protection Officer will notify the Trust Management Team (TMT) of any identified or potential resource implications incurred by the implementation of the Information Governance Policy/Strategy and Improvement Plan. TMT will serve to assess any identified or potential resource implications and identify or reallocate resources as applicable. Reporting is only undertaken as and when required.

Audit Committee
The annual audit of information governance shall be reported with any recommendations identified and associated improvement plans.

5.8 **The IG Improvement/Action Plan**
Identifies with this IG strategy framework document by;

- Specifically - defining the improvements to be made
- Measurable - identifies that improvements made will be recorded as part of the annual IG assessment
- Achievable - planning improvements through agreement at IGSsC

as to what can be achieved respecting time constraints and taking in to consideration the resources available
- Relevant – relates specific actions to on-going improvements, new systems and changes to existing systems, working practices and links to other organisational strategies
- Time-bound –identifies realistic time frames for completion
- Risks & Issues – will be identified where they may impact upon delivery of the IG improvement plan

6. Training Requirement 112 (See Appendix 3)
Training needs – Supporting People

6.1 Fundamental to the success of delivering the Information Governance Strategy is developing an Information Governance culture within the Trust. In order to promote this culture, training needs to be provided continuously to all staff that utilise information in their day-to-day work. This training is cascaded to all new staff at the start of their employment during their local induction with their manager and all staff then undertake annual refresher training.

6.2 Information Asset Owners & Information Asset Custodians are encouraged to request additional bespoke training where they feel it would be beneficial to their teams.

6.3 Following a Serious Incident (SI) additional training is given as a mandatory requirement to the team where the incident has occurred, as deemed appropriate and relevant as part of the investigation findings. A communications log records where information and updates have been provided throughout The Trust.

7. Performance Monitoring of Strategy Effectiveness

7.1 Performance will be monitored in two ways:

a) Against the criteria set in the Information Governance Toolkit using the baseline submissions in July & October and associated improvement plan clearly identified by the IGT.
b) The IG Strategy will be reviewed annually and an action plan will be developed against the toolkit to identify key areas of continuous improvement.
c) An annual internal audit should be arranged and will take place prior to the final annual submission.

8. Policy Approval (see Appendix 4)

8.1 The Policy Group acknowledges that information is a valuable asset, therefore it is in its interest to ensure that the information it holds, in whatever form, is appropriately governed, protecting the interests of all of its stakeholders. This is done by ensuring that all IG related poliices are reviewed annually, in accordance with the IG Toolkit and they meet legal requirements and the needs of the organisation.

8.2 The IG Framework & Strategy and its supporting standards are fully endorsed by the Board through the production of these documents and

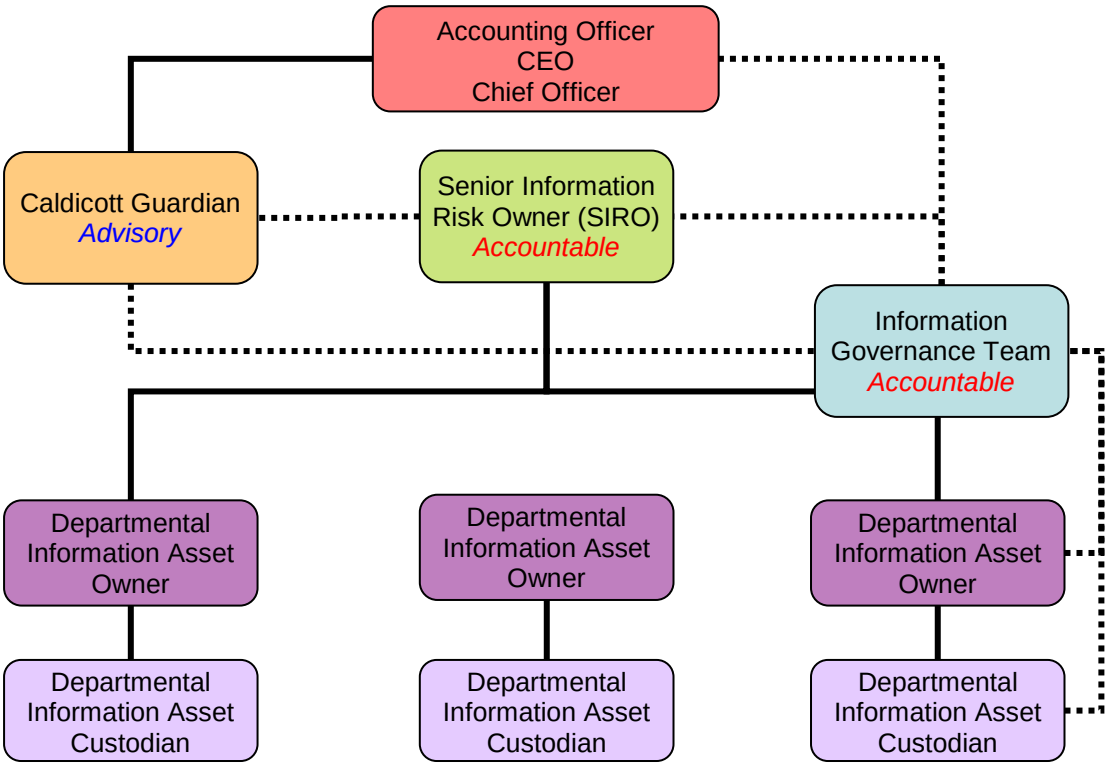
their documented approval.

9. Conclusion

9.1 The implementation of the Information Governance Management Framework, Strategy, and Improvement Programme will ensure the deliverance of the Information Governance Policy undertaking that information is effectively managed within The Trust.

9.2 The Management Framework and Strategy will be reviewed annually (IG requirement 101,3b) in line with Trust procedure and an Improvement program developed against the Information Governance Toolkit to identify key areas for continuous improvement. Improvements will be scheduled via a work plan inclusive of an implementation timetable.

Appendix 1: Information Governance Management Framework Accountability Diagram / Reporting Structure



Appendix 2: Information Handling Guidance & Considerations for requests

Data Accreditation	Information Security Management ISO/EEC27001 & ISO/EEC27002
Consent to sharing of personal information	Caldicott sharing of patient identifiable information
Common law duty of confidentiality	Records Management Code of Practice
The Freedom of information Act 2000 The Abortion Regulations 1991 Administrative Law The Blood Safety and Quality Regulations 2005 – Directive 2002/98/EC of the European Parliament and of the Council of 27 January 2003 – Commission Directive 2005/61/EC of 30 September 2005 The Census (Confidentiality) Act 1991 The Civil Evidence Act 1995 The Common Law Duty of Confidentiality Confidentiality: NHS Code of Practice The Electronic Communications Act 2000 The Environmental Information Regulations 2004 The Gender Recognition Act 2004 – The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) (No. 2) Order 2005 The Health and Safety at Work Act 1974	The Data protection Act 1998 The BSI 'BIP008:2004 code of practice for legal admissibility and evidential weight of information stored electronically. The Access to Health Records Act 1990 The Computer Misuse Act 1990 The Congenital Disabilities (Civil Liability) Act 1976 The Consumer Protection Act (CPA) 1987 The Control of Substances Hazardous to Health Regulations 2002 The Copyright, Designs and Patents Acts 1990 The Crime and Disorder Act 1998 The Data Protection Act (DPA) 1998 – The Data Protection (Processing of Sensitive Personal Data) Order 2000 Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community Code Relating to Medicinal Products for Human Use The Disclosure of Adoption Information (Post-Commencement Adoptions) Regulations 2005 The Limitation Act 1980

The Health and Social Care Act 2001 The Human Rights Act 1998 The Human Fertilisation and Embryology Act 1990, as Amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992 The Re-use of Public Sector Information Regulations 2005 The Sexual Offences (Amendment) Act 1976 Subsection 4(1) as Amended by the Criminal Justice Act 1988 Relevant Standards and Guidelines BSI BIP 0008 BSI PD 5000 BS 4743 BS 5454:2000 BS ISO/IEC 17799:2005 BS ISO/IEC 27001:2005 BS 7799-2:2005 ISO 15489 ISO 19005 The NHS Information Governance Toolkit	The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 The Police and Criminal Evidence (PACE) Act 1984 The Privacy and Electronic Communications (EC Directive) Regulations 2003 Public Health (Control of Diseases) Act 1984 and Public Health (Infectious Diseases) Regulations 1988 The Public Interest Disclosure Act 1998 The Public Records Act 1958 The Radioactive Substances Act 1993 – The High-activity Sealed Radioactive Sources and Orphan Sources Regulations

Appendix 3: IG Training Plan 2017/18

Bespoke IG Training

Information Governance Team have accountability for the provision, implementation and monitoring of IG training. As part of this the IG team have produced a Solent NHS Trust tailored IG training package which includes the following training options for staff:

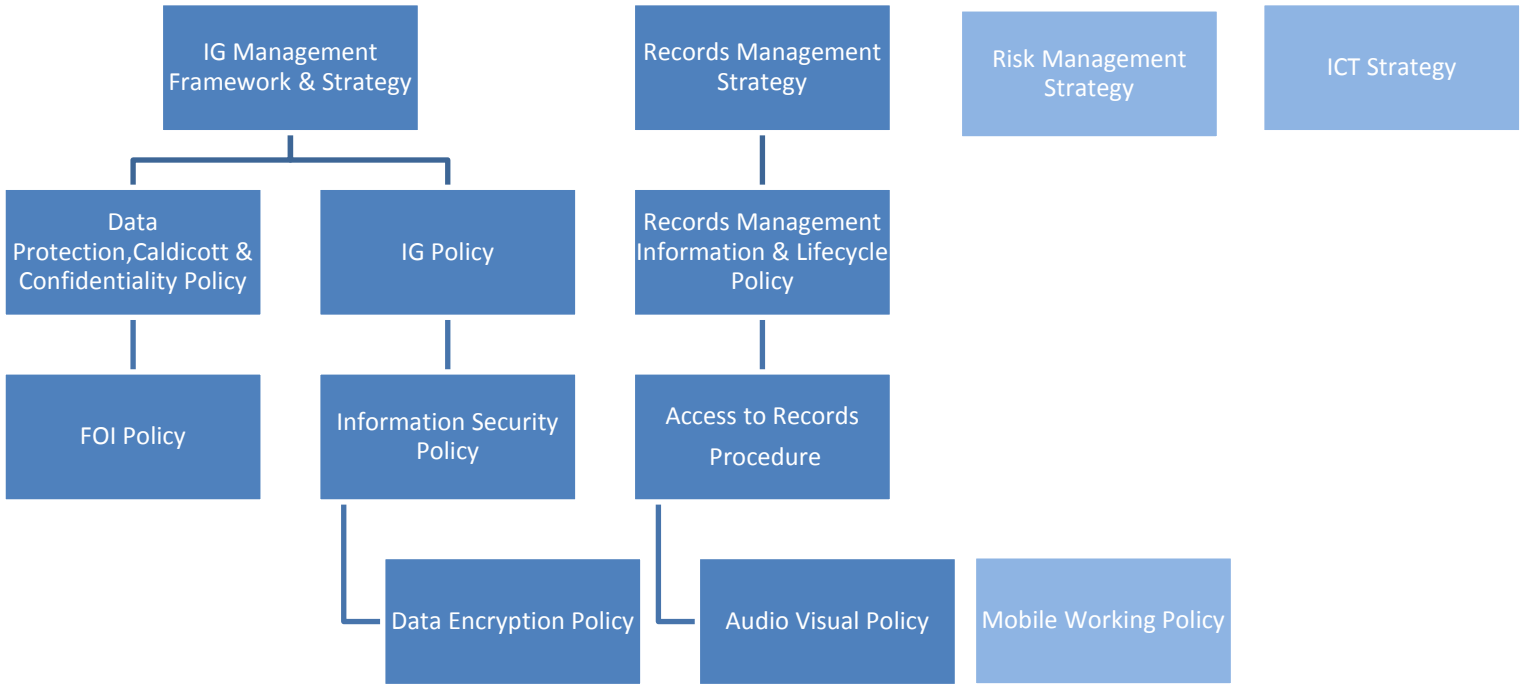
1. All newly appointed members of staff will be required to undertake their mandatory IG assessment whilst having their local induction with their manager.
2. Bespoke IG online training tool via E-Learning; the training tools are categorised by Corporate, Clinical and Estates service and are tailored to focus on Community & Mental Health Trusts IG practices. The examples of shared learning used within the training are real service incidents that have happened.
2. Bespoke face to face service line/corporate level training delivered by the IG team in which staff undertake the mandatory assessment
3. Service lines who report a high number of incidents as well as HRI's & SI's are to be given the option of further IG training that will then be bespoke to them. If relevant a spot check and audit will be carried out on the service line as a recommendation of the incident investigation.
4. Bespoke training for Information Asset Custodians (IAC's) and Information Asset Owners (IAO's) are provided to ensure that they can fulfil their role in implementing and monitoring IG compliance at a service level.

Additional support for staff

All training options have a customisable option for staff who require additional support to undertake the training. All training can be tailored upon request to meet additional needs of staff, e.g. visually impaired, dyslexic, etc.)

Appendix 4: IG Policies & Procedures

This Management Framework & Strategy links to other interrelated, strategies, policies, procedures and codes of practice that are in place within The Trust to promote and ensure the delivery of Information Governance Standards throughout the organisation and must be read in conjunction with those listed below that are available on the intranet**:** http://solent/corp/igov/Lists/IG%20Policies/AllItems.aspx



Policies:

- **Access to Records Procedure**
  This document details how the organisation will handle requests for information relating to all records including health records for living persons (Subject Access Request), deceased persons (Access to Records) and staff records and relevant charges that may be applicable

- **Information Governance Risk Policy**
  This Policy & Strategy documentation sets out the approach taken within Solent NHS Trust to the management of Information Governance Risk.

- **Audio Visual Records Policy**
  This policy is concerned with the storage and retention of audio-visual records created within Solent NHS Trust. The policy addresses both audio-visual records management for the purpose of Clinical and Corporate benefit

- **Data Encryption Policy**
  This document describes the NHS Solent Policy on data encryption and employees' responsibilities for ensuring that personal identifiable/business critical information is stored and transferred securely.

- **Data Protection, Caldicott and Confidentiality Policies & Procedures**
  This document describes Solent NHS Trust's policy on Data Protection, Confidentiality and Caldicott Guidance, and employees' responsibilities for the safeguarding of confidential information held both manually (non-computer in a structured filing system) and on computers.

- **Information Governance Policy**
  Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources in creating a corporate memory. Information plays a key part in clinical governance, service planning and performance management. This policy serves to underpin those areas of Information Governance that The Trust is working toward.

- **Information Security Policy**
  All Solent NHS Trust staff has a responsibility for information security. Therefore awareness and compliance of ALL staff is essential.
  This document describes the Solent NHS Trust policy on information security and employees' responsibilities for security of information held both manually and on computers.

- **FOI Policy**
  Solent NHS Trust actively promotes a climate of openness and accountability. This policy outlines the organisations responsibilities in complying with the Freedom of Information 2000 Act, the Environmental Information Act 2004, the Re-use of Public Sector Information and the relation to the Data Protection Act 1998. These items of legislation and codes of practice are brought together in this policy and uphold Solent NHS Trust records management practice. This Policy is a statement of what Solent NHS Trust intends to do to ensure and

maintain compliance with the Act and regulations. It is not a statement of how compliance will be achieved; this will be a matter for operational procedures.

- **Records Management & Information Lifecycle Policy**
  This Policy is written to give the organisation a clear Information &Records Management Framework which includes advice and guidance on all aspects of Records Management and Data Quality to inform staff of their operational and legal responsibilities.

Other Strategies:

- **Records Management Strategy**
  The Solent NHS Trust Records Management Strategy Sets out how the organisation's Records Management and Information Lifecycle Policy will be delivered, the strategy meets two needs, operational and strategic. It is supported by a comprehensive baseline records management assessment which provides a full status check on records storage and identifies strengths and weaknesses within the domain of records management. The assessment provides a framework in which to implement effective records management solutions.

Procedures

- **Privacy Impact Assessment Procedure**
  This is a Government & Information Governance (Req 323) mandated requirement for all new projects where systems are about to be implemented, to ensure any risks to Privacy are addressed at the implementation

Item 16

Minutes

Members Council

Date: Thursday 19th October 2017
Time: 10:00-12:00noon
Venue: Conference Room B, Floor 2, Civic Offices, Portsmouth, PO1 2AL

Chair: Alistair Stokes (AMS) Chairman **Governor Members** **Michael North** (MN), Lead Governor - Portsmouth **Bob Blackman** (RB), Governor - Hampshire **Cllr Warwick Payne** (WP), Appointed Governor – Southampton County Council **David Stephen Butler** (DSB), Governor - Portsmouth **Board Members** **Sue Harriman** (SH), Chief Executive **Helen Ives** (HI), Chief People Officer **Andrew Strevens** (AS), Director of Finance **Stephanie Elsy** (SE), Non-Executive Director **Mick Tutt** (MT), Non-Executive Director **Jon Pittam** (JP), Non-Executive Director **Francis Davis** (FD), Non-Executive Director **Mike Watts** (MW), Non-Executive Director	**Attendees** **Andrea Hewitt** (AH), Head of Communications **Jayne Edwards** (JE), Corporate Support Manager & Assistant Company Secretary **Sam Stirling** (SS), Corporate Affairs Administrator (minutes) **Apologies** **Lesley Munro** (LM), Chief Nurse **Daniel Meron** (DM), Chief Medical Officer **Sarah Austin** (SA), Chief Operating Officer Portsmouth and Commercial Director **David Noyes** (DN), Chief Operating Officer Southampton and County Services **Rachel Cheal** (RC), Associate Director Corporate Affairs & Company Secretary

1	**Welcome, Apologies and Declaration of Interests**
1.1	Apologies were received as noted above. AMS welcomed members to the meeting. AMS welcomed SE to her first Members Council.
1.2	The meeting was confirmed as quorate.
2	**Minutes of the last meeting and action tracker**
2.1	The minutes of the meeting held on the 10th March were agreed as an accurate record.
2.2	Action Tracker • Action 64- The Council discussed challenges surrounding WIFI access on the top floor of Highpoint. SH explained that resolutions were complicated and agreed to request a further update from Simon Sturgeon. **Action- SH.** The following actions were confirmed as complete: 63, 65, 66, 67, 68

3	**Matters Arising**
3.1	DSB shared his frustrations regarding the lack of formal engagement with his constituency and subsequent challenges with effectively fulfilling the role. It was agreed to discuss this further under item 5 of the agenda.
3.2	*HI joined the meeting*. AMS welcomed HI to her first Members Council as Chief People Officer.
4	**Any Other Business**
4.1	No other business was discussed.
5	**Discussion on future of Members Council**
5.1	AMS referred to the summary position paper provided. AMS summarised the Trust's decision to step away from the FT pipeline and following advice sought from NHS England. AS explained the financial due diligence undertaken and SH also highlighted a change in direction following the launch of the STP initiative involving collaborative and partnership working across NHS bodies.
5.2	AMS confirmed there to be no statutory or regulatory requirement to hold a formal Council of Governors. The Council were briefed on information received from other organisations across the country on their governor arrangements. AMS emphasised the need to consider all options regarding the future role that will suit the changing needs of the Trust going forward.
5.3	MN acknowledged a lack of recent governor engagement and reflected on reasons for joining the Trust to actively engage and support. MN also commented on difficulties in being able to access Committees to effectively utilise Governor skills and knowledge. MN's full support of the presented proposal was noted and the importance of identifying an effective solution that suits the STP and local area needs was acknowledged The future name of Governors was discussed.
5.4	BB shared current interaction through CCG and Trust members and raised concerns regarding the lack of public engagement events held by Solent. AH confirmed that quarterly membership meetings are held and discussed how these could be adapted in line with the framework currently on hold. DSB suggested establishing a focus forum to ensure contact and challenge to fulfil public engagement functions.

5.5	WP agreed the importance of providing clarity of the role and how it can assist with public engagement. WP suggested the possibility of holding a geographical event across all NHS Trusts and providers in the local area, so that the public can discuss NHS issues as a whole. WP suggested changing the Governors name to 'trustee' however SE emphasised the need to consider potential legal implications to do so. AMS agreed with the idea of holding a geographical based event however acknowledged potential challenges in bringing organisations together. SH commented that the event would be a positive progression in line with the STP and ACS delivery.
5.6	AH commented on current communications work being progressed across the STP, including joint communications for Winter Preparedness.
5.7	JP suggested that Governors no longer have a role in the scrutiny of the Board or calling the Chief Executive and other Board members to account. SH agreed and highlighted the need for a wider public engagement strategy which incorporates a specific representative role. MT emphasised the need to be conscious of pace of NHS change and establish a compelling vision that encourages development and learning. The Council agreed to being open to change and debate as required.
5.8	SH informed the Council that the proposal will be considered at Board and at management level based on discussions today and previous conversations with ACS to review a joined up approach to public and service user engagement. It was agreed that further consideration be given to the name of the role. The Council discussed the importance of progressing with the current proposal and ensuring appropriate engagement from both Governors and the Trust. **The Members Council endorsed the proposal presented.**
6	**Any other business**
6.1	The Council discussed convenience of the meeting venue and agreed suitability for future meetings.
7	**Close**
7.1	No other business was discussed and the meeting was closed.

Item 19.1

Exception and recommendation report

Committee /Subgroup name	**Assurance committee**	**Date of meetings**	17th october & 21st november 2017
Chair	**mick tutt**	**Report to**	Trust Board

Key issues to be escalated

We received a **deep dive briefing** on **Safeguarding** at our October meeting, with the major issues discussed including:-

- the Looked after Children Service, and both plans for wider safeguarding support and on-going challenges regarding health assessments for out-of-area placements. Progress of understanding safeguarding cultures, integration challenges and themes at local level were highlighted and discussed
- concerns regarding escalation processes for both C&AMHS and the Safeguarding team were noted
- issues of interpretations of guidelines and variations of enhanced training and supervision, within specific services, were noted
- the CD was keen to stress the positive relationship with the Local Authority – evidenced through information-sharing and responsiveness
- the CD was also keen to stress the benefits of well-designed clinical records

the October meeting also received:-

- an up-date on **CQC 'state of readiness'** – with a confirmation from the Chief Nurse that, whilst there were currently no actions which management colleagues were concerned of an ability to address and resolve, the entire Action Plan related to CQC feedback remained under continual review
  the sensitivity of corporate service support in resolving potential issues – with regard to timely resolution of ligature risks – was acknowledged
- a report on a **recent** Information Governance (**IG**) **breech** within our Primary Care service, with confirmation of the immediate Trust response and notification to the Information Commissioners Office (ICO), together with assurance regarding on-going action
- a second quarterly up-date on the work of our **Freedom-to-Speak-Up Guardians**, with an up-date on activity – including the necessity to replace one of the original appointees, consideration being given to 'associate' F-t-S-UGs, and a potential for an – unintentional – lack of evidence of diversity
- a quarterly up-date on **activity around complaints, compliments and other feedback** from people who accessed our services. This included learning, as a consequence; the emerging evidence of a positive reaction where staff had engaged in early local resolution meetings and an acknowledgement of the effectiveness of the Complaints Scrutiny Panel
  we agreed a future reporting structure; to both this committee and the Board for all aspects of experience for people who accessed our services and those who cared for them – and how this needed to be aligned to reporting arrangements to other organisations (such as our commissioning Clinical Commissioning Groups)

Decisions made at the (October) meeting

We received a revised reporting structure; for exception reports from the Chief Operating Officers and the Quality Improvement & Risk group, and agreed that this format should be reviewed in the New Year

noted the Chair's Action, taken since the previous meeting, with regard to

- **Mortality Policy** (on the basis of amendments made, following comments at the previous meeting)
- **IPC03 MRSA Policy**

We undertook our delegated function, of considering policies submitted for ratification, as follows:-

- **Data Assurance Policy**
- **Audio-Visual Policy**

We noted that amendments requested of the:-

- **Social Media Policy**

remained to be actioned

Recommendations to the Trust Board

The Board are asked to:-

- the further up-date on action taken to address concerns raised by the CQC
- note the other issues set out above from the October meeting
- receive a verbal update on the 21st November meeting

Other risks to highlight (not previously mentioned)

none of note

Item 19.2

	Assurance Committee		
Title of Paper:	Mortality Update	**Author(s):**	Hilary Todd
Executive Lead:	Dan Meron Chief Medical Officer Lesley Munro Chief Nurse	**Date of Paper:**	31st October
Committees presented:			
Link to CQC Key Lines of Enquiry (KLoE)	[X] Safe [ ] Well Led [ ] Effec [ ] Car [X] Re nsive		

Executive Summary

The Assurance Committee received an update on the work being undertaken in line with the National Quality Board (NQB) on the National Guidance on Learning from Deaths report in September of this year and requested an update to this meeting.

The Mortality Policy was approved and published on both the Intranet and the Solent web page in accordance with the NQB requirements and timescales.

The following paper identifies key requirements of the document, the progress to date and the results actions required to ensure compliance.

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

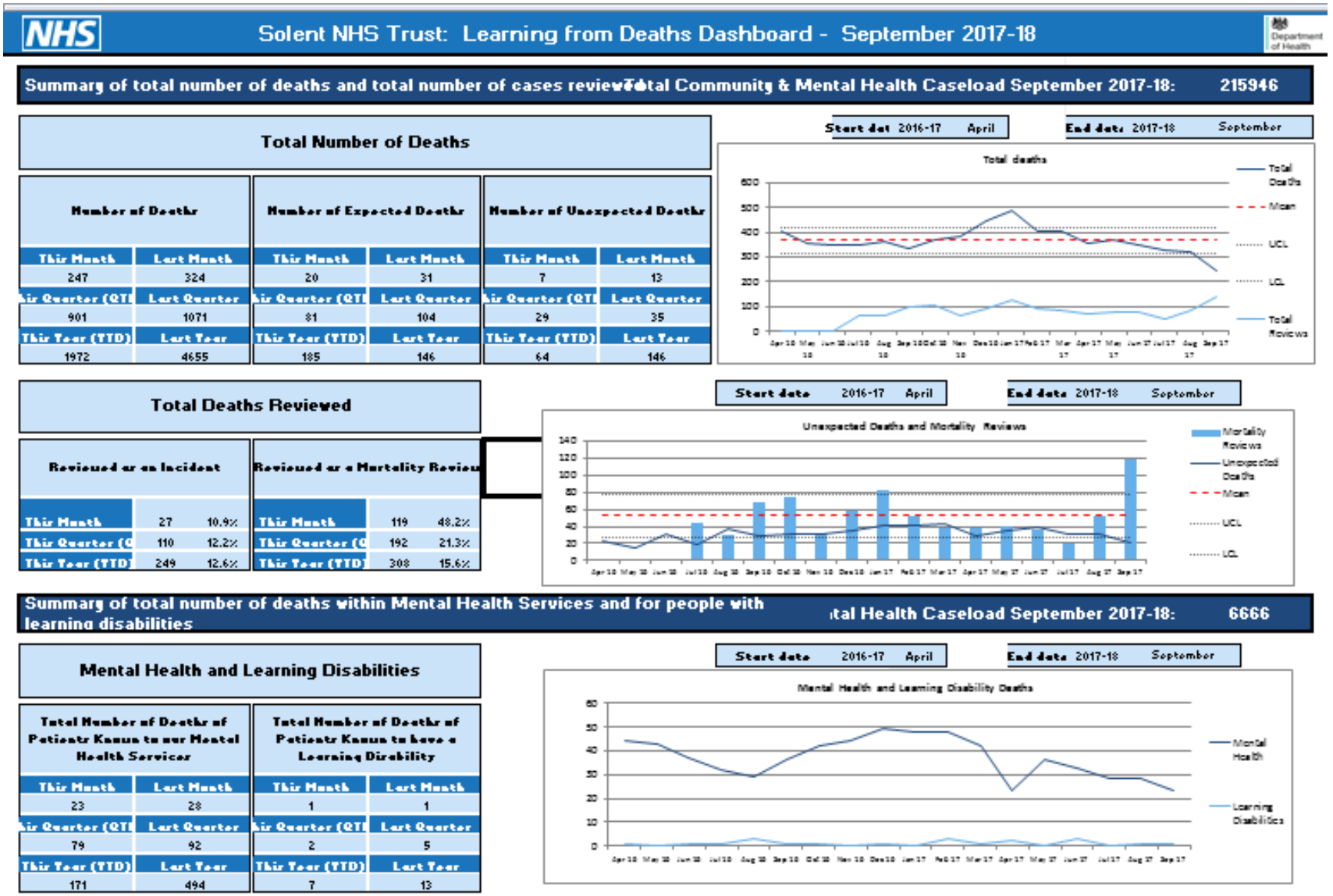
The Associate Director of Quality and Safety attended the Clinical Judgment Training provided by the Royal College of Physicians and, as such, is now a Tier One trainer. The training has been modified and made applicable to Community and Mental Health settings. The first two sessions delivered a learning opportunity for both staff involved in Mortality Reviews and the Associate Director of Quality and Safety. A number of training sessions will now be made available to those staff completing mortality reviews.

Key Decisions/ Action(s) requested

The Assurance Committee is asked to note the following requirements as agenda items:

Framework Requirement	Current status
Governance and Capability Learning from a review of the care provided to patients who die should be integral to a provider's clinical governance and quality assurance processes. We need to ensure our governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. We also need to ensure any learning derived from these processes is shared and acted upon.	The clinical judgement training will now be made available to staff. Monthly mortality panels have now been scheduled where Services report all mortality reviews and learning is identified and shared.
Mortality Policy – this includes How the Trust responds to, and learns from deaths of patients who die under our management and care, including specifically : individuals with a learning disability,or mental health needs and an infant or child death. The Trust's approach to case record reviews, including the way in which we undertake structure judgment reviews and the category of deaths in scope for review.	The clinical judgement reviews will take place and its implementation will be monitored over the next quarter. We currently have in place: • LeDar Process • Mortality review process • Mortality Panels • Service led mortality processes recognizing the different parameters eg Sexual Health only review HIV deaths, AMH within 12 months of discharge, Children and Families – all deaths.
Data Collection and publication. From April 2017, we are required to collect and publish specified information on deaths on a quarterly basis.	Data Collection will continue and be presented to Assurance Committee as planned. Please note the Quarter 2 dashboard contained in this report. The increased number of mortality reviews in September is as a result of a back log of expected deaths in Jubilee being reported at the October Mortality Panel. The downward trend, whilst still within expected variation, is consistent with the data from this time last year.
Bereaved Families and Carers We are required to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. We operate according to key principles including ensuring that staff, including family liaison officers where available, have the necessary skills, expertise and knowledge to engage with bereaved families and carers.	The Every One Counts project will continue to be led by the Chief Nurse and will be reported via the QIR meeting. An event with Making Families Count and the Action against Medical Action for all staff is being arranged. Where we have permission, the patient's name is now being used in SI reports and families are actively engaged in the

	investigation process and in developing the 'commissioning brief' for the investigation.


NHS
Solent NHS Trust: Learning from Deaths Dashboard - September 2017-18
Department of Health
Summary of total number of deaths and total number of cases reviewed
Total Community & Mental Health Caseload September 2017-18: 215946
Total Number of Deaths
Number of Deaths
This Month 247
Last Month 324
Quarter (QTD) 901
Last Quarter 1071
This Year (YTD) 1972
Last Year 4655
Number of Expected Deaths
This Month 20
Last Month 31
Quarter (QTD) 81
Last Quarter 104
This Year (YTD) 185
Last Year 146
Number of Unexpected Deaths
This Month 7
Last Month 13
Quarter (QTD) 29
Last Quarter 35
This Year (YTD) 64
Last Year 146
Start date 2016-17 April
End date 2017-18 September
Total deaths
Total Deaths
Mean
UCL
LCL
Total Reviews
Total Deaths Reviewed
Reviewed as an Incident
This Month 27 10.9%
This Quarter (Q 110 12.2%
This Year (YTD) 249 12.6%
Reviewed as a Mortality Review
This Month 119 48.2%
This Quarter (Q 192 21.3%
This Year (YTD) 308 15.6%
Start date 2016-17 April
End date 2017-18 September
Unexpected Deaths and Mortality Reviews
Mortality Reviews
Unexpected Deaths
Mean
UCL
LCL
Summary of total number of deaths within Mental Health Services and for people with learning disabilities
ital Health Caseload September 2017-18: 6666
Mental Health and Learning Disabilities
Total Number of Deaths of Patients Known to our Mental Health Services
This Month 23
Last Month 28
Quarter (QTD) 79
Last Quarter 92
This Year (YTD) 171
Last Year 494
Total Number of Deaths of Patients Known to have a Learning Disability
This Month 1
Last Month 1
Quarter (QTD) 2
Last Quarter 5
This Year (YTD) 7
Last Year 13
Start date 2016-17 April
End date 2017-18 September
Mental Health and Learning Disability Deaths
Mental Health
Learning Disabilities

Item 22

Exception and recommendation report

Committee /Subgroup name	Audit & Risk Committee	**Date of meeting**	9th November 2017
Chair	Jon Pittam, Non-Executive Director	**Report to**	Board

Key issues to be escalated

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

- A report was presented by the Deputy Chief Executive and Director of Finance and Performance regarding six single tender waivers, one special payment and proposal to write off outstanding debts.
- A verbal update on reference costs was provided.
- The Committee were provided with an update on the External Audit Plan for 2017/18.
- An Internal Audit progress report on audit activity was received and an update provided on the IT and clinical supervision audits. The draft report on clinical supervision results in a high risk assessment and it was recommended that this should be referred to the Assurance Committee when comments on the draft had been received.
- The Committee received the Counter Fraud update report on actions undertaken in the August to October reporting period.
- The Chief Nurse briefed the Committee on an unannounced CQC inspection within Children's Services.
- The Committee received the progress report on implementing the recommendations of the internal audit report on Safe Staffing. The audit had identified that the Trust does not have a formal, documented and agreed process for setting of its establishment levels across the various teams and wards, and that there is no formal review process and no central oversight of the safe staffing levels set for each area. It was noted that little progress has been made as services are not yet including the recommendations in their planning processes. The recommendations need to be more formally included in the planning cycles and it was proposed that this is firmly embedded from the start of the 2018/19 planning cycle. The main risk associated with the progress report is that there has not been sufficient progress with implementation to inform safe staffing decisions and therefore it is not possible to be assured that safe staffing levels are in place across the inpatient areas. It was noted that work is progressing but requires further support to embed the audit recommendations.
- The Associate Director of Research and Clinical Effectiveness provided a mid-year update on national audits and local projects planned and completed by service lines.
- It was agreed that the Committee recommend the appointment of EY as External Auditors.
- The Committee mid-year review report was presented and it was agreed to include continued monitoring of governance controls for Safe Staffing as an additional objective.

Decisions made at the meeting

Work on Safe Staffing is progressing but requires further support to embed in practice.

Recommendations

It is recommended that the Board:

- Note the above report from the Audit & Risk Committee.

It is recommended that the Assurance Committee

- Consider the internal audit report on clinical supervision and any actions required.

- Receive the progress report on implementing the internal audit recommendations on Safe Staffing.
Other risks to highlight (not previously mentioned)
There are no risks to highlight.

Item 23

Exception and recommendation report

Committee /Subgroup name	**Complaints Review Panel**	**Date of meeting**	**22nd September 2017**
Chair	**Lesley Munro**	**Report to**	**Trust Board**

Key Issues to be escalated
Three complaints were randomly selected for review at the panel. The complaints selected on this occasion were from Mental Health services, Adults Portsmouth and Adults Southampton. There were no specific trends or themes across the three areas. Key Learning noted from the complaints response and process: The need for services to ensure PALS & Complaints are made aware at an early stage when dealing with complaints or concerns. In one instance this could have led to a much more productive conversation with the people affected and may have avoided further difficulties in communication. The language used in complaints letters needs to be consistent – in one instance the language and tone was reflected to be unhelpful. Additional training will be provided to those who may benefit from it. There has been a change in practice in response to one of the complaints reviewed at the panel. When carers contact the complaints team they are now routinely offered some signposting to carer support agencies. It was noted that the new matrix relating to timescales for responding to complaints is now in place, although, as yet there has been no reason to enact it. Everyone Counts (Duty of Candour) was discussed in terms of progress. There will be an organisational wide event for staff in March. The Chief Nurse is securing some national speakers to be present and will confirm in due course. The panel also noted that we have seen some positive feedback received from people who have raised concerns, and the services have responded or intervened in a timely way. The meeting had external representation from Healthwatch Portsmouth. Feedback and observations were taken - they observed a willingness to learn from complaints and a professional approach to dealing with the issues. **Service changes as a result of learning:** In addition to changes referred to above additional learning from services was noted. This included the development of a standardised referral process for GP's to use for community nursing, and a more streamlined approach to how referrals are submitted into the service. Changes have also been made in relation to how visits are re-arranged and the communication that has been put in place to ensure patients are aware of what is happening and why. Some services have implemented an immediate phone call being made to the person raising concerns to apologise and to discuss what can be done to put things right.
Key Issues to be escalated Matters for escalation to Board – for noting
Nil
Recommendation
Board is asked to note the contents of this exception report.