# Agenda Board Meeting
**Tuesday 5 June 2018**  
**10:30 – 14:00**  
**Venue:** The Ark Conference Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>09:00</td>
<td>Confidential Session</td>
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<tr>
<td>10:00</td>
<td>Tea/Coffee Break</td>
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<tr>
<td>10:30</td>
<td>Public Session</td>
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<tr>
<td>14:00</td>
<td>Lunch</td>
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## Opening Administration

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<tr>
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<tbody>
<tr>
<td>10:30</td>
<td>1</td>
<td>Chair’s Welcome</td>
<td>Chair</td>
<td>Oral</td>
<td>Noting</td>
</tr>
<tr>
<td>10:30</td>
<td>2</td>
<td>Apologies for Absence</td>
<td>Chair</td>
<td>Oral</td>
<td>Noting</td>
</tr>
<tr>
<td>10:30</td>
<td>3</td>
<td>Declarations of Interest</td>
<td>Chair</td>
<td>Paper</td>
<td>Noting</td>
</tr>
<tr>
<td>10:35</td>
<td>4</td>
<td>Questions from the Public (submitted in advance of the meeting)</td>
<td>Chair</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>10:40</td>
<td>5</td>
<td>Minutes of the meetings held on 27.03.2018 and 17.04.2018, matters arising and action log</td>
<td>Chair</td>
<td>Paper</td>
<td>Decision</td>
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## Patient Story

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>10:45</td>
<td>6</td>
<td>Patient story: Reflections on a service users involvement in the future design workshops</td>
<td>Medical Director</td>
<td>Oral</td>
<td>Discussion</td>
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## Performance

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<tr>
<th>Time</th>
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<th>Action</th>
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<tbody>
<tr>
<td>11:05</td>
<td>7</td>
<td>Chair’s Board Update</td>
<td>Chair</td>
<td>Paper</td>
<td>Information</td>
</tr>
<tr>
<td>11:10</td>
<td>8</td>
<td>Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>Paper</td>
<td>Information</td>
</tr>
<tr>
<td>11:20</td>
<td>9</td>
<td>Executive Directors’ Reports</td>
<td>Executive Directors</td>
<td>Paper</td>
<td>Information</td>
</tr>
<tr>
<td>11:50</td>
<td>10</td>
<td>Integrated Performance Report</td>
<td>Director of Finance</td>
<td>Paper</td>
<td>Assurance</td>
</tr>
<tr>
<td>12:00</td>
<td>11</td>
<td>2018/19 Operating Plan</td>
<td>Director of Finance</td>
<td>Paper</td>
<td>Decision</td>
</tr>
<tr>
<td>12:10</td>
<td>12</td>
<td>Infection &amp; Prevention Control Annual Report</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Paper</td>
<td>Assurance</td>
</tr>
<tr>
<td>12:15</td>
<td>13</td>
<td>Learning from Deaths: Mortality Data and Learning for Quarter Four 2018.</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Paper</td>
<td>Assurance</td>
</tr>
<tr>
<td>12:25</td>
<td>14</td>
<td>Complaints, Concerns and Compliments Annual Report</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Paper</td>
<td>Assurance</td>
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## Break (12:30 – 12:40)

## Strategy

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<tr>
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<tbody>
<tr>
<td>12:40</td>
<td>15</td>
<td>Transformation Programme Update</td>
<td>Chief Executive</td>
<td>Paper</td>
<td>Assurance</td>
</tr>
<tr>
<td>12:45</td>
<td>16</td>
<td>Memorandum of Understanding</td>
<td>Director of Operations (ISD)</td>
<td>Oral</td>
<td>Information</td>
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180605 TB 00 Agenda Final
<table>
<thead>
<tr>
<th>Time</th>
<th>No.</th>
<th>Item Description</th>
<th>Responsible Person(s)</th>
<th>Document Type</th>
<th>Decision Type</th>
</tr>
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<tbody>
<tr>
<td>12:55</td>
<td>17</td>
<td>Compelling Case for Change Statement</td>
<td>Chief Executive</td>
<td>Paper</td>
<td>Assurance</td>
</tr>
<tr>
<td>13:05</td>
<td>18</td>
<td>Board Assurance Framework</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Paper</td>
<td>Decision</td>
</tr>
<tr>
<td>13:15</td>
<td>19</td>
<td>Risk Report</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Paper</td>
<td>Decision</td>
</tr>
<tr>
<td>13:20</td>
<td>20</td>
<td>Corporate Governance Report</td>
<td>Company Secretary</td>
<td>Paper</td>
<td>Decision</td>
</tr>
<tr>
<td>13:25</td>
<td>21</td>
<td>Monitor Licence Compliance</td>
<td>Company Secretary</td>
<td>Paper</td>
<td>Decision</td>
</tr>
<tr>
<td>13:30</td>
<td>22</td>
<td>Reporting from Board Committees</td>
<td>Committee Chairs</td>
<td>Oral &amp; Paper</td>
<td>Information</td>
</tr>
<tr>
<td>13:40</td>
<td>23</td>
<td>Risk Appetite Statement and Risk Management Policy</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Paper</td>
<td>Decision</td>
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**Closing Administration**

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<tr>
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<th>Document Type</th>
<th>Decision Type</th>
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<tbody>
<tr>
<td>13:45</td>
<td>24</td>
<td>Any other urgent business (previously notified to the Chair)</td>
<td>Chair</td>
<td>Oral</td>
<td>-</td>
</tr>
<tr>
<td>13:45</td>
<td>25</td>
<td>Questions from the public</td>
<td>Chair</td>
<td>Oral</td>
<td>-</td>
</tr>
<tr>
<td>13:45</td>
<td>26</td>
<td>Review of Meeting</td>
<td>Chair</td>
<td>Oral</td>
<td>-</td>
</tr>
<tr>
<td>13:45</td>
<td>27</td>
<td>Close</td>
<td>Chair</td>
<td>Oral</td>
<td>-</td>
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**Date of next Board meeting:** Tuesday 31st July 2018, Venue: Aldershot Centre for Health

**Quorum**

No business shall be transacted at meetings of the Board unless there is a minimum of two Executive Directors and at least three Non-Executive Directors (including the Chairman or a designated Non-Executive Deputy Chairman) present.

**The Trust will take an audio recording of Board meetings held in public and of Council of Governors’ meetings held in public. The recording will be held on file with the meeting documentation and published following the meeting. In accordance with Standing Order 4.1.2 of the Trust’s Constitution and Standing Orders, any other audio recordings of the proceedings of Board meetings held in public or of Council of Governor’s meetings held in public will require the prior agreement of the person chairing the meeting.**
**Register of Interests for Members of the Board of Directors**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Declaration of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Anderson</td>
<td>Director of Finance</td>
<td>• Director of Culverly Consulting LLP – currently dormant, whilst request for strike off is processed.</td>
</tr>
<tr>
<td>Jeni Bremner</td>
<td>Non-Executive Director</td>
<td>• Trustee – Quaker Care Home New Milton&lt;br&gt;• Director – Philips Kay Partnership&lt;br&gt;• Co-Director - Centre for Empowering Patients and Communities</td>
</tr>
<tr>
<td>Dr Nick Broughton</td>
<td>Chief Executive</td>
<td>• Trustee - Charlie Waller Memorial Trust&lt;br&gt;• Board Member – Mental Health Network, NHS Confederation</td>
</tr>
<tr>
<td>Julie Dawes</td>
<td>Director of Nursing &amp; AHPs</td>
<td>• Company Secretary – Ian Dawes Marine Ltd</td>
</tr>
<tr>
<td>Paul Draycott</td>
<td>Director of Workforce and Organisational Development</td>
<td>None declared</td>
</tr>
<tr>
<td>Dr David Hicks</td>
<td>Non-Executive Director</td>
<td>• Specialist advisor/inspector to the CQC&lt;br&gt;• Interim Medical Director at the Bupa Cromwell Hospital, London</td>
</tr>
<tr>
<td>Paula Hull</td>
<td>Interim Director of Operations (Integrated Services)</td>
<td>• Partner - Willow Group (SHFT Primary Care Group)</td>
</tr>
<tr>
<td>Lynne Hunt</td>
<td>Chair</td>
<td>• Director – Lynne Jay Hunt consulting Ltd&lt;br&gt;• Husband is joint director</td>
</tr>
<tr>
<td>David Kelham</td>
<td>Non-Executive Director</td>
<td>• Treasurer and Trustee Alzheimer’s Society&lt;br&gt;• NED Chairman Meetonvc Ltd</td>
</tr>
<tr>
<td>Dr Karl Marlowe</td>
<td>Medical Director</td>
<td>• Chair - The Social Interest Group (Charity)&lt;br&gt;• Wife - Partner at Good Innovation – A consultancy working within the charity sector</td>
</tr>
<tr>
<td>David Monk</td>
<td>Non-Executive Director</td>
<td>• Partner – Health &amp; Care Consultancy (Symmetric Networks Ltd)&lt;br&gt;• Spouse is NMC Lay member and member of HCPC</td>
</tr>
<tr>
<td>Debbie Robinson</td>
<td>Acting Director of Operations (Mental Health, Learning Disabilities &amp; Social Care)</td>
<td>None declared</td>
</tr>
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Minutes of the Trust Board meeting
Tuesday 27 March 2018
10:00 – 13:45
Conference Room, Sterne 7, Tatchbury Mount,
Calmore, Southampton, SO40 2RZ

Members:
Jeni Bremner  Non-Executive Director and Deputy Chair
Dr Nick Broughton  Chief Executive
Paula Anderson  Finance Director
Dr Sarah Constantine  Acting Medical Director
Julie Dawes  Director of Nursing & Allied Health Professionals
Dr David Hicks  Non-Executive Director
David Kelham  Non-Executive Director
David Monk  Non-Executive Director

In Attendance:
Paul Draycott  Director of Workforce, Organisational Development &
Communications
Paula Hull  Acting Director of Integrated Services
Mark Morgan  Director of Operations (Mental Health & Learning
Disabilities
Paul Streat  Director of Corporate Governance
Anna Williams  Company Secretary & Head of Corporate Governance

Apologies:
Lynne Hunt  Chair

Public:
Peter Bell  Public Governor, Rest of England
Malc Carpenter  Public Governor, South East Hampshire
Sophie Carr  Work experience
Scottie Gregory  Member
Lois Hack  Member of staff
Andrew Jackman  Public Governor, Southampton
Sue Jewell  Member of staff
Lorna Squires  NHS Improvement
Adrian Thorne  Appointed Governor, Carers Together
Marina Webster  Culture Specialist
Tom Westbury  Acting Associate Director of Communications

1. Chair’s Welcome and Meeting Protocol
1.1. Jeni Bremner welcomed members to the meeting, which she opened at 10:00.
1.2. She noted that she would be chairing the meeting, in the absence of Lynne Hunt.
2. **Apologies for Absence**

2.1. Jeni Bremner reported the apologies received.

3. **Declarations of Interest**

3.1. The Register of Interests was noted.

3.2. There were no declarations of interest relating to items on the agenda.

4. **Questions from the public (submitted in advance)**

4.1. Two questions had been submitted by Richard West; the first relating to the use of Sodium Valproate medication within the Trust, and the second in relation to Regulation 28 notices received by the Trust and action plans put before coroners following a patient death.

4.2. Dr Sarah Constantine responded to the question on the use of Sodium Valproate medication, advising that the Trust obtained medicines for patients via a number of sources. It was therefore not possible to provide a complete response as to the number of prescriptions issued by the Trust, and similarly, it was therefore not possible to provide the split by gender. She confirmed that the Trust had responded to the recently issued Sodium Valproate patient safety alert.

4.3. Julie Dawes responded to the question regarding the issuing of Regulation 28 reports, noting that since the Trust was established there had been five reports issued (including one Rule 43 report, which preceded the Regulation 28 report). Since the publication of the Mazars report, all Serious Incidents and Root Cause Analysis reports have been shared with the coroner where the inquest took place after the conclusion of a Serious Incident investigation.

5. **Minutes of the meeting held on 27.02.2018 and matters arising**

5.1. It was noted that Peter Bell, Public Governor, had attended the meeting.

5.2. Subject to this amendment, the minutes were agreed as an accurate record of the meeting held on 27.02.2018.

5.3. The Board considered the action log; the actions completed and the target dates for submission of items to the Board and relevant Committees were noted.

5.4. The following updates were noted:

- TB 28.11.2017/16.6 – In addition to reporting to the Board on diversity and inclusion, it was anticipated this would be a standing item for the Workforce & Organisational Development Committee; action closed.

- TB 28.11.2017/17.4 – The report on training outcomes would come forward to the Workforce & Organisational Development Committee, pending establishment; action closed.

- TB 30.01.2018/8.1 – It was suggested that the Research & Development Annual Report needed to be considered via Committee prior to presentation to the Board.
TB 30.01.2018/8.12 – It was noted that the issue relating to the Multi-Agency Safeguarding Hub was yet to be resolved; this would continue to be monitored by the Quality & Safety Committee.

TB 30.01.2018/16.4 – A review had been undertaken in terms of access to the Ulysses system, and a report provided to the Audit, Risk & Assurance Committee. It was agreed that this action remain open until satisfactory assurance be provided that broader system access weaknesses had been resolved.

TB 30.01.2018/18.8 – A report had been provided to the Quality & Safety Committee. The risk would continue to be monitored through the risk management arrangements, including a further update to the Quality & Safety Committee; action closed.

TB 27.02.2018/4.6 – The policy review was being led by the SAFER Forum, with particular consideration being given to the use of passive and remote processes to undertake observations. A report would be provided back within two months.

TB 27.02.2018/8.9 – The report relating to the Mental Health Act inspection of Daedalus ward had yet to be received; this would be circulated in due course; action to remain open.

TB 27.02.2018/10.6 – Julie Dawes confirmed that there was a data error within the report in relation to allegations management; the report would be amended and recirculated with the correction. Action closed.

5.5. The need to develop consensus in the use of terminology was commented on, with particular reference to terms such as “engagement” and “co-production”. It was suggested that either consideration be given at a Board seminar, or in a short paper to the Board; Dr Sarah Constantine agreed to take this forward. This could be aligned to the discussion at the Board seminar on risk appetite.

**Action:** Acting Medical Director to provide a paper for Board discussion relating to the use of key terminology

**Date:** TBC

6. **Chair’s Board Report**

6.1. The Board received and noted the report.

6.2. Jeni Bremner commented on two recently published Health Service Ombudsman reports, relating to mental health services and to anorexia respectively; the Trust’s response, including identification of areas of learning was being led by Julie Dawes.

6.3. The new Non-Executive Director appraisal process, which had been co-designed with Governors, was being rolled out.

7. **Chief Executive’s Report**

7.1. Dr Nick Broughton opened by reflecting on the sentencing decision made the day before at Oxford Crown Court against the Trust for breaches of the Health and Safety at Work Act 1974, in which the Trust had been fined £2m. The Judge’s sentencing remarks had been circulated to Board members and had been read out
in full. The Judge highlighted the unnecessary human tragedy that underpinned the two convictions. This recognised the seriousness of the failings and acknowledged that the deaths of both TJ Colvin and Connor Sparrowhawk were preventable and should not have occurred. The Judge recognised the Trust's commitment to providing and maintaining a safe environment for all patients and staff and others effected by the Trust's activities. The Judge's closing comments were considered to be fair, balanced and very moving, as were the victim impact statements. Dr Nick Broughton emphasised the importance that health and safety considerations underpinned all Trust activities.

7.2. Dr Nick Broughton presented his report, highlighting:

7.2.1. The Senior Leaders Away Day scheduled for 28.03.2018;

7.2.2. The establishment of the Transformation Programme Board which was meeting fortnightly, with good representation from patients and carers. The Trust was in the process of identifying the first cohort for staff to be trained in QI methodology which would take place in mid-May;

7.2.3. The Trust was engaged with commissioners regarding the future provision of community services; a draft Memorandum of Understanding was being considered, and would come forward to the Board in due course.

7.2.4. The Quality Summit for the CQC system review was due to take place in June; high level feedback had identified some areas of good practice relating to services provided by the Trust;

7.2.5. The Trust had demonstrated improvement on the Information Governance Toolkit performance;

7.2.6. He thanked Paul Streat and Dr Sarah Constantine respectively for their contributions to the Board.

7.3. David Monk suggested that time be allocated at a forthcoming Board seminar for a full update on the STP and to understand the impact on the Trust’s strategy; this was agreed, with a suggestion that Richard Samuel be invited to attend.

Action: Board seminar on STP to be scheduled
Date: 05.06.2018

8. Executive Directors’ Reports

8.1. Paula Anderson presented her report, highlighting:

8.1.1. The consequences of the fine arising from the HSE prosecution. The Trust was behind on the Month 11 position, and this would not be recovered in Month 12. The aspiration remained to deliver the Month 12 position, with the exception of the impact of fines and legal fees. The consequence of failing to deliver the Trust’s control total in quarter four would mean the Trust would not achieve the final quarter’s Sustainability & Transformation Fund and would also not be eligible to receive any further payments from this funding. The full cash impact was therefore expected to be between £3.1m and £5m. She reinforced the commitment to protect frontline services, but noted that this reduced the
Trust’s ability for capital expenditure. Paula Anderson confirmed that she would be writing to NHS Improvement on behalf of the Board,

**Action:** Finance Director to write to NHS Improvement regarding the impact of the fine on the Trust’s achievement of Sustainability & Transformation Funding

**Date:** 31.03.2018

8.1.2. This was a key point in terms of forward planning for 2018/19, with a separate paper on 2018/19 budgets on the agenda;

8.1.3. The CQUIN report on healthy eating; the evidence of improvements were noted by the Board;

8.1.4. The continued focus on training for senior staff in relation to health and safety;

8.2. David Monk sought clarification as to the timescales for completion of anti-ligature works. Paula Anderson confirmed that there had been a risk-based programme in place over the last few years; work was prioritised via the Ligature Management Group. The main area of focus was currently in relation to windows, and there were active conversations about mitigating risks relating to doors;

8.3. Dr Sarah Constantine presented her report, highlighting:

8.3.1. Following the withdrawal of trainees from Elmleigh in January the Trust had taken prompt action and she was confident that trainees would return in August;

8.3.2. Initial feedback from the system wide inspection of psychiatry by the GMC, which had included a visit to the Trust on 13 March, had been positive;

8.3.3. A presentation on the Emotionally Unstable Personality Disorder was planned for the next Quality & Safety Committee meeting;

8.3.4. The Trust had currently declared a position of non-compliance in relation to the Patient Safety Alert on Sodium Valproate; an action plan was in place and would be delivered by the end of the month;

8.3.5. Medical appraisal returns were currently being collated; the Responsible Officer’s report would come to the Board in September;

8.3.6. An ongoing focus on reducing medical locums, in conjunction with the Director of Workforce, Organisational Development & Communications and the finance team;

8.4. Board members commended the work on clinical pathways; this was suggested as an opportunity for focus as part of the QI programme;

8.5. Julie Dawes presented her report, highlighting:

8.5.1. Feedback from the Chief Nursing Officer conference which she had attended had provided an opportunity for sharing learning on tackling workforce challenges;
8.5.2. An internal workshop on nursing workforce had enabled a focus on short term and longer term actions to increase recruitment and retention, such as more flexible rostering and improved career pathways;

8.5.3. The appointment of Dawn Buck as the new Head of Patient and Public Involvement and Engagement;

8.5.4. The Trust was completing the Provider Information Request for the CQC in advance of the forthcoming comprehensive review; this would inform the CQC’s key focus for the inspection;

8.5.5. The contribution of staff and the support from the local community following the recent adverse weather; thanks were expressed on behalf of the Board for the commitment of staff and others.

8.6. Paul Draycott presented his report, highlighting:

8.6.1. A priority focus continued to be on actions in relation to recruitment and retention; these would be fed in to the Workforce & Organisational Development Strategy;

8.6.2. The appointment of Robert Crag as Deputy Director of Organisational Development & Inclusion;

8.6.3. The inclusion of the Trust’s report on gender pay gap. Whilst the Trust was not inconsistent with peers, the aspiration to address the pay gap through the Workforce & Organisational Development Strategy was noted. The significant skew in terms of application of Clinical Excellence Awards was noted;

8.6.4. A new national pay deal was expected; the Trust was engaged in the consultation process;

8.6.5. The launch of the Employee and Team of the Month awards. Dr Nick Broughton commented on his recent visit to the School Nursing team, which had been really positive;

8.7. Paula Hull presented her report, highlighting:

8.7.1. The ongoing focus on work to reduce delayed transfers of care; a system diagnostic work was being undertaken by an external company and would inform further actions;

8.7.2. The Trust continued to work with care homes across the system to open beds to increase capacity to support discharge from hospitals;

8.7.3. A reported increase in complaints in the Willow Group; this was understood to be in relation to issues with the telephone system, meaning that patients and families were unable to get through. Short-term changes had been made, and longer term, a new phone system was being procured. A letter had been sent to all patients outlining these plans;

8.7.4. Work continued with Hampshire County Council to look at how the two organisations aligned teams and processes to improve the service for patients;
8.8. David Monk sought clarification as to the level of risk arising from the review of Service Level Agreements and service specifications; Paula Hull indicated that the Trust had currently reviewed 79 of 101 Service Level Agreements and 56 of 69 service specifications. The importance of moving to a more outcome-focussed approach was noted and ensuring that services were provided that best met patient need. Escalation would be to the Service Performance & Transformation Committee for decision as required.

8.9. Mark Morgan presented his report, highlighting:

8.9.1. The continuing focus on out of area bed usage, including the impact on financial position, which was reported to be £2.4m. Action was focussed on reducing length of stay, as opposed to reducing admissions;

8.9.2. The support from Northumberland Tyne & Wear NHS Foundation Trust to redesign access to services in South East Hampshire;

8.9.3. The Outline Business Case for the development of a 14 bed CAMHS service would be considered by the Board in the confidential session.

8.10. David Monk asked what the Trust’s current length of stay was; Mark Morgan confirmed that the average was 41 days, but there was significant variation across units. Work was focussed both on improving access to services, and also on early discharge planning. The importance of focussing on the care pathway including links to the community, most notably in relation to housing provision, was agreed.

8.11. David Monk invited a view from Dr Sarah Constantine specifically on the provision of services for people with Borderline Personality Disorder; she confirmed that there were varying models in place across the country, but that there was general consensus that a lengthy admission to hospital was not therapeutic, and that options such as 72 hour wards or Crisis Lounges could better suit the needs of these patients.

8.12. Dr Nick Broughton asked for an update on the issues raised regarding services provided from Dame Mary Fagan House; it was confirmed that the Trust continued to work with Hampshire County Council, with identified mitigations in place. Paula Anderson confirmed that discussions had been underway for some time with Hampshire County Council, but agreed that a full resolution was required.

8.13. Paul Streat presented his report, highlighting:

8.13.1. The developing governance arrangements to support the Transformation programme, including the potential for the establishment of a Committee to provide Board oversight;

8.13.2. Consideration of the Trust’s readiness for the General Data Protection Regulations coming into effect; legal advice was being sought as to any actions required in relation to membership. An update would be provided to the Council of Governors in April;

8.13.3. The intention for the development of a patient-led technology strategy, which would be overseen via the Transformation Programme;


Integrated Performance Report

9.1. The Board received the Integrated Performance Report; this had been reviewed via the Service Performance & Transformation Committee the previous day; the improved format and ongoing development was acknowledged.

9.2. Julie Dawes highlighted that the graph within the report on pressure ulcers did not enable Board members to be fully sighted on the issues relating to performance in this regard. Whilst the Trust had not seen a significant rise in the number of pressure ulcers, there had not been a noticeable reduction, despite actions taken to improve performance. She confirmed that this would remain a priority for next year; with an amended graph included in future reports.

9.3. Dr Nick Broughton expressed concern regarding the statement in the report relating to mental health risk assessments; Paul Streat confirmed that the concerns related to process challenges, and specifically where the risk assessment was held within the patient notes held on RiO. Assurance was provided that risk assessments were undertaken as a minimum annually, or at the time of a Care Planning Assessment meeting or in response to any significant event. Dr Nick Broughton asked that the wording within the report be amended to accurately reflect the concerns within the report. Mark Morgan suggested that he and Dr Sarah Constantine would discuss any concerns with the Clinical Directors and report these by exception to the Board. Additionally, it was suggested that further discussion be provided at Quality & Safety Committee. Dr Nick Broughton challenged the reported target, and suggested that this should be 100%.

Action: Director of Corporate Governance to amend narrative within Integrated Performance Report relating to risk assessment compliance to reflect discussions at Board
Date: 05.06.2018

Action: Director of Operations (Mental Health & Learning Disabilities) and Acting Medical Director to discuss mental health risk assessment compliance with Clinical Directors and report any concerns to the Board, with scrutiny via the Quality & Safety Committee
Date: 05.06.2018

9.4. Dr David Hicks commended the work undertaken to improve the compliance position on reporting of serious incidents.

Safer Staffing Report

9.5. The Board received the Safer Staffing report; this would come forward to the Workforce & Organisational Development Sub-Committee upon establishment.

9.6. In presenting the report, she highlighted:

9.6.1. That staffing figures for School Nursing staff were planned to take account of school holidays; as such, the red flags were not considered to be a concern. Consideration would be given to ensuring this was better reflected in future reporting;
9.6.2. That the report only took account of nursing staff, and as such, whilst there may be gaps in terms of nursing workforce, the report did not take account of the contribution of other healthcare professionals to teams.

9.7. The Board noted this report.

10. **Annual Budget**

10.1. Paula Anderson presented the report, highlighting:

10.1.1. The proposed control total surplus figure of £3.4m, which took account of the receipt of £4.1m Sustainability & Transformation Funding;

10.1.2. The outline of the approach to determining the budget;

10.1.3. The intention to review corporate teams further in 2018/19, with a £1m savings aligned to take account of the reduction in services;

10.1.4. Application of a 3% savings target for divisions, of which 2% was determined nationally, and 1% generated a contribution to reserves;

10.1.5. That central budgets had been reviewed and, where possible, had been released and allocated to service delivery areas to best align income and budget;

10.1.6. The agency cap for 18/19 was further reduced. The profiling of performance through the year was profiled to be realistic and achievable;

10.1.7. The inclusion of the assumption that the CAMHS business case is approved by the Board;

10.2. The assumptions had been reviewed by both the Senior Management Committee and the Service Performance & Transformation Committee.

10.3. David Kelham provided feedback on the presentation of the report, so as to enable better interpretation of the relative performance position. He also advocated a zero-based budgeting approach be adopted for Corporate and Estates services, with a view to seeking to bring down expenditure over a planned period.

10.4. The reliance on non-recurrent Cost Improvement Plans in 2017/18 was noted; Paula Anderson acknowledged this, noting the internal rigour on Cost Improvement Plan identification and impact assessment process for 2018/19. This remained an area of risk for 2018/19.

10.5. The Board accepted the Trust’s revised control total surplus of £3.4m for the final plan submission to NHS Improvement and approved the Trust’s revenue and capital budgets for 2018/19.

11. **Quality Account Priorities**

11.1. Julie Dawes presented the Quality Account priorities for 2018/19 for approval by the Board. She highlighted the consultation and engagement undertaken to inform these priorities, including oversight via the Quality & Safety Committee in March and engagement with the Council of Governors.
11.2. David Kelham sought assurance that there were measures underpinning each of these; this was confirmed.

11.3. David Monk recognised the engagement undertaken in the development of the priorities, and suggested that this could be strengthened even further for 2018/19.

11.4. Board members discussed the priority under the “Improving Patient Safety” domain that related to a commitment to reduce suicide; it was suggested that the Board seek to sign up to the Campaign Against Living Miserably, which had recently been launched, alongside the existing organisational commitment to the Zero Suicide Alliance. Dr Nick Broughton noted that he had recently attended the Health & Wellbeing Board, and had strongly challenged the extent of the ambition, suggesting that the aspiration should be to achieve beyond the 10% reduction in suicide rate set out in the Five Year Forward View for Mental Health.

Action: Acting Associate Director of Communications to look into the process for the Trust to sign up to the Campaign Against Living Miserably (relating to reduction in male suicide)

Date: 05.06.2018

11.5. The Board approved the priorities for improvement as outlined within the report and supported the continuing engagement with staff in the development of the priorities for 2018/19.

12. Staff Survey

12.1. Paul Draycott provided a presentation on the staff survey, to accompany the report provided to Board members. He reminded Board members of the national context to the survey, noting that there was a direct correlation between staff engagement and the outcome for people who use our services. He highlighted:

12.1.1. The Trust’s response rate was 36%; this was down slightly on the response rate of 37% from the previous year. This was considered to be a proxy for staff engagement, and an aspirational target for a 60% response rate was suggested;

12.1.2. The Trust’s performance for the 2017 survey showed five areas of statistically significant improvements, and one area of statistically significant deterioration;

12.1.3. Benchmarked performance compared to other similar organisations showed that the Trust performed better than average in six areas, in line with average in 16 areas, and below average in 10 areas;

12.1.4. The Trust had maintained the overall staff engagement score, which was favourable compared to the general performance trend across the sector;

12.1.5. In terms of next steps, the intention to undertake a more in depth analysis by different groups, to help inform and develop the Trust’s action plans, was noted. This included BME staff; staff with a disability; and staff groups with a lower response, including medical, admin & clerical and maintenance staff.
12.2. In discussion of the findings, the following points were noted:

12.2.1. The opportunity to use the QI programme to address specific areas of deterioration;
12.2.2. That generally this showed an improving performance trajectory;
12.2.3. The Board supported the agreement of an aspirational target of 66% response rate for 2018;
12.2.4. The need for better insight as to where actions taken have had a positive impact.

12.3. It was agreed that future reporting and oversight would be via the Workforce & Organisational Development Sub-Committee, pending its establishment.

13. Board Assurance Framework

13.1. Paul Streat presented the report, highlighting:

13.1.1. The framework had been reviewed at respective Committee meetings through March. The review process had supported the need for a comprehensive review; this would take place via a facilitated Board seminar session in May;
13.1.2. There had been generally good progress in putting controls in place to manage the identified risks;
13.1.3. The need to take account of the significant progress with the Workforce & Organisational Development strategy as an assurance within the framework;
13.1.4. The importance of consistency with other reporting frameworks, such as that for the Integrated Performance Report. A data quality process was being instigated to address any discrepancies and variances.

13.2. In discussion of the report, the following points were raised:

13.2.1. The current framework was not easily accessible, and there were some inconsistencies in terms of presentation. Where there were incomplete actions, it was suggested that a further narrative be provided;
13.2.2. Where “leads” were identified, these should be by identification of the office, rather than a named officer;
13.2.3. To improve the correlation between the Board agenda and the Board Assurance Framework, work was underway to revise the Board cover sheet to cross-refer to the Board Assurance Framework risks.

13.3. It was agreed that the Director of Nursing & Allied Health Professionals would take forward the feedback on the Board Assurance Framework.

**Action:** Director of Nursing & Allied Health Professionals to take forward feedback on Board Assurance Framework

**Date:** 08.05.2018
14. Risk Report

14.1. Julie Dawes presented the report; highlighting the key operational risks scored at fifteen or above on the risk register. The highest operational risks related to the achievement of Cost Improvement Plans for 2018/19, workforce, and out of area bed usage. The risk relating to the removal of anti-tamper screws at Bluebird House had reduced, following the implementation of mitigating actions.

14.2. The Board noted this report.

15. Risk Appetite Statement and Risk Management Policy

15.1. The Board considered and supported the proposal to extend the risk appetite statement for three months, to take account of the planned Board seminar on risk that was scheduled for early May.

16. Fit and Proper Persons Requirement Policy

16.1. Anna Williams presented the report, highlighting the changes as shown within the Policy.

16.2. It was noted that the dates on the front page of the policy needed to be updated, and that reference should be made to post-holders, as opposed to individuals. Subject to these comments, the Board approved the policy.

17. Corporate Governance Report

17.1. Anna Williams presented the report. In consideration of the report, Board members:

17.1.1. Supported the draft agenda framework for the Trust Board, with a request that further consideration be given as to greater visibility on the Trust’s application of the Mental Health Act, whether as part of an Annual Report, or routinely via the Medical Director’s report to Board;

17.1.2. Approved the proposed amendments to the Terms of Reference for the Mental Health Legislation Sub-Committee and Senior Management Committee;

17.1.3. Approved the establishment of the Workforce & Organisational Development Sub-Committee and the Terms of Reference thereof;

17.1.4. Approved the adoption of the Code of Conduct of Directors and Code of Conduct for Governors without any amendments.

18. Reporting from Board Committees

18.1. The Board noted the report and the minutes from the Committees.

18.2. David Kelham reported on the recent Audit, Risk & Assurance Committee; highlighting:

18.2.1. The need for Executive review of the draft Internal Audit plan prior to sign off by the Committee;
18.2.2. The year-end work by External Audit was on track;

18.2.3. The Trust’s consideration of the Going Concern statement took account of the likely fine. On this basis, the Committee recommended to the Board the following statement: “Based on these assessments the directors have a reasonable expectation that Southern Health NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the ‘going concern’ basis in preparing the accounts.” This was approved by the Board.

18.3. Jeni Bremner reported on the work of the Service Performance & Transformation Committee, noting that the Committee had met twice in March; the first meeting had focussed on the draft Workforce & Organisational Development Strategy, which was the subject of the focussed Board meeting in April. At the meeting the previous day, consideration had been given to the Outline Business Case for the CAMHS service, and the Business Plan, both of which would be considered by the Board in the confidential session. Additionally, support had been given in principle to the refocussing of the meeting and the establishment as Finance & Performance Committee; the Terms of Reference would come forward to the Board in due course for approval.

19. Any Other Urgent Business

19.1. There was no other business reported.

20. Questions from the public

20.1. Scottie Gregory congratulated Jeni Bremner on her chairing of the meeting, and commended the positive challenge from the Non-Executive Directors. In terms of the recent sentencing decision following the prosecution by the Health & Safety Executive, Scottie Gregory acknowledged the new leadership in place within the Trust and suggested that this should be recognised and support given to the Trust.

20.2. Andrew Jackman endorsed Scottie Gregory’s comments. He noted his support for the Board’s articulation of an ambitious target for the staff survey engagement.

20.3. Jeni Bremner noted that a statement had been received the day before from Geoff Hill; she confirmed that Geoff would be meeting with the Chair and Chief Executive in the coming weeks, which would provide an opportunity for these issues to be picked up.

21. Review of meeting

21.1. Jeni Bremner invited comments from Board members, and members of the public in attendance, on the meeting. Points made were as follows:

21.1.1. The improvements made seemed positive, and the discussions had demonstrated openness;
21.1.2. That more assurance work should be done outside of the Board, to enable an increased focus on strategy at Board meetings;

21.1.3. The need for a patient and / or staff story to be included;

21.1.4. The need to continue to improve reporting, including the avoidance of the use of acronyms and abbreviations within reports and presentations;

21.1.5. The opportunity for meetings to be more forward-looking, with better horizon-scanning of the external environment and impact thereof.

22. Close

22.1. Jeni Bremner thanked Board members for their attendance and closed the meeting at 13:30.

Certified as a true record of the meeting

Chair – Lynne Hunt

Date
Trust Board  
27 March 2018  
Questions from the public

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<tr>
<th>Date received</th>
<th>6 March 2018</th>
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<tbody>
<tr>
<td>Enquirer</td>
<td>Richard West</td>
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</table>

The number of prescriptions issued by Southern Health for the medication Sodium Valproate for each of the years since the Trust was established please and if possible do you know the number of patients you have prescribed this medication to, broken down between the number of men and women for each year?

Trust Response  
Sarah Constantine

The question is best answered in sections:

a) The number of prescriptions issued by Southern Health for the medication Sodium Valproate for each of the years since the Trust was established?

Southern Health obtains medicines for its patients via several different sources:

i. dispensed by other NHS hospital trusts contracted to Southern Health (Solent, PHT, UHS and HHFT)

ii. our in-house pharmacy at Lymington hospital (for Lymington hospital patients)

iii. FP10 prescriptions (similar to GP-issued prescriptions) that patients take to their local community pharmacy to get dispensed

iv. Referral letters back to patient’s GP, advising of medication to be prescribed.

Due to the multiple sources, there is no central database of prescriptions issues for SHFT patients. We could obtain some information from the sources above but this would be incomplete and not give information about the number of individual patients. Letters to GPs are held in individual patient clinical records and cannot be searched electronically. Therefore, I am not able to provide a detailed response on this.

b) The split of valproate prescribing between men and women?

For the same reasons in part a), we cannot answer this question; the data isn’t held in any record other than individual patient clinical records.
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<tr>
<th>Date received</th>
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Can the Trust confirm how many section 28 notices have Southern Health received since it was incepted.

Can the Trust confirm how many Action Plans it has put before Coroners when patients have died since the Trust was incepted.

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<tr>
<th>Trust Response</th>
<th>Julie Dawes</th>
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In relation to details of all Regulation 28 and 29 reports since the Trust was established, there have been four cases of Regulation 28/29 reports, and one of Rule 43 reports which preceded the current regulations for coroners (for information Rule 43 reports were not public documents, and were simply summarised in a report published by the Ministry of Justice).

In terms of action plans being put before Coroners; since the publication of the Mazars report, all Serious Incident reports / Root Cause Analysis reports have been shared with the Coroner where an inquest is taking place after the conclusion of a Serious Incident investigation. In some instances draft copies are shared prior to completion of the report. In each case where learning is identified the Serious Incident / Root Cause Analysis will have an action plan which will also be shared.
Minutes of the Trust Board
Tuesday 17 April 2018
14:00 – 16:00
The Ark Conference Centre, Dinwoodie Drive, Basingstoke, RG24 9NN

Members:
Lynne Hunt  Chair
Dr Nick Broughton  Chief Executive
Paula Anderson  Director of Finance
Jeni Bremner  Non-Executive Director and Deputy Chair
Julie Dawes  Director of Nursing & Allied Health Professionals
Dr David Hicks  Non-Executive Director
David Kelham  Non-Executive Director
Dr Karl Marlowe  Medical Director
David Monk  Non-Executive Director

In Attendance:
Paul Draycott  Director of Workforce, Organisational Development & Communications
Paula Hull  Acting Director of Integrated Services
Mark Morgan  Director of Operations (Mental Health & Learning Disabilities
Anna Williams  Company Secretary & Head of Corporate Governance

Present:
Peter Bell  Public Governor
Alia Gomez  Staff Governor
Scottie Gregory  Member
Ian Hartley  Member
Jane Hartley  Member
Geoff Hill  Member of Public
Andrew Jackman  Public Governor
David Lee  Public Governor
Venus Madden  Public Governor
Margaret Martins  Staff Governor
Josie Metcher  Public Governor
Arthur Monks  Public Governor
Andy Scorer  Member
Susie Scorer  Public Governor
Sue Smith  Public Governor
Sarah Spooner  Member of Staff
Adrian Thorne  Appointed Governor
Tom Westbury  Acting Associate Director of Communications

1. Chair’s Welcome and Meeting Protocol
1.1. Lynne Hunt welcomed members to the meeting, which she opened at 14:00.
1.2. She outlined the decision by the Board to hold up to four additional meetings a year with an in depth focus on different strands of strategy.

1.3. She welcomed Dr Karl Marlowe to his first meeting since joining the Board as Medical Director.

2. Apologies for Absence
2.1. There were no apologies received.

3. Declarations of Interest
3.1. The Register of Interests was noted; with updates acknowledged in relation to Dr David Hicks, David Monk and Dr Karl Marlowe.

3.2. Consideration was given as to whether the role of Mental Health Act Review Managers should be declared by Non-Executive Directors.

3.3. There were no declarations of interest relating to items on the agenda.

4. Workforce Strategy
4.1. Dr Nick Broughton opened the discussion, acknowledging the importance of the strategy, in the context of:

4.1.1. The workforce being the largest asset for the Trust;

4.1.2. The highest organisational risk related to recruitment and retention of staff, which was a common theme across the NHS. This was particularly significant in some specialties, and was further compounded due to the organisations history.

4.1.3. Some positive developments had been reported on the recent staff survey;

4.1.4. A commitment to optimise opportunities for the workforce, given evidence that there is a clear correlation between staff satisfaction and improved patient care;

4.1.5. This was a key strategy to the delivery of the overarching transformation programme;

4.1.6. A need to improve areas relating to wellbeing, such as in relation to work-related stress, physical violence and bullying at work.

4.2. The strategy had undergone a number of iterations prior to coming to the Board for discussion and further comment; there had been extensive engagement sought to inform the development to date, including with staff side via the Joint Consultation & Negotiating Committee and with the Council of Governors.

4.3. It was intended that the newly established Workforce & Organisational Development Sub-Committee would monitor and oversee the delivery of the strategy on behalf of the Board.

4.4. Jeni Bremner confirmed that this was the fourth iteration of the strategy document; this had been considered by the Service Performance & Transformation
Committee on three occasions. This version was considered to be a significant improvement.

4.5. Paul Draycott provided an overview of the strategy, highlighting the key themes identified within the strategy, namely:

4.5.1. Collective leadership, devolution and engagement;
4.5.2. Well-being, inclusion and diversity;
4.5.3. Learning, education and research;
4.5.4. Workforce development;
4.5.5. Partnership and system working;
4.5.6. Attracting and retaining people to pursue a relentless focus on improving and providing quality services to enable people to reach their full potential (patients and staff).

4.6. Lynne Hunt invited comments from Board members.

4.7. In discussion, the following points were raised:

4.7.1. There was consensus that the strategy had made significant progress since the initial draft, and that generally this was seen to be ambitious. In terms of the format and style, it was suggested that this was a good model for other corporate strategies to adopt;

4.7.2. There was challenge as to whether the identified actions were sufficiently tangible, or whether further description as to how the end state would be achieved needed to be described;

4.7.3. The need for the strategy to be underpinned by a comprehensive workforce plan that described how the Trust would deliver the strategy, recognising the ambitious nature of this;

4.7.4. The need to ensure that the strategy was aligned with the draft national workforce strategy released by Health Education England that set out the need for service, financial and workforce planning to be intertwined;

4.7.5. In terms of the shape of the future workforce, the importance of ensuring that there was an appropriate balance between front-line staff and support services;

4.7.6. A recognition for the importance of both “quality assurance” and “quality improvement”, and that both had their place in a successful organisation;

4.7.7. The need for further explanation on some of the proposed initiatives;

4.7.8. Whether the Trust should consider undertaking a culture audit. Paul Draycott noted that the intention for this to be done on a quarterly basis; this was included in the detailed programme of work that underpinned the strategy delivery;

4.7.9. The opportunity to emphasise the Trust’s commitment to continual professional development as a key mechanism for staff recruitment and retention;
4.7.10. The need to adequately describe what a “first-class employer” was, and how the Trust would achieve this;

4.7.11. The need to identify where identified actions have either costs attached, or will generate savings. The need for clarity on any required financial commitment to support the strategy was necessary;

4.7.12. An opportunity for a closer relationship with the Trust’s Research strategy was noted;

4.7.13. The need to ensure that the strategy reflected the intention for the organisation to become “clinically-led and managerially enabled” could be further emphasised;

4.7.14. That consideration be given to recognising the importance of health and safety as part of the wellbeing agenda, namely that sufficient credence be given to ensuring that the organisation is a safe place for people to work and provide care;

4.7.15. The need for some bullet points to become sharper and more action focussed;

4.7.16. That the description of the relationship between clinicians and service users reflected the move towards a greater balance of power;

4.7.17. There was an opportunity to articulate how the Trust would work alongside and support and empower patients; this was considered to be simultaneously empowering for both patients and staff;

4.7.18. Whether some areas within the strategy could be more ambitious, in terms of the identified targets. Specifically, there was challenge from Board members as to whether the identified vacancy rate target could be stretched further;

4.7.19. The opportunity to work with partners to find creative solutions, such as in relation to the provision of accommodation was supported;

4.7.20. Whether the strategy could be further contextualised via the inclusion of an expected demand profile;

4.7.21. Whether there was adequate understanding of the factors that would attract and motivate the future workforce, with opportunities such as flexible working, and opportunities for travel cited.

4.7.22. The need to undertake a “market segmentation” to understand the key drivers on a service by service basis.

5. Invitation for public questions on Workforce Strategy

5.1. Lynne Hunt invited questions and comments from members of the public and Governors on the draft strategy.

5.2. Venus Madden commended the work on the strategy. She suggested that whilst there was lots of attention on recruitment, that there could be more focus on existing staff, in terms of actions taken to retain, motivate and develop. She suggested in particular that there needed to be greater attention on actions taken to retain staff within the 30-50 year age bracket.
5.3. Scottie Gregory suggested that there needed to be greater focus on ensuring that the Trust sought to recruit, retain and develop a workforce that was valued, supported, motivated, kind and caring, above the descriptors set out in the bullet points within the report.

5.4. Alia Gomez also confirmed her support for the strategy, but echoed comments from Venus Madden, namely the need to ensure that the focus on the drive to recruit staff did not alienate staff who had remained committed to the Trust. She asked that the recruitment initiatives be balanced with ensuring that the loyalty and commitment of existing staff was recognised to support retention. Paul Draycott agreed, noting that the aspiration was for the Trust to become a desirable place to work, which would mean that there would be less need to focus proactively on recruitment.

5.5. Adrian Thorne commended the strategy, recognising that this had developed significantly since Paul’s appointment. He echoed comments from Paula Anderson and Dr Karl Marlowe in relation to the need to ensure that there were adequate resources in place to support the Trust’s transformation agenda.

5.6. Geoff Hill suggested that in terms of accommodation for staff, whilst there was a covenant on the land at the Tatchbury Mount site, the Trust could seek to appeal this.

5.7. Peter Bell commented on the poor access to the Tatchbury Mount site, and in particular the cost to get to work for staff who worked there. He also commented on the absence of voluntary workers being included in the strategy, and of any reference to Governors.

5.8. Commenting on the typical profile of Learning Disabilities nurses, Margaret Martins suggested that the strategy should look at segmentation, to take account of the profiles of different staff groups. She supported the suggestion of job carving, but noted that from experience this took some time to work through the process; it was important to look at how this was valued and understood. Lynne Hunt noted the importance of encouraging lived experience as a positive contribution to the Trust’s workforce.

5.9. Adrian Thorne urged the Trust to engage with Housing Authorities in relation to the housing issues identified within the strategy.

5.10. Geoff Hill challenged the figure of 25% quoted in the strategy as staff recognised as delivering compassionate services; Paul Draycott confirmed that this was based on the experience of the Recognition of compassion scheme that had been implemented elsewhere in the NHS.

5.11. Andy Scorer asked whether the Trust understood why there was a poor level of engagement in the staff survey. Paul Draycott noted that whilst the Trust was not sure on the drivers, this was generally considered to be a proxy measure for engagement within the organisation. Dr Nick Broughton commented that anecdotally there was apathy linked to people not seeing action in response to results; the Trust was focussing on ensuring messages of “You said, We did” were cascaded to staff. Andy Scorer suggested that the Trust needed to think how to reach staff who were not engaged, including better understanding the reasons for this.

5.12. Alia Gomez asked that consideration be given to what actions could be taken by the Trust to improve the health and wellbeing of staff.
6. **Board decision on next steps**

6.1. Paul Draycott thanked Board colleagues and members of the public for their input and contributions, noting that this would lead to a far richer, more ambitious, but more importantly, owned and deliverable strategy.

6.2. Jeni Bremner observed that the comments provided had been helpful; delivery of the strategy would be monitored and supported through the Workforce & Organisational Development Sub-Committee. The importance of appropriate investment and a robust underpinning workforce plan were agreed.

6.3. It was agreed that an updated version of the strategy be submitted to the Service Performance & Transformation Committee on 15.05.2018, and the final version to the Board for approval in June.

6.4. Thanks were given to Paul Draycott for the significant contribution provided to date in the development of this work.

7. **Any Other Urgent Business**

7.1. There was no other business reported.

8. **Review of Meeting**

8.1. In consideration of the meeting, the following comments were made:

8.1.1. The need to include a patient or staff story on the agenda;

8.1.2. The opportunity to encourage greater attendance from staff to attend meetings via improved publicity of these;

8.1.3. The desire to hear stories from staff on local quality improvement initiatives.

9. **Close**

9.1. Lynne Hunt thanked Board members for their attendance and closed the meeting at 15:55.

Certified as a true record of the meeting

Chair – Lynne Hunt

Date
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
<th>Action Ref</th>
<th>Action</th>
<th>Lead</th>
<th>Report to</th>
<th>Target Closure Date</th>
<th>Current Position</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Board</td>
<td>30/01/2018</td>
<td>8.1</td>
<td>Company Secretary to schedule R&amp;D Annual Report for Board</td>
<td>CoSec</td>
<td>Trust Board</td>
<td>27/02/2018</td>
<td>R&amp;D Annual report added to agenda framework - timing to be confirmed TB 27.03.18 - Research &amp; Development Annual Report to be considered via Committee (TBC) prior to presentation to the Board.</td>
<td>In progress</td>
</tr>
<tr>
<td>Trust Board</td>
<td>30/01/2018</td>
<td>16.4</td>
<td>Director of Nursing to confirm that a review had been undertaken in terms of access to the Ulysses system</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Trust Board</td>
<td>27/02/2018</td>
<td>A review had been undertaken in terms of access to the Ulysses system, and a report provided to the Audit, Risk &amp; Assurance Committee. It was agreed that this action remain open until satisfactory assurance be provided that broader system access weaknesses had been resolved. Report considered by SMC in April - with actions agreed for monitoring. Assurance was provided that the identified weaknesses in relation to access to the whistleblowing module had been addressed. A progress report would be provided to SMC in June, and to Audit, Risk &amp; Assurance Committee in July.</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>Trust Board</td>
<td>30/01/2018</td>
<td>20.4</td>
<td>Company Secretary to liaise with Charitable Funds Committee Chair regarding training in relation to corporate trustee responsibilities</td>
<td>CoSec</td>
<td>Trust Board</td>
<td>31/03/2018</td>
<td>Added to forward schedule for Board development.</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/02/2018</td>
<td>4.6</td>
<td>Director of Operations (Mental Health &amp; Learning Disabilities) to provide a progress update on the review of the Trust's engagement and observation policy</td>
<td>Dir. Ops (MH &amp; LD)</td>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>TB 27.03.2018 - The policy review was being led by the SAFER Forum, with particular consideration being given to the use of passive and remote processes to undertake observations. A report would be provided back within two months.</td>
<td>In progress</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/02/2018</td>
<td>8.9</td>
<td>Director of Nursing &amp; Allied Health Professionals to circulate CQC service reports to Board members</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>Outstanding report relating to MHA Inspection of Daedalus ward circulated to Board members</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>5.5</td>
<td>Acting Medical Director to provide a paper for Board discussion relating to the use of key terminology</td>
<td>Acting MD</td>
<td>Trust Board</td>
<td>TBC</td>
<td>Update to be provided.</td>
<td>In progress</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>7.3</td>
<td>Board seminar on STP to be scheduled</td>
<td>CoSec</td>
<td>Trust Board</td>
<td>05/06/2018</td>
<td>Added to the forward schedule for a Board Seminar Session; contact made with Richard Samuel with an invitation to attend.</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>8.1.1</td>
<td>Finance Director to write to NHS Improvement regarding the impact of the fine on the Trust's achievement of Sustainability &amp; Transformation Funding</td>
<td>Finance Director</td>
<td>Trust Board</td>
<td>31/03/2018</td>
<td>Letter sent to NHS Improvement on behalf of the Trust</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>9.3(a)</td>
<td>Director of Corporate Governance to amend narrative within Integrated Performance Report relating to risk assessment compliance to reflect discussions at Board</td>
<td>Dir. Corp Gov</td>
<td>Trust Board</td>
<td>05/06/2018</td>
<td>Update to be provided.</td>
<td>In progress</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>9.3(b)</td>
<td>Director of Operations (Mental Health &amp; Learning Disabilities) and Acting Medical Director to discuss mental health risk assessment compliance with Clinical Directors and report any concerns to the Board, with scrutiny via the Quality &amp;Safety Committee</td>
<td>Dir. Ops (MH &amp; LD)</td>
<td>Trust Board</td>
<td>05/06/2018</td>
<td>Update to be provided.</td>
<td>In progress</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>11.4</td>
<td>Acting Associate Director of Communications to look into the process for the Trust to sign up to the Campaign Against Living Miserably (relating to reduction in male suicide)</td>
<td>AD Communications</td>
<td>Trust Board</td>
<td>05/06/2018</td>
<td>Update to be provided.</td>
<td>In progress</td>
</tr>
<tr>
<td>Trust Board</td>
<td>27/03/2018</td>
<td>13.3</td>
<td>Director of Nursing &amp; Allied Health Professionals to take forward feedback on Board Assurance Framework</td>
<td>Director of Nursing &amp; AHPs</td>
<td>Trust Board</td>
<td>08/05/2018</td>
<td>Board Assurance Framework updated following Board seminar session in May 2018; on agenda for TB 05.06.2018</td>
<td>Superseded</td>
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TB 05- Action Log
<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>7</td>
</tr>
<tr>
<td>Title</td>
<td>Chair’s Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Lynne Hunt, Chair</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Lynne Hunt, Chair</td>
</tr>
</tbody>
</table>

**Purpose & Action Required**
The Board is asked to note this report.

**Executive Director Overview**
To provide the Board with an update on the Chair’s activities since the last meeting and other areas of interest to bring to the attention of Board members.

**Previously considered by:**
This report has not previously been considered by another forum or committee.

**Strategic Priorities this paper supports:**

<table>
<thead>
<tr>
<th>Quality</th>
<th>Update on Board and Council of Governors’ activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>NED appraisal update</td>
</tr>
<tr>
<td></td>
<td>Board development</td>
</tr>
<tr>
<td>Transformation</td>
<td>Learning from serious incidents</td>
</tr>
<tr>
<td>Money</td>
<td></td>
</tr>
</tbody>
</table>

**Does this impact any Board Assurance Framework / Corporate Risks**
SR5: There is a risk that we have ineffective governance which prevents effective decision making.
1. **Purpose**

1.1. To provide the Board with an update on the Chair’s activities since the last meeting and other areas of interest I wish to bring to the attention of Board members.

2. **Board seminar**

2.1. Since the Board met at the end of March we have held two seminar sessions; the first of these, on 10.04.2018, provided the Board with an opportunity to receive a presentation from the clinical team on a report relating to the death of a patient in our care, and the associated learning and actions being taken in response to this. We also discussed the Trust’s response to the ongoing discussions with patient and family representatives and the articulation of the compelling case for change statement that will form the basis of the transformational work undertaken by the Trust. This has been included on the agenda for this meeting.

2.2. On 08.05.2018, the Board met again for a further seminar. At this session we were joined for the first part by NHS Improvement, as part of the ongoing support to the Trust in strengthening our governance arrangements. Associated reports are on the agenda for this meeting, including a revised Board Assurance Framework which takes account of new strategic risks identified by the Board. We also spent time as a Board getting an improved understanding of the governance arrangements in place within the Trust so that board was aware of the structures that sit below the board.

3. **Board meetings**

3.1. The first of the Board meetings with a focussed agenda on a single topic was held in March; there was excellent engagement and input from members of the public and governors in attendance to support the ongoing development of the Trust’s People & Organisational Development Strategy. It is expected that this will come forward to the Board in July for final sign-off, following a full consultation process.

3.2. The minutes from this session are enclosed with these papers; future meetings are being arranged where possible to coincide with key decision points by the Board.

4. **Board development**

4.1. In recognition of the introduction of a new leadership team over the last 12 months, we are seeking to support the Board in its ongoing development via a formal programme of support. In addition to the support provided by our regulator, we seek to commission a partner to provide support for a whole Board development programme. The first facilitated development session for Board members will be held on 13.06.2018.

5. **Council of Governors**

5.1. The Council of Governors met on 17.04.2018; at this meeting, a number of matters were raised by Governors that warranted further Executive consideration. Board oversight of these matters will be provided via the relevant Board Committees.

5.2. I am pleased to note that the Council of Governors supported the recommendation from the Appointment Committee to reappoint Jeni Bremner as a Non-Executive Director.
and as Deputy Chair on a three year term, from July 2018. I look forward to continuing to work with Jeni on the Board.

5.3. In line with the requirements of the NHS Foundation Trust Code of Governance, we are committed to working to support Governors to discharge their duties effectively and in discussion with the Lead Governor and Company Secretary I have agreed to work with the Council of Governors to introduce a process for collective review of effectiveness of the governing body. We will be seeking to undertake this work during summer 2018, to enable the output to be shared with members at the Annual Members’ Meeting in September.

5.4. On 01.05.2018, we held a Development Day for the Council of Governors; this was well attended and feedback has been extremely positive. Topics included the use and monitoring of risk assessments within the Trust, and the mechanisms for patient feedback (both in response to questions raised at recent Council of Governor meetings). We also received presentations on the Trust’s CQC readiness, and a training and information session on Mental Health legislation. We discussed the use of technology in supporting patients to stay well at home and also considered the use of technology on our inpatient wards to support patients in their recovery. Finally, Cllr Paul Lewzey, Sue Smith and Susie Scorer gave moving farewells to their Governor colleagues; most notably, for Sue and Susie, this marks the end of their third three-year term with the Trust, and I would like to personally thank them both for their contribution during this period.

6. Non-Executive Director appraisal process

6.1. Further to the update provided to the Board in March, the roll-out of Non-Executive Director appraisals has continued (including my own). As before, input has been sought invited from Executive Directors, Non-Executive Directors and Governors. Appraisal meetings are scheduled as set out below; the output from these will be reported to the Council of Governors:

- 6.1.1. David Kelham (undertaken by Lynne Hunt) – 29.05.2018
- 6.1.2. David Monk (undertaken by Lynne Hunt) – 05.06.2018
- 6.1.3. Lynne Hunt (undertaken by David Monk, with Andrew Jackman in attendance) – 05.06.2018

6.2. The appraisal for Dr David Hicks will be undertaken in November / December 2018.

7. Chair Activities

7.1. I continue to meet with staff and visit services across the Trust, as well as other external partners. A list of some of the key meetings I have attended in April and May is set out below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
</tr>
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<tbody>
<tr>
<td>03.04.2018</td>
<td>1:1 Exec Director Meeting with Strategic Business Partner – Workforce, regarding development peer support workers project Meetings with candidates for Chief Operating Officer role</td>
</tr>
<tr>
<td>05.04.2018</td>
<td>Meeting with Lead Governor and Associate Director of Communications regarding the Annual Report Discuss with Associate Director of Communications the use of patient stories at the board meeting Non- Executive Director Appraisal Meeting with new provider organisation regarding housing opportunities for people with complex mental health problems in Hampshire</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
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<td>------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| 09.04.2018 | Chief Operating Officer Interviews  
Meeting with NHS Improvement and  
Chief Executive to discuss governance  
arrangements  
Meeting with family regarding care of a service user |
| 10.04.2018 | Board Seminar  
Nominations & Remuneration Committee  
Meeting with Southampton City Council Councillors to discuss liaison between  
organisations  
Meeting with Chair and Chief Executive of Isle of Wight NHS Trust |
| 12.04.2018 | Meeting with Chief Executive and member of the public  
Meeting with Associate Director of Communications to discuss Compelling Case for Change |
| 16.04.2018 | Meeting in relation to HSE sentencing  
Families meeting |
| 17.04.2018 | Appointment Committee  
Council of Governors’ meeting  
Board meeting  
Non-Executive Director meeting |
| 19-20.04.2018 | HSJ Modernising Healthcare Summit |
| 23.04.2018 | 1:1 Governor  
Meeting with  
Chief Executive and National Mental Health Director, NHS England |
| 24.04.2018 | 1:1 Governors  
Site visit to Antelope House with Non-Executive Director |
| 25.04.2018 | Meeting with  
Chief Executive to discuss board development |
| 26.04.2018 | 1:1 Governors  
Meeting regarding Mental Health Service user involvement/engagement and  
employment strategy |
| 01.05.2018 | 1:1 Associate Director of Estates Services  
Non-Executive Director meeting  
Governor Development Day |
| 02.05.2018 | 1:1 Staff  
Meeting with member of public |
| 03.05.2018 | 1:1 Medical Director  
Meeting with Chair, Healthwatch Hampshire  
Member of public meeting |
| 04.05.2018 | Meeting with Chair Solent Mind discussion  
Discussions regarding Governor development programme with external  
facilitators |
| 08.05.2018 | Trust Board Seminar |
| 11.05.2018 | Meeting with Clinical Chair CCG  
Meeting with Non-Executive Director and Lead Governor  
Completed Executive Director appraisal |
| 15.05.2018 | Site visit – Willow Ward and Intensive Support Team, Moorgreen Hospital  
Meeting with member of staff to discuss career development and arranged day  
for shadowing |
| 17.05.2018 | Site visit – Alton Community Hospital |
| 18.05.2018 | 1:1 Chief Executive |
| 21.05.2018 | Presentation to CQC |
| 22.05.2018 | Audit, Risk & Assurance Committee |
| 24.05.2018 | Site visit to Thomas Lewis House  
Trust Board meeting  
Meeting with  
Chief Executive to review board packs  
Meeting to sign annual report and accounts |
| 25.05.2018 | Meeting with Chair Frimley Health NHS Foundation Trust |
| 29.05.2018 | Visit to Dorset Frimley Healthcare NHS Foundation Trust and meeting with Chair & |

180605 TB 07 Chair’s Report
8. **Recommendation**

8.1. The Board is asked to note this report.
### REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
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<tbody>
<tr>
<td>Agenda Item</td>
<td>8</td>
</tr>
<tr>
<td>Title</td>
<td>Chief Executive’s Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Dr Nick Broughton, Chief Executive</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Dr Nick Broughton, Chief Executive</td>
</tr>
</tbody>
</table>

**Purpose & Action Required**

This report provides information on a number of national and local topics that will be of interest to Board members. Members are asked to note the contents.

**Executive Director Overview**

This report highlights key areas for the attention of Board members; the Chief Executive will provide a further update on matters of interest at the Board meeting.

**Previously considered by:**

This report has not previously been considered by another forum or committee.

#### Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Quality</th>
<th>☒</th>
<th>CQC inspection update</th>
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<tbody>
<tr>
<td>People</td>
<td>☒</td>
<td>Changes to executive director team</td>
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<tr>
<td></td>
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<td>Executive team development</td>
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<tr>
<td>Transformation</td>
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<td>Digital innovation</td>
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<td>Money</td>
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<tr>
<td>Does this impact any Board Assurance Framework / Corporate Risks</td>
<td>N/A</td>
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</tbody>
</table>
CHIEF EXECUTIVE’S REPORT

1. Purpose
1.1. This report provides information on a number of national and local topics that will be of interest to Board members.

2. Report

2.1. Care Quality Commission

2.1.1. We have now received confirmation from the Care Quality Commission that its inspection of the Trust will take place on the following dates:

- W/C 21 May – Community health core services inspection
- W/C 11 June – Mental health core services inspection
- W/C 18 June – Mental health core services inspection.
- 3 - 5 July – Well-led review

2.1.2. In light of the fact that this will be a large inspection, a planning afternoon is scheduled to take place on 21 May for community services and on 11 June for mental health and learning disabilities services when I have been asked to provide an overview of the Trust and its achievements.

2.1.3. We obviously look forward to welcoming colleagues from the Care Quality Commission during the weeks ahead.

2.2. Executive Team Development

2.2.1. A facilitated away day for the Executive Team took place on Tuesday 1 May 2018. This was attended by Barry Day, the Trust’s Chief Operating Officer designate. It provided a valuable opportunity to consider the way in which the Executive Team can work more effectively and also allowed for a review and revision of Executive portfolios. A further away day is planned for late October.

2.3. Director of Operations for Mental Health and Learning Disabilities

2.3.1. Mark Morgan left the Trust on Friday 18 May 2018. I therefore would like to again formally thank Mark for his considerable contribution to Southern Health during the period he was with us. Debbie Robinson has been appointed as the Interim Director of Operations for Mental Health and Learning Disabilities initially for a four month period. I would like to welcome Debbie to both the Executive Team and the Trust Board.

2.4. Chief Operating Officer

2.4.1. Barry Day will be joining the organisation on a permanent basis as of 9 July 2018, prior to this he hopes to be able to attend a number of key meetings including the next Senior Leaders Away Day which is scheduled to take place on 28 June 2018. A copy of the draft agenda is appended to this report. Once more Non Executive and Governors are extremely welcome to attend the event.
2.5. Future Plans for Secure Mental Health and Learning Disabilities Services

2.5.1. During the evening of Wednesday 9 May 2018 I chaired a public meeting at Tatchbury Mount regarding the Trust’s plans to develop a new Low Secure Unit for Children and Adolescents and build a new Low Secure Unit for Adults with Learning Disabilities on the site.

2.5.2. The meeting was well attended and demonstrated broad support for the proposals as they stand. It is clearly extremely important that all our key stakeholders are now kept fully informed regarding developments and therefore further public meetings will be scheduled for later in the year. A copy of the PowerPoint presentation given at the meeting is appended to this report.

2.6. Technology

2.6.1. The two pilots currently underway to evaluate if there are clinical and efficiency benefits if community nursing teams are on the community version of the Electronic Patient Record system used by the patients GP, are progressing well and initial evaluation looks positive. CCG funding is being sought to continue the pilots for a further year.

2.6.2. The Trust has to comply with an NHS England target to have all clinical correspondence for GP’s being sent electronically by October 2018. The project to achieve the deadline is making good progress and is expected to deliver on time and within budget.

2.6.3. Text Messaging / appointment reminders directly from RiO is being implemented and will be available for use by clinical teams as from the end of May.

2.6.4. All NHS trusts have to move off the N3 network onto the new HSCN network, this change is significant for Southern Health as it has an extensive network. The procurement process is underway and the Trust is working as part of a collaborative with Trusts across Hampshire, Dorset and Wiltshire so as to gain best price. The move to the HSCN network should see Southern Health making significant savings on its network costs.

2.6.5. Following the Trusts successful bid against NHS Digital’s end of year ‘Cyber Security’ fund significant work is underway to further strengthen the Trusts Technology security.

2.6.6. Technology have passed stage 1 of the ISO 9000 (Quality Management) audit and are hoping to achieve full accreditation this year.

2.6.7. Lesley Barrington has been appointed interim Data Protection officer for the Trusts

2.6.8. Work is underway to ensure that the Trust is ready to meet the General Data Protection Regulation (GDPR) implementation requirement by May 2018. The Trusts auditors have carried out a readiness review and the initial de-brief was positive, and no “major” issues were identified, the final report is awaited.

2.7. Information Team

2.7.1. The Information Team’s priority at present is to enhance the performance analytics available across the Trust to ensure it is possible to triangulate performance at a team level across all of the CQC domains and key lines of enquiries. Significant progress has been achieved during April and May and
team level triangulation hotspot views are now available for all core service lines.

2.7.2. The function continues to be under severe resourcing challenges and will be going through a period of, sustained, high turnover over the forthcoming months as a number of current post holders are due to leave in July due to new roles external to the Trust. Recruitment has been very successful in replacing these individuals however the new staff will take time to start with the Trust and as such resource pressures are expected to remain until Q3 18/19. All risks associated with this are being proactively managed.

2.7.3. A challenge remains in terms of the completion of the Trust’s diagnosis for finished consultant episode inpatient stays. The Trust recently outsourced the Clinical Coding function to achieve a more sustainable model; the outsourcing has progressed well however there remains 1 issue where by coding cannot be completed for Lymington Hospital due to IT connectivity to the UHS patient system. It is hoped this will be resolved during June 2018; after which time the Trust’s outsourcing partners will have a 3 month coding backlog to clear.

2.8. Site Visits

2.8.1. Since joining the Trust last November visiting the Trusts services has been a key priority for me. To date I have been able to visit the following services and sites on at last one occasion:
Southfield
Antelope
Woodhaven
Bluebird
Cannon House
Petersfield Hospital
Fareham Community Hospital
April House
Lymington Hospital
Parklands Hospital
Psych Liaison at UHS
Research and Development Team at Moorgreen
Willow Ward at Moorgreen
Community Mental Health Team at Moorgreen
Chase Hospital
Melbury Lodge
Aerodrome
ECT Antelope
Autism Service at Thomas Lewis House
Ravenswood
Alton Community Hospital
Willow Group, SDAD, Accelerator Teams (Gosport )

2.8.2. Further visits are planned during the weeks and months ahead. In addition to this, and in an effort to provide more accessible leadership to colleagues across the organisation I have recently introduced a CEO drop in clinic. The
first such clinic took place on Monday 30 April 2018 and further clinics are scheduled to take place on:

- 29 May 2018
- 11 June 2018
- 5 July 2018
- 7 August 2018
- 17 September 2018
- 15 October 2018
- 12 November 2018
- 10 December 2018

2.9. Joint Innovation Event

2.9.1. On Friday 4 May 2018 I, along with a number of senior colleagues from the Trust, attended a Joint Innovation Event co-hosted by the South East Mental Health CEO group and the Care Quality Commission. This was the second such event to take place. The focus of the day was how digital innovation can be used to improve quality in mental health provider organisations. The event included presentations from all the Mental Health Trusts in the South East. Our own presentation was delivered by Lisa Franklin in her capacity as Director of Information & Technology and Chief Information Officer and this focused on the Trusts recent “Digital Journey”.

2.9.2. The event proved to be extremely stimulating and I anticipate going forward we will be able to replicate some of the innovations that are currently in train in neighbouring Trusts particularly those involving telehealth and mobile working.

2.10. Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) Executive Delivery Group

2.10.1. On 14 and 15 May I attended a two day workshop along with other members of the STP Executive Delivery Group. The purpose of this was to agree and develop a set of system reform proposals for consideration by the STP’s wider stakeholders. The event also proved to be a valuable opportunity to further build trust and relationships within the Executive Delivery Group and agree ways of more effective collaborative working.

2.11. Mental Health Sustainability and Transformation Programme Board

2.11.1. I have continued to chair the programme board and am pleased to report that Dr Karl Marlowe in his capacity as the Trust’s Medical Director is now a member of this.

2.12. Latest developments in the Mental Health Programme of the STP

2.12.1. We were pleased to host a visit by Claire Murdoch, NHSE Director of Mental Health, to Hampshire and the Isle of Wight on 24 April. This was an opportunity to share the positive system-wide work that has been achieved so far. She constructively challenged us about our 2018/19 plans to deliver the Five Year Forward View for Mental Health investment standard and to ensure this investment reaches front line mental health services.
2.12.2. We have adopted the commissioning standards developed by the London Strategic Clinical Network, which mirror the national Crisis Concordat approach.

2.12.3. The system-wide crisis pathway developments are progressing, including:

- Exploring the use of the Care and Health Information exchange (CHIE) to support the crisis pathway.
- Development of a Mental Health Nurse in NHS 111 business case
- Drafting of an Information Agreement for Hampshire CAMHs services to access Care Notes in the NHS 111 Call Centre for the Mental Health nurses.
- Review of the section 136 monitoring form in order to address inconsistencies and gaps in S136 data reporting
- A new Secure Transport contract came into effect on the 1st April 2018.

2.13. **NHS 70th Birthday**

2.13.1. I will be attending a service to celebrate the 70th anniversary of the creation of the National Health Service on Thursday 5 July 2018 at Westminster Abbey. I will be joined at the service by Jane Williams, Deputy Director for Transformation and Jan Berry, School Nurse. My two colleagues were selected from a list of colleagues nominated for the annual Star Awards and monthly Southern Star awards.

2.14. **Recent Reports on Mental Health and Learning Disabilities Provision**

2.14.1. Since our last Board meeting three significant reports focusing on Mental Health and Learning Disabilities have been published. These are the:

- Government’s Green Paper on mental health: Failing a Generation, a joint report by the Health and Social Care Select Committee and the Education Select Committee.
- The interim report of the independent review of the Mental Health Act. This review is being chaired by Professor Simon Wesley, previously President of the Royal College of Psychiatrists and has been commissioned by the Department of Health and Social Care.

2.14.2. The relevant governance committees within the Trust have been asked to consider the content and findings of these reports. Considerable work has already been completed in relation to the recommendations contained within the aforementioned LeDeR report, particularly across the Trust’s Learning Disability services. There are however areas where further work is required and as such an action plan is currently being produced which will be monitored by the Trust’s Senior Management Committee.

2.15. **Recommendation**

2.15.1. The Board is asked to note the contents of this report.
2.16. **Appendices**

2.16.1. Appendix A  Presentation from event on 9 May 2018

2.16.2. Appendix B  Draft agenda for Senior Leaders Away Day 28 June 2018
Future plans
to develop our Secure Forensic Mental Health and Learning Disabilities Services
What are our plans?

We will provide a 14 bed adolescent low secure hospital on the Tatchbury Mount site for young people.

We will build a brand new purpose built 10 bed low secure residential unit for adults with learning disabilities on the Tatchbury Mount site.
Woodhaven is currently an Adult Forensic Low Secure Hospital for people with learning disabilities based on the Tatchbury Mount site in Totton.

Ashford ward

OUR VALUES

Patients & people first   Partnership   Respect
Plans for Woodhaven

Woodhaven (currently a Low Secure Hospital for adults with a learning disability) will be redesigned to become an Child and Adolescent Low Secure Hospital.

This will provide up to 14 beds for young people primarily from the south of the country.

14 beds
Young people

The interim low secure ward currently located in Bluebird House will transfer over to the new low secure hospital when it is ready.

We would like to start building work:

October 2018

Completion:

October 2019

OUR VALUES

Patients & people first
Partnership
Respect
Plans for new low secure forensic building for patients with learning disabilities

To accommodate the patients currently being supported at Woodhaven we plan to build a brand new bespoke 10 bed low secure forensic residential unit on the main Tatchbury Mount site.

We have a building, Rufus Lodge, which is currently not in clinical use. The new building will be on this site, to allow us to use this more efficiently.

10 BEDS

We plan to start building work: September 2018 Completion: October 2019

OUR VALUES

Patients & people first Partnership Respect
The unit will have state of the art:

- Sensory rooms
- Therapy suites
- Art rooms
- Fitness suite
- Music room
- Comfort cooling (temperature control)
- Modern bespoke furniture – designed by the patients
- Outside space for activities

The new building will be tailored around the needs of our patients with all the up to date facilities needed to enable us to continue providing the best care to our patients.

Our patients and our staff will be working with us on the interior design of the building.
Your thoughts and views
Quarterly Senior Leader Away Day
Thursday 28 June 2018
8.30 – 16.30
Hope Church Winchester, The Middle Brook Centre,
Middle Brook Street, Winchester, SO23 8DQ

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Subject</th>
<th>Lead</th>
</tr>
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<tbody>
<tr>
<td>8.30</td>
<td>1.</td>
<td>Open and Welcome</td>
<td>Nick Broughton, CEO</td>
</tr>
<tr>
<td>8.40</td>
<td>2.</td>
<td>Developing the new Trust Vision</td>
<td>Tom Westbury, Associate Director of Communications</td>
</tr>
<tr>
<td>9.00</td>
<td>3.</td>
<td>Service Improvements: Delayed Transfers of Care (DTOC)</td>
<td>Sarah Olley, ISD Strategic Programmes General Manager</td>
</tr>
<tr>
<td>10.30</td>
<td>Refreshment break – Tea, Coffee and Biscuits</td>
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<td>11.00</td>
<td>4.</td>
<td>New People and Organisational Development Strategy</td>
<td>Paul Draycott, Director of Workforce and Organisational Development</td>
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<td>11.45</td>
<td>5.</td>
<td>Equality and Diversity</td>
<td>Ricky Somal, Head of Engagement and Wellbeing</td>
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<tr>
<td>12.15</td>
<td>Lunch</td>
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<td>13.00</td>
<td>6.</td>
<td>CQC Feedback</td>
<td>Julie Dawes, Chief Nurse</td>
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<tr>
<td>13.30</td>
<td>7.</td>
<td>Management Structure</td>
<td>Nick Broughton, CEO</td>
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<td>14.30</td>
<td>8.</td>
<td>Transformation update including South East Hampshire work</td>
<td>Dean Garrett, Business Development Manager</td>
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<tr>
<td>15.00</td>
<td>9.</td>
<td>Integrated care – Mental Health and Learning Disabilities services: Clinical areas of Practice and MAPs</td>
<td>Debbie Robinson, Interim Director of Operations MH/LD</td>
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<tr>
<td>15.30</td>
<td>10.</td>
<td>Q&amp;A session</td>
<td>Nick Broughton, CEO</td>
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<tr>
<td>16.00</td>
<td>Nick Broughton to close - Tea, Coffee, Biscuits and networking</td>
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**Poster display (lobby area):** Time to shine poster initiative, Specialised Services (Victoria Tippins)
### REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
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<tbody>
<tr>
<td>Agenda Item</td>
<td>09</td>
</tr>
<tr>
<td>Title</td>
<td>Executive Directors’ Report</td>
</tr>
</tbody>
</table>
| Author(s)  | Paula Anderson, Director of Finance  
Dr Karl Marlowe, Medical Director  
Julie Dawes, Director of Nursing and Allied Health Professionals  
Paul Draycott, Director of Workforce and Organisational Development  
Paula Hull, Acting Director of Integrated Services  
Debbie Robinson, Director of Operations (Mental Health, Learning Disabilities and Social Care) |
| Sponsoring Director | As above |

**Purpose & Action Required**

The Board is asked to note these updates and discuss this report.

**Executive Director Overview**

These reports provide updates on activities and issues relating to each Director’s portfolio which are not covered in the standing business and performance reports.

**Previously considered by:**

N/A

### Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>This report provides an update on activities and issues across all four of the Trust’s strategic priorities</th>
</tr>
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<tbody>
<tr>
<td>Quality</td>
<td>✗</td>
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<td>People</td>
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<td>Transformation</td>
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<td>Money</td>
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<td>Does this impact any Board Assurance Framework / Corporate Risks</td>
<td>As set out within the report</td>
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1. Director of Finance Report

2017/18 Forecast Outturn

1.1. The final outturn for the Trust was a deficit of £8.9m but once the technical, non-cash accounting adjustments are taken out, we delivered a £1.8m surplus. Although we missed the £2.9m surplus control total by £1.1m, within this position we accounted for the fines and legal costs arising from the prosecutions. The draft annual accounts were submitted on time in April, the audit by PwC did not identify any errors and the accounts and annual report will be considered in the confidential session of the Board in June. Publication is not permitted until the documents have been laid before parliament in July.

Capital

1.2. The final position for capital in 2017/18 was spend of £8.7m. The plan for 2018/19 is ambitious and includes a full range of projects which ensure that our buildings, medical equipment and technology continue to work effectively for patient care. In addition there are a number of areas where spend will be prioritised for improvement. This includes £1m for transformation projects, £1m protected for spend to save schemes and the impact of the CAMHS Low Secure provision; the full business case for which will be considered by the Board in June.

1.3. A number of executives attended the South East Mental Health CEO Group which was facilitated by David Monk in early May. This event was inspirational in terms of showcasing digital innovation in local mental health trusts and will support us in continuing to move this agenda forward within Southern Health.

2018/19 Financial Plan

1.4. Since our last Board meeting the 2018/19 plan has been finalised and submitted to NHS Improvement. We will now report against this plan within the performance report on all the key objectives and metrics.

1.5. The financial risk remains significant for the year both in terms of identifying and implementing cost improvement plans as well as other areas of major spend such as the use of out of area mental health beds.

Estates Services

1.6. The operational maintenance teams achieved the following response times for reactive and planned preventative maintenance in April:

- 95% of 247 Planned Preventative Maintenance jobs were completed on time. – those incomplete are low risk items such as gutter clearance
- 4 hour response: 96% of 66 events were completed on time. Even though some events took longer than the 4 allocated hours, attendance was prompt
- 24 hour response: 91% of 21 events were completed on time. Some events required materials but all were completed the next working day
- Non-Urgent response: 75% of 879 events were completed on time.

1.7. An update on the significant capital projects:
• Completion of the window replacements (anti ligature) at Beechwood Ward

• Commencement of the final ward for anti-ligature windows replacement at Ravenswood

• The work to overcome the recent water safety issues experienced on the Melbury Lodge site has been completed and a contractor has been commissioned to proceed with the replacement water heaters which commenced in April with further work to replace the defective boilers to follow on later this year,

• Roll over capital work from last year is about to complete in May on numerous schemes throughout the Gosport War Memorial site.

• The installation of the new compliant Fire alarm system on the Romsey site is now complete and was commissioned in April.

1.8. Following feedback received from a number of sources including staff and patients we have taken the opportunity to review the current guidance for testing electrical portable equipment. As a result of this we have been able to confirm alternative arrangements to staff which will reduce the burden and delays of unnecessary checks.

Ligature Management Reduction

1.9. Work has continued within the Mental Health Division and the Estates Services team to identify additional measures which can be put into place to reduce the risk of ligature incidents involving doors. In early May the Executive Team accepted recommendations from the Ligature Management Group to extend the trial that had begun on the Elmleigh site to remove en suite bathroom doors and replace with shower curtains on AMH, PICU and OPMH functional wards. All other wards will be reviewed on a ward by ward basis. In addition they also recommended that we start a three month trial on the use of a door top alarm linked to the ward nurse on call system at Trinity Ward in Antelope House. These projects are currently being planned for implementation at pace.

Fire Safety Management

1.10. Good progress continues to be made with Hampshire Fire & Rescue Service working alongside our Fire Safety team. Having completed 8 of the 20 planned inspections this year they are not anticipating carrying out any further visits this year due to the confidence they have in our arrangements.

Senior Information Risk Owner (SIRO)

1.11. During May we submitted a report to NHS Improvement detailing our compliance with the Data Security Protection Requirements (DSPR). This was signed off by the Board following scrutiny of the advice from our IT Security Specialist. All requirements were met with the exception of the following: the business continuity plan for data and cyber security has not yet been tested in 2017/18, we have not checked all organisations that supply IT systems have the appropriate certification and we do not have a plan for GDPR implementation that has been fully signed off by the Board.

1.12. All remaining actions are being followed up and will be reported to the Audit Committee in July.

1.13. During April, all NHS organisations were written to regarding the increased threat of cyber security issues and a reminder to Trusts to learn from the WannaCry ransomware incident.

180605 TB 09 Executive Directors Report
1.14. Our response to this has been to ensure that roles have been assigned in the new Data Security and Protection Toolkit (DSPT) and responsibility for individual assertions has been assigned. The 40 assertions, each grouped under the 10 data security principles, cover each of the themes discussed in the letter from NHS Digital. The new toolkit is the primary framework that NHS organisations must meet to comply with the 10 Data Security and Protection Requirements, the General Data Protection Regulations (GDPR) and also the Networks and Information Systems (NIS) directive. The first status report against the DSPT will be available to the next Information Governance Group that takes place 9th July and this will also include action plans for any areas that require development.

1.15. In addition to the mandatory frameworks and legislation that we must comply with the Trust has also chosen to adopt the International Standard ISO27001. This is the gold standard for Information Security management and in many places exceeds the requirements of the DSPT. This accreditation is not prevalent in the NHS and the accreditation, and annual re-assessment, to this standard demonstrates our aspiration to provide exceptional information/cyber security controls. The technical services teams are also working towards accreditation to ISO9001 quality management system which is not specifically an information security standard, although it does ensure that underpinning operational processes that contribute to information security are robust, monitored and regularly reviewed through audit.

**New Low Secure CAMHS Service and the reprovision of our Low Secure Learning Disability Service**

1.16. Previously the Board has signed off an outline business case which has now been developed into a full business case and will be considered by the Board in its confidential session in June. Key milestones will be reported in future meetings.
2. Medical Director Report

Medical Education
2.1. Appointments:
• New East Clinical Tutor (Aug): Martin Brown; TPD FY Drs: Adam Cox.

2.2. Action Plans:
• GMC recommendations: Handover/Info sharing: trainee led systems being piloted.
• Antelope House: “tribalism” allegations – action plan with CSD, Nurse Leads
• Elmleigh & East Hants: training support, rota issues: action plans in place.
• College keep: GMC report on unsatisfactory post – under investigation
• UG Budget (35% ↓): meeting due with Kim Perry, discussion due with CMO

2.3. Highlights:
• Core Trainees: all excellent feedback apart from 2 posts (being addressed); next cohort of trainees has full complement; good recruitment from FY posts.
• Mentoring schemes being developed for trainees by senior trainees.
• Chief Registrar appointment: Dr Panos Prevezanos.

Appraisal and Revalidation
2.4. We have completed our annual organisational return to NHSE. A board report for Chief Executive sign off is done, to be submitted in September 2018.
2.5. There will be some changes to the timing of appraisals in future to reduce the number due at the end of the appraisal year (March). Continuous process over the year.

Medical Locums
2.6. This remains an area of focus; Finance, HR and the Chief Medical Officer meet fortnightly to review the position.
2.7. Current financial projections are that locum spend will be under the ceiling of £2,678K for 2018/19.

Medicines Management
2.8. The Medicines Management Team continues to work on safe and effective use of medication. Offer professional advice and support on medicines supply, clinical pharmacy and clinical governance functions. Performs services including medicines reconciliation, medication review, and discharge planning.
2.9. The Medicines Administration Technician pilot project was recently evaluated after 6 months post implementation and a report presented at Clinical Effectiveness Group and Medicines Management Committee. The report was very well received with clear benefits to nursing time saved on wards and additional benefits on stock control, safe and secure
handling of medicines standards, interventions and medicines omissions. Looking to rapidly expand the service to other wards and community.

2.10. The medicines reconciliation KPI data for Feb 2018 was 98% which is a significant improvement from previous months and meets the agreed target of 80%.

2.11. The work on electronic prescribing extension at Parklands is in progress and a Project Group and Project Steering Group have been formed to ensure successful delivery. It is anticipated that implementation will be in early July 2018.

2.12. Work is in progress regarding future provision of pharmacy supply with an in-house option and pharmacy tender being considered as two options.

2.13. There has been a recent addition on the risk register regarding clozapine and is risk rated 9. An action plan to mitigate against the risk is in action and reviewed via the Senior Management Committee.

Clinical Effectiveness

2.14. NICE: Structure for identification of relevant NICE guidance and disseminating it in place, assurance gap relates to evidence of implementation and compliance. Audits for core NICE guidance; results have been reviewed at NICE group, next steps to be decided.

2.15. Clinical audit programme 2018/19 is in place

2.16. CPA compliance audits completed – high rates of compliance across services noted, with minor areas for improvement

2.17. SAFER: New restraint programme in place, evaluation plan in place; violence reduction strategy being worked through and will come to SAFER then informal exec; will also be focus of one of the first QI projects

2.18. Mortality: Mortality reporting, recording and investigating systems in place and robust, supported by a monthly audit; recent half day conference for staff and stakeholders on thematic analyses, which was well received.

Research and Development

2.19. Commercial clinical Trials:

   a) Liraglutide and the management of overweight and obesity in people with schizophrenia (L.O.S.E Weight): a pilot study, a home grown Investigator led clinical trial. This trial has now received both MHRA and HRA/REC approval with recruitment target of 60 patients due to start from 1st July 2018.

   b) Digital Medicines: A multicentre 8-week, Single-arm, Open-label, Pragmatic Trial to Explore Acceptance and Performance of Using a Digital Medicine System with Healthcare Professionals and Adult Subjects with Schizophrenia, Schizoaffective Disorder, or First Episode Psychosis on an Oral Atypical Antipsychotic (Aripiprazole, Olanzapine, Quetiapine, or Risperidone). We aim to recruit 12 participants and would benefit from Trust wide publicity in identifying potential participants to take part in the study. We have to recruit our first patient by 21st May 2018.

   c) A 26 week, randomised, double-blind, controlled, parallel-group, multicentre study to evaluate the efficacy and safety of Sotagliflozin compared to Empagliflozin and placebo in patients with Type 2 Diabetes who have inadequate glycaemic control with DPP4(i) with or without Metformin: SOTA-EMPA
2.20. Appendix 1 provides a summary of the work of the Research & Development Department.

**Out of Area Placements**

2.21. Started work on analysis of data over last year:

This shows changes in mean OAPs since mid 2017.

The variation of LOS across the AMHS wards is benchmarked against Solent.
3. Director of Nursing and Allied Health Professionals Report

Regional Visit
3.1. Sue Donehy, South Regional Nurse, visited the Trust on 29th March 2018. She took the opportunity to visit Bluebird House and met a number of Senior Nurses. It proved to be a useful opportunity to discuss a number of key nursing and AHP issue, including workforce, specifically lack of training places for LD Division and the decline of Continued Personal Development Opportunities available for staff.

NMC
3.2. On 21st May 2018 the NMC hearings commenced for the six nurses referred by Southern Health NHS Foundation Trust following the death of Connor Sparrowhawk. None of the nurses are currently employed by Southern Health NHS Foundation Trust, however four remain in employment with local health Trusts following a TUPE from the Trust. The hearings are scheduled to take place from 21st May 2018 to 29th June 2018 and then a further six week period from 9th July to 17th August 2018. A number of staff have given witness statements and four members of staff have been called to give evidence as witnesses at the hearings. These staff are being provided with support and communications on a regular basis, and close links are being maintained with the NMC Witness Liaison Manager.

Nursing Appointments
3.3. I am delighted to report two new appointments, Julia Lake has been appointed as Interim Divisional Deputy Director of Nursing for the Integrated Service Division and Emma Wadey as the Divisional Deputy Director of Nursing for Mental Health. Both have strong backgrounds in Physical and Mental Health Services respectively and will provide a major role in strengthening the nurse and AHP leadership.

AHP Appointment
3.4. A new role description has been developed for a Lead AHP Professional Lead. The aim is to provide Professional AHP advice to the organisation and will report directly to the Director of Nursing & AHP.

CQC
3.5. The Care Quality Commission has commenced the process of inspection. They have met and spoken to over two hundred staff in focus groups, have undertaken inspections on two wards to pilot a new inspection tool specifically to assess Dementia care. They are observing and inspecting Community Services during the week commencing 21st May 2018. They will be inspecting Mental Health and Learning Disabilities services during the weeks of 11th and 18th June 2018. They are also running further focus groups in addition to many meetings with individual staff members. The inspection will include an assessment of the well led domain during July.
International Nurses Day

3.6. Saturday 12th May was International Nurses Day and we were delighted to participate in this day and celebrate the brilliant nurses and nursing in Southern Health NHS Foundation Trust. A number of Senior Nurses went ‘back to the floor’ on Saturday to say a huge thank you to all our nursing staff for their continued commitment to patients and families.

Florence Nightingale Commemoration

3.7. Julia Lake, Emma Wadey and I were fortunate enough to be invited to Westminster Abbey for a service to commemorate the life of Florence Nightingale which was a very moving a special occasion and humbling to hear many stories from inspiring nurses.
4. Director of Workforce and Organisational Development Report

Attracting and retaining our people

4.1. The focus of the work of the Division continues to be in attracting and retaining people to work with us particularly within clinical services. The work to gain greater detailed understanding of the reasons people are leaving the Trust has been finalised and there are three major reasons why staff appear to be leaving

- Lack of flexibility in their current working arrangements
- Lack of career progression
- Attitude/approach by manager

4.2. This has contributed to our NHSI Retention Plan (which continues to progress), Staff Survey Plan and the People and OD Strategy with teams being supported to explore how they can provide greater flexibility. The People and OD Strategy will come to the July Board.

4.3. The Medical Workforce Team has already started to make an impact working closely with Divisions and Dr Marlowe as Medical Director. Plans are now in place to recruit to every medical vacancy. We are also investing in a new approach to recruitment using both traditional and social media.

Proposed Pay Deal - Agenda for Change

4.4. The consultation process in respect of a 3-year pay deal for non-medical NHS staff, along with reforms to the Agenda for Change contract, is nearing completion. The proposed changes are to be funded centrally and include higher starting salaries for all pay bands, a reduction in the number of pay points within each pay band and new pay progression rules that support staff development. The deal, if agreed, would also result in the removal of unsocial hours payments for the majority of staff during periods of sickness absence, a reduction in unsocial payments for the lowest bands, the introduction of a national framework for buying/selling annual leave and enhanced parental leave and child bereavement leave. Trade unions are expected to confirm the outcome of their consultation by the middle of June and, if the deal is agreed, new pay rates will be applied retrospectively to 1 April 2018.

“My ESR” – Electronic Staff Record Self Service

4.5. Self-service for our staff within the Electronic Staff Record (ESR) system has been implemented; this online portal enables staff members to access their individual record for the purposes of changing personal details such as home address, next of kin and bank account details as well as view their payslips and Total Rewards Statement. This initial development is part of a wider strategy to enhance our workforce systems in order to improve quality and increase efficiency.

Clinical Excellence Awards (CEA)

4.6. The Clinical Excellence Awards (CEA) scheme to recognise and reward consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. In addition this includes those consultants and senior academic GPs who do so through their contribution to academic medicine.
Applications are currently being invited for the 2017/18 round; these are particularly encouraged from a cross-section of our consultant workforce, especially those who have not applied previously and those consultants who work on a part-time, flexible basis in an effort to address our gender pay gap in relation to bonus payments.

Appointments within Workforce, Organisational Development and Communications

4.7. As reported at last Board Rob Cragg has commenced as Deputy Director of Organisational Development and Communications. Tom Westbury was Acting Director of Communications and after a national recruitment process was successful in securing the post substantively. Can I wish them both great success in their new roles.

4.8. The post of Deputy Director of Workforce is currently being advertised with interviews planned for the 22nd June and once recruited will complete the senior team within the Directorate.

Education and Training

4.9. Statutory and Mandatory training sits at a healthy 94.4% at the end of April. However there are a couple of areas where further work is being undertaken to improve compliance sSs refresher which is at 64.5% (up in the last three weeks from 59.3%). Fire has an overall compliance 76.4%.

4.10. LEaD is currently working on Inter Authority Transfer (IAT) which automatically provides the training history for new staff who have previously worked in another NHS Trust, enabling training records to be passported into MLE (our Learning Management System). It is envisaged that this will lead to greater compliance at an earlier stage in the induction period. This is part of the ESR Staff Self-serve project outlined in section 4.3.

4.11. There was also a successful End of Life Conference with 70 delegates on 8th May, supporting the End of Life Strategy and highlighting role of End of Life champions, education framework and the new Tier 2 End of Life eVerfication.

Communications Update

4.12. The latest Southern Health Stars continues to gain momentum winners for our monthly staff reward and recognition scheme. The latest winners were Ruth Paley, Mental Health Nurse and Care Co-Ordinator, Southampton Central CMHT who was nominated by Alia Sidki Gomez, Team Leader; and The Finance Team nominated by Alison Shore, Executive PA to Paula Anderson & Lisa Franklin. There have already been over 30 nominations received for the next award.

4.13. The Communications Team is providing extensive support to the transformation project taking place in Portsmouth and South East Hampshire, examining the effectiveness of community mental health services provided by Southern Health and Solent teams through the use of workshops with a range of staff, stakeholders, families, carers and patients.

4.14. They have also supported staff in producing entries for the NHS 70 Parliamentary Awards, and created almost 40 videos of staff for our NHS 70 celebration. The team is also working with other agency colleagues to prepare for the upcoming publication of the report from the Gosport Independent panel.
4.15. International Nurses Day and Experience of Care Week both provided opportunities to showcase our staff and the feedback we receive with videos and messages posted internally and on social media.

4.16. A highlight on social media has been in the thunderclap arranged for the ongoing nurse recruitment campaign, which launched our new recruitment video with a flurry of activity across Twitter that reached 110,000 people.
5. **Acting Director of Integrated Services Report**

5.1. Quality and governance escalations for the ISD include four Serious Incidents (SIs) in April. These included two falls in the Gosport community inpatient wards where patients sustained fractures, one fall at Lymington and a pressure ulcer that deteriorated in our care in Basingstoke ICT. Adi Phillips, the Falls Clinical Lead has been asked to carry out a thematic review into the SI falls. A further fall was reported for Romsey that has not been reported as an SI but is undergoing internal investigation.

5.2. In terms of the responsiveness of the ISD services there are two areas to escalate this month. Our Referral to Treatment (RTT) incomplete position has improved over the last six months to previous levels and is now 94.55% in April 2018. This is due to additional sessions being provided in Gastroenterology and ENT, and a redesign to the Endocrinology pathway. Specialty level challenges remain in; pain (64.13%) with escalations to CCGs over the last year regarding sustained increasing demand, cardiology (88.71%) there is internal redesign being scoped to skill mix the staff against the current case mix, which will increase capacity, diabetic service (88.89%) recent investment from West Hants CCG is being spent on additional clinical staff. The Tier 2 ENT service which has an additional 6 week first appointment target has not been met for the second month in a row. This is due to unexpected long-term sickness of the main clinician, and a sustained lack of available staff within the SLA with UHS. Alternative models of provision are being considered and options for next steps are being drafted.

5.3. The Delayed Transfers of Care (DTOC) within our Community Hospitals has remained above the target of 13% by the end of March – with April being 16.7%. A review of the DTOC reduction programme is being presented at Strategic Management Committee, and there will be a workshop held with key stakeholders to review the actions undertaken to date to identify what worked well and other actions that could impact positively on the DTOC rate.

5.4. Orthopaedic choice – Following lengthy discussions with WHCCG, there has been an agreement to invest £105k from the population growth funds to cover excess spend incurred across 16/17 and 17/18, mainly diagnostics. Discussions are to continue regarding the funding that is required to reduce the current waiting times to preferred levels, and to enable the service to receive additional referrals currently going to the Acute Providers.

5.5. Tenders that have been received or are expected include:

- **Child Health Information Systems (CHIS) HIOW procurement** – letter of notice received about termination at the end of March 2019. Procurement commences June or July 2018 with expected start from April 2019. Potential additional £500-£600k business.

- **The 0-19 procurement** is likely to commence in September or October 2018. HCC engagement events are currently underway. There are internal plans in development preparing a presentation to Board Seminar. Potential additional £8-9 million business.

- **Urgent Treatment Centre (UTC), the development of which would see the bringing together of MIU, Extended Access and OOH service – the selection questionnaire (SQ) for the procurement of an UTC in Lymington was released 11th May 2018. Procurements for three other extended access hubs across West Hampshire and an UTC in Andover have also been launched. A business case with options appraisals is being drafted for Executive approval.**
5.6. A Memorandum of Understanding (MOU) has been drafted which defines the circumstances under which Southern Health NHS Foundation Trust (SHFT), West Hampshire CCG and Hampshire Partnership of CCGs will work together to deliver improved outcomes for patients through the implementation of an effective integrated out of hospital model of care; the primary aim of which is to take forward the transformation of community and primary care services at scale and across all localities. It also describes how the relationship between the commissioning parties and the provider party will be managed and sets out the principles under which the parties will work together to implement the transformation requirements of the new care model. The final draft is being reviewed by the ISD Senior Management team ahead of presentation to Board.
6. Acting Director of Operations (Mental Health and Learning Disabilities) Report

6.1. The Out of Area bed position across the division has reduced since the last report due to increasing mechanisms to tighten the grip on this situation. Additional actions agreed at the Right Care Right Place workshops during April are yet to show a positive impact.

6.2. Work is planned to develop Business Intelligence tools to better understand demand and hotspots and enable management of predicted demand to become proactive in planning capacity. There will be a focus on managing the internal bed capacity and development of an Area Bed Management model which is anticipated will further reduce the need for Out of Area Admissions. This will increase the local accountability for demand. Current Out of Area Placements will continue to be reviewed by senior clinical staff and discharges planned appropriately. It is anticipated that the introduction of more local accountability structures resolve this and the position continues to improve.

6.3. The collaborative work with Northumberland Tyne and Wear in the South East Hampshire system continues. Two of the four design workshops have been held and the outputs from these are being shared daily with attendees, stakeholders and more widely on Twitter. The design workshops will conclude in June and commissioners and providers will meet to discuss further developments and commissioning plans for future service redesign.

6.4. The Project Plan for the full transition of Eastleigh Southern Parishes Patients to the Eastleigh Team from the Southampton East CMHT is making positive progress. Recruitment is underway and CMHT resources are being built up to accept new referrals whilst patients on the existing caseload will be discharged as appropriately instead of “lifting and shifting” a cohort from one team to another.

6.5. The draft section 75 has been developed with Southampton City Council and is now awaiting Trust approval and legal sign off. Discussions continue with Hampshire County Council around the arrangements in the absence of the S75 between the organisations.

6.6. The Outline Business case for the Child and Adolescent Mental Health (CAMHS) Unit in Woodhaven and the Learning Disability Residential unit (LDRU) was approved by the board on the 27th March 2018. Detailed designs have been finalised and agreed. The process of developing the more detailed plans has commenced and will be complete by the end of June. The hoardings around Rufus lodge will be erected week commencing 17th May with demolition planned to start in July.

6.7. The perimeter fence around Ravenswood has been designed and agreed by the clinical teams. Details around the CCTV, access control, external lighting and anti-climb guttering are being finalised in preparation for the submission of the planning application in July with a completion date of January 2019.

6.8. A number of service user engagement groups have been held and the response and ideas have been very positive. Further activity workshops will be held with the service users and the interior designer to further develop the ideas into usable products. A stakeholder event was held on the 9th May with Dr Nick Broughton outlining our plans and vision for the CAMHS and LDRU on Tatchbury Mount. The feedback was positive and encouraging; further events will be planned as the projects mature.

6.9. The full business case has been circulated for comment and will be presented to the closed trust board on the 5th June.

6.10. A security and reception consultation was formally launched on 8th May 2018 as part of the service-wide consultation which proposes to implement a new workforce model in Specialised Services and ensures consistency across all units enabling the same level
of cover in security with a robust reporting and accountability structure. The units affected are:

- Ravenswood House – Medium Secure
- Bluebird House – Medium Secure
- Southfield – Low Secure
- Woodhaven – Low Secure

6.11. The consultation will have a focus on Band 3 HCSW’s and reception staff across Bluebird House, Ravenswood House, Southfield and Woodhaven although other staff bandings are affected. All initial engagement meetings have been held and 1:1 sessions booked.

6.12. Meetings have taken place with Hampshire County Council (HCC) to inform them of the intentions to move the Learning Disability Teams out of their buildings. Further meeting involving Estates from both HCC and SHFT to work out the leases and notice. Our estates team are scoping the options for the teams.

6.13. The Service is still awaiting West Hampshire CCG to confirm how they wish to progress with a block purchase arrangement for Willow Ward and commissioners continue to refuse to pay the new price. A report is being pulled together to show all the work we have done on the model, our rationale for the increase and all the correspondence to date. This will be escalated through CRM.

6.14. As part of the Memorandum Of Understanding with Hampshire Commissioners the £180k which was stopped by HCC last April for Campus re-provision is being relooked at. We have provided commissioners with a timeline of all communication including letters regarding this, information about the number of clients still supported as well as the acuity in the East.

6.15. Work has begun to look at the model within OPMH inpatient services with staff due to visit a number of local services to look at the models, in particular around dementia care. In addition, a number of workshops have taken place with staff in OPMH regarding the new business unit, the vision and business planning. This is the first time that staff have had the opportunity to come together as one business unit. Business plans and priorities are being aligned with AMH services and work is underway to ensure that OPMH is represented both internally and externally with key stakeholders.

6.16. There are ongoing discussions with Hampshire Commissioners about where the OPMH services should sit contractually. A letter outlining our position and recommendation to bring the service back into the MHLD Divisional was sent to commissioners on 14th May.

6.17. OPMH DTOC’s are down to the lowest position to date which is real progress however there continues to be pressure on beds particularly functional beds.

6.18. There are still outstanding issues that are preventing the main italk contract signing. These are around the CIP and CQUIN components of the contract. Ongoing discussions suggest that commissioners may be flexible around applying a CIP to this contract, and a further meeting is being arranged to finalise arrangements.

6.19. Long Term Condition (LTC) funding to the level anticipated has not been put in place by commissioners. A small amount of money (circa £94k) has been put in to the contract by North Hampshire and West Hampshire CCGs. No funding has been agreed from SE Hampshire or Fareham & Gosport CCGs. This money had been agreed for training purposes.
6.20. The italk service has applied for 15 LTC training places to enable them to be in a state of readiness for 5YFV monies and the expansion to LTC work, which is already being undertaken by the team.

6.21. The contract has not yet been signed with Solent Mind (subcontract arrangement for step 2 italk services) due to discussions and clarification on the SHFT position around CIP/pay uplift and proportion of budget assigned to Solent Mind.

6.22. italk remain on the divisional risk register because of the ongoing risk of delivery of increased access targets due to low referral numbers and staffing issues at step 2. The team presented at both TARGET meetings in SE Hampshire and Fareham and Gosport CCGs and have suggested an electronic referral form that can be printed as a prescription for the patient and then tracked to italk who are then able to actively follow up patients who the GP recommended for the service.

6.23. Teams under intensive support were noted as:

- Antelope House (Trinity Ward) – care quality and recruitment leading to quality and safety issues
- Southampton East Community Mental Health Team - Caseloads remain high and the recent Acuity and Dependency audit demonstrated a staffing gap of 8 WTE. The move to Bitterne Park and the Eastleigh and Southern Parishes caseload transfer are in progress to assist the team.
- Southampton Central Community Mental Health Team - The service experiences high demand due to being an area of high deprivation where there has been a population growth and there is a high student population as two Universities are located locally. The team also supports many homeless people, people with substance misuse issues and 44% of people on the caseload have psychosis. Work in progress to establish a pilot with Primary Care designed to reduce caseloads with support for a step down model of care.
- Winchester Community Mental Health Team – recruitment and retention.
FOREWORD

Southern Health NHS FT has a small but growing Research and Development Department based at Moorgreen Hospital. The department participates in clinical research and has significantly grown over the last five years due to a committed albeit small research team and dedicated clinicians to delivering first class clinical research to the organisation.

Our organisation provides a diverse portfolio of services and we have a well-established research department that undertakes a number of clinical trials and contribute to our overall recruitment target and a growth income and expenditure.

Research is an integral part of our organisation

Clinical research is critical to Southern Health; to advancing our knowledge and to the development of health care generally. The public and patients benefit from a thriving and innovative research culture is evident in real clinical gains.

>Participating in research is a quality driver and reflected in the NHS Constitution. The benefits of this participation extend from direct patient care, reduced mortality to staff satisfaction and economic reward, all critical in the current climate.

>The National Institute for Health Research (NIHR) recognises that there must be a strong commitment to clinical research in the UK, and the past few years have seen a significant investment and dramatic increase in research infrastructure both locally and nationally.

>We understand that participating in clinical research is in our interest as an NHS organisation and we have a duty to contribute to high level research.

>Southern Health is committed to a fully integrated clinical research strategy, for which every staff member is responsible.

We understand that research enhances staff skills set and Trust reputation.

Vision:

Southern health has the following vision for the research culture:

To encourage a culture of research enabling every patient and clinician the opportunity to participate in research (To embed research)

Our aim is to:

>Be seen as world leaders in research in Mental and Physical Health, Learning Disability and Community Care regionally and at national level (develop capability and capacity)

>Attract national and regional research funding (maximise benefits)

>Develop the infrastructure to be able to grow further in commercial trials in accordance with national agenda (grow infrastructure)

>Embed research and the use of evidence in every day clinical practice (improve standards)

>to be able to offer research in every service that Southern Health offers (increase opportunity, participation and performance)

Quality: We take part in a significant number of NIHR CRN portfolio clinical trials. Here are a few examples:

>SCIMITAR – A Smoking Cessation trial that aimed to establish the clinical effectiveness of a bespoke smoking cessation (BSC) intervention in comparison to existing NHS smoking cessation services delivered under usual care for people with severe mental illness. Patients were offered 8-12 sessions of BSC. We recruited 44 participants.

>STEPWISE trial: A multicentre RCT comparing structured life style education (adapted DESMOND) with usual care to reduce weight gain in people with schizophrenia, schizoaffective disorder and first episode psychosis prescribed antipsychotic medication. We successfully
recruited 54 patients and were the second highest recruiting site.

>**PoMeT**: A randomised trial of positive memory training for the treatment of depression within Schizophrenia. We recruited 54 patients.

>**DFEND**: A randomised, double-blind, placebo-controlled. Parallel-group trial of Vitamin D supplementation compared to placebo in people presenting with their First Episode of Psychosis Neuroprotection Design, so far we have recruited 23 participants.

>**CORKA trial**: Community based Rehabilitation after Knee Arthroplasty. Patients undergoing knee replacement assessed at risk of poor outcome were after surgery randomly allocated to receive either Community based rehabilitation programme or usual care. We recruited 28 participants.

In the 2017/18 financial year we hosted **258** research studies being conducted across the Trust. A total of 34 new studies were set up.

A key function of the research department is to ensure robust research governance, as set out in the UK Policy Framework for Health and Social Care Research (v3.2 2017).

**Upcoming studies:**

>Home grown Investigator Led Clinical Trial: **Liraglutide and the management of overweight and obesity in people with schizophrenia (L.O.S.E Weight)**: a pilot study. This trial has now received both MHRA and HRA/REC approval with recruitment target of 60 patients due to start from 1st July 2018.

>Digital Medicines: A **multicentre 8-week, Single-arm, Open-label, Pragmatic Trial to Explore Acceptance and Performance of Using a Digital Medicine System with Healthcare Professionals and Adult Subjects with Schizophrenia, Schizoaffective Disorder, or First Episode Psychosis on an Oral Atypical Antipsychotic (Aripiprazole, Olanzapine, Quetiapine, or Risperidone)**. We aim to recruit 12 participants from 14th May 2018.

**Performance**

>Our recruitment into NIHR portfolio studies exceeded our target of 1,303; we are pleased to report that we recruited a total of 1,700 participants in 2017/18.

>Patients through research have early access to new and improved medicines, diagnostics techniques and therapies thereby improving clinical outcomes and patient satisfaction. In 2014/15 a total of 792 therapy sessions provided by clinical trial therapists were received by patients randomised to the three trials (REFRAMED, FOCUS and PoMeT).

>Most recently: In SCIMITAR trial we had 28 patients receiving Smoking cessation intervention. CORKA trial (MSK) 12 patients received 50 intervention visits. STEPWISE trial, provided group treatment with a total of 117 sessions to patients with Schizophrenia.

**Staffing**

>Our income and expenditure in 2017/18 was £1,313,872 largely generated from external funding sources through competitive awards for volume of research delivered (main source of R&D funding comes from NIHR via Comprehensive Research Network (CRN); Research Capability Funding (RCF); Performance premium; Contingency strategic funding; Grants and Commercial research income)

**Estates**: We have been successful in attracting more commercial and non-commercial trials and are now limited by estates and infrastructure.

> In order to sustain growth, we need to develop the capacity and capability to meet national high level objectives.
REPORT TO THE TRUST BOARD

Date 05.06.2018

Agenda Item 10

Title Integrated Performance Report

Author(s) Sue Damarell-Kewell, Associate Director Planning, Performance & Business Development

Sponsoring Director Paula Anderson, Executive Director of Finance

Purpose & Action Required This paper provides the Board with an overview of performance across all domains for the month of April.

Executive Director Overview The IPR continues to be revised in response to live feedback. Changes this month include:

- Trend arrows in the summary report for the Trust
- Presentation of ‘heat maps’ which provides team level performance on a number of key operational, workforce, quality and finance measures.

Key performance issues highlighted:

- Continued increase in the number of out of area placements
- There were 2 cases of Clostridium difficile reported at community hospitals last month ISD delayed transfers of care remains non-compliant.
- The vacancy rate saw a marked increase due to additional posts being included as a result of potential growth in contracts expected to occur in 2018/19.
- The trust is reporting a £1.2m deficit at month 1 which is £0.6m worse than planned.
- The CIP target for the year is £13.1m
- Incorrect reporting of pressure ulcer and ligature data last month was identified and due to technical error. This has been resolved.

Attached as an Appendix is the Safer Staffing Monthly Exception Report for May 2018 (April 2018 data)

Previously considered by: Trust Executive Committee
<table>
<thead>
<tr>
<th>Strategic Priorities this paper supports:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>X The IPR sets out performance against the strategic priorities for 2018/19 for the Trust.</td>
</tr>
<tr>
<td>People</td>
<td>X</td>
</tr>
<tr>
<td>Transformation</td>
<td>X</td>
</tr>
<tr>
<td>Money</td>
<td>X</td>
</tr>
<tr>
<td>Does this impact any Board Assurance Framework / Corporate Risks</td>
<td>The IPR will inform the Board Assurance Framework and monitoring of risks from the BAF will be captured in the IPR.</td>
</tr>
</tbody>
</table>
Southern Health NHS Foundation Trust Board Integrated Performance Summary
Analysis of key themes, learning and actions
For data relating to the period 01/04/2018 through 30/04/2018 inclusive
1. Executive Summary

This Integrated Performance Report summarises our delivery against key metrics for April 2018. This single report plots a clear line between our objectives, priorities and activities. The intention is to continue to develop the report to present our progress against plans, the requirements of our regulators and commissioners. It will highlight areas of achievement and give the Board an early indication of any potential hotspots and how these can be mitigated. The report covers:

- A summary of current performance of key metrics under the CQC domains (with trend analysis in the appendices). This will also include information on contract activity as against the other key metrics
- A more detailed analysis of specific indicators where there has been a significant or sustained change in performance
- A “hot spots” report initially based on key workforce indicators, summarising team risk within divisions. This will be extended over the year to include finance, quality and operational data. This provides the basis of the oversight process within the Performance Management and Accountability Framework.
- Over time this report will change to include further analysis and a greater focus on outcomes
- Trust Operating Plan Priorities are set out in the Appendices with current and proposed metrics.

1.1 Performance Summary Narrative for April

Areas of concern

- The highest number of out-of-area beds per day peaked at 62 in April and remains an area of concern. This has had a significant impact on the financial position, with an overspend of £0.2m over plan. See page 12. A detailed analysis to better understand overall demand and capacity is underway.
- The overall number of incidents continues to increase over the last year. The proportion of incidents of moderate or above severity has increased slightly. The top-three cause groups for incidents in the last 12 months were:
  - assault, abuse or threat to staff
  - self-harm or self-injurious behaviour
  - slips, trips or falls
- A technical issue in the reporting of pressure ulcers has been identified which resulted in over-reporting, this has been resolved (11 fewer grade 4 pressure ulcers). See page 9.
- The technical issue also affected the reporting of ligatures. This has also been resolved.
- Mental health risk assessment standard remains non-compliant at 84.7% (85.2% in March) against the Trust-defined standard of 90%. See page 9. Use of Tableau ‘i’ to understand to highlight and work with areas of non-compliance
- ISD delayed transfers of care remains non-compliant. The unvalidated position for April is 16.7% against a target of 13.5%. This is an improvement on the March position of 22% See page 11.
- A review of the cause of last month’s 52-week breach has been undertaken and additional quality controls have been put in place whilst administrative processes are improved.
• There were 2 cases of Clostridium difficile reported at community hospitals last month, which are being fully investigated by the IPC team and will be brought before Root Cause Analysis panels. The metric for this year remains 4 in physical health hospitals and 2 in mental health hospitals.

• The trust is reporting a £1.2m deficit at month 1 which is £0.6m worse than planned. This is partly due to not assuming income before contracts have been signed, out of area placement pressures and £0.2m unmet CIP. We have also not assumed the PSF for month 1 of £200k. There is continued strong balance sheet performance and the Use of Resources rating has deteriorated to a 3 but this is in line with plan and has been determined by the I&E position.

• The CIP target for the year is £13.1m (£12.8m last year). Currently schemes of £10.2m (77%) have been identified compared to 83% identified in April, which has resulted in slippage against the M1 target of £0.8m. Urgent action is required by the Divisions to accelerate delivery by fully identifying the CIP targets supported by robust project plans.

• The vacancy rate saw a marked increase due to additional posts being included as a result of potential growth in contracts expected to occur in 2018/19.

Areas of Good Practice

• Incidents relating to medicines management have reduced from 190 to 128 in the last month, particularly in the number of incidents reported in the Older Peoples Mental Health division. This followed the OPMH division being provided with additional training in medicines management by our pharmacy technician.

• The number of complaints reduced from 31 to 22, with concerns increasing from 56 to 73. The top categories reported in April 2018 were; Clinical Care, Confidentiality, Access to Services. The median time for closing complaints is currently 43 days which is down for 78 days at the same point in 2017. There was a significant increase in the number of compliments which increased for 242 to 415.

• There was an improvement in the responses to the friends and Family Test in ISD to 98% but with almost half the number of responses received. Mental Health saw a slight drop in the number of people that would recommend the Trust from 96.7% to 94.2%.

• There is continued focus on retention and recruitment with the launch of the new nurse recruitment campaign and video and wider use of social media. Turnover has reduced this month; this plus locum conversion to substantive contracts has seen agency costs decrease (pages 12 and 15).

• A thematic review of falls is to be undertaken into falls classified as Serious Incidents by the Falls Clinical Lead, and any learning will be shared across the divisions.
### 1.2 Performance Summary

CQC domain summary of performance metrics for performance relating to April 2018

<table>
<thead>
<tr>
<th>Responsive</th>
<th>Well led</th>
<th>Safe</th>
<th>Safe</th>
<th>Colours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Physical Health</td>
<td>Workforce</td>
<td>Finance</td>
<td>Incidents &amp; &gt;= Moderate severity %</td>
</tr>
<tr>
<td>Mental Health Risk Assessments</td>
<td>ISD DTOC</td>
<td>Leavers with less than 12 months service</td>
<td>Capital YTD</td>
<td>All Incidents</td>
</tr>
<tr>
<td>CPA 12 Month Reviews</td>
<td>GIDS</td>
<td>Rolling 12 Bank and Agency</td>
<td>Cost improvement Programme YTD</td>
<td>Abacond</td>
</tr>
<tr>
<td>CPA 7 Day Follow Up</td>
<td>Diagnostics</td>
<td>Vacancy Rate (Trust)</td>
<td>I&amp;E Surplus/(Deficit) in month</td>
<td>Falls</td>
</tr>
<tr>
<td>EIP 2 week wait</td>
<td>End of Life - Dying in preferred location of care</td>
<td>Appraisal compliance</td>
<td>I&amp;E Surplus/(Deficit) YTD</td>
<td>Ligature</td>
</tr>
<tr>
<td>Gatekeeping</td>
<td>MIU</td>
<td>LEaD Training compliance</td>
<td>Management of Violence and Aggression</td>
<td>Medicines Management</td>
</tr>
<tr>
<td>IAPT waiting times - 18 weeks</td>
<td>Rapid Response Performance</td>
<td>Sickness absence</td>
<td>Agency spend YTD</td>
<td>Pressure Ulcers Grade 3</td>
</tr>
<tr>
<td>IAPT waiting times - 6 weeks</td>
<td>RTT Incomplete</td>
<td>Turnover</td>
<td>Cash balance Month end</td>
<td>Pressure Ulcers Grade 4</td>
</tr>
<tr>
<td>MH LD Inpatient - Delayed Transfers of Care</td>
<td>Waiting Times - External Referral Clock Stops</td>
<td>Use of Resources YTD</td>
<td>Use of Resources YTD</td>
<td>Self Harm</td>
</tr>
</tbody>
</table>

Arrows: Up ▲ - improving position, down ▼ - deteriorating position, right arrow ► - static position
### 1.3 Mental Health Performance Summary

#### Responsive

<table>
<thead>
<tr>
<th>Mental Health Risk Assessments</th>
<th>CPA 12 month Review</th>
<th>CPA 7 day Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leavers with less than 12 months service</td>
<td>Rolling 12 Bank and Agency</td>
<td>Vacancy Rate (Trust)</td>
</tr>
</tbody>
</table>

#### Workforce

<table>
<thead>
<tr>
<th>EIP 2 week wait</th>
<th>Gatekeeping</th>
<th>IAPT waiting times - 18 weeks</th>
<th>Sickness absence</th>
<th>MH LD Inpatient - Delayed Transfers of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal compliance</td>
<td>LEaD Training compliance</td>
<td></td>
<td>Turnover</td>
<td></td>
</tr>
</tbody>
</table>

#### Finance

<table>
<thead>
<tr>
<th>MHSDS Identifiers</th>
<th>MHSDS Outcomes</th>
<th>Waiting Times - External Referral Clock Stops</th>
</tr>
</thead>
</table>

#### Safe

<table>
<thead>
<tr>
<th>Incidents &amp; &gt;= Moderate severity %</th>
<th>Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>All incidents: 1,404, 2.8%</td>
<td></td>
</tr>
<tr>
<td>Abscond: 20, 0.0%</td>
<td></td>
</tr>
<tr>
<td>Falls: 63, 1.6%</td>
<td></td>
</tr>
<tr>
<td>Ligature: 137, 2.2%</td>
<td></td>
</tr>
<tr>
<td>Management of Violence and Aggression: 224, 1.3%</td>
<td></td>
</tr>
<tr>
<td>Medicines Management: 77, 3.9%</td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcers Grade 3</td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcers Grade 4</td>
<td></td>
</tr>
<tr>
<td>Self Harm: 373, 4.0%</td>
<td></td>
</tr>
<tr>
<td>Seclusion: 26</td>
<td></td>
</tr>
</tbody>
</table>

#### Restraint & Seclusion

| Restraint: 412 | |
| Seclusion: 26 | |

#### Complaints

- Out Of Area placements (OBDs): 1,534
- Mortality Review: 100.0% (15)
- Mixed Sex Accommodation: 0
- Patient experience friends and family test: 94.2%
- Carer experience friends and family test: 82.5%

Trend arrows will be added to the dashboard from next month.
1.4 ISD Performance Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Performance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>ISD DTOC</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leavers with less than 12 months service</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In month budget variance</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CIDS</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Appraisal compliance</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td>End of Life - Dying in preferred location of care</td>
<td>LEAD Training compliance</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td>MIU</td>
<td>Rolling 12 Bank and Agency</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td>Rapid Response Performance</td>
<td>Sickness absence</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td>RTT Incomplete</td>
<td>Turnover</td>
<td>Achieving standard</td>
<td></td>
</tr>
<tr>
<td>Waiting Times - External Referral Clock Stops</td>
<td></td>
<td>Achieving standard</td>
<td></td>
</tr>
</tbody>
</table>

Colours explained:
- Complaint - Achieving standard
- Non compliant - Failing standard
- No standard set

Effective:
- Mortality Review 100.0% (31)
- Mixed Sex Accommodation 0

Caring:
- Patient experience friends and family test 98.4%
- Carer experience friends and family test 82.5%

Restrain & Seclusion:
- Restraint: 412
- Seclusion: 26

Trend arrows will be added to the dashboard from next month.
2. Hot Spots Analysis

The 'hot spot' analysis has been developed to map clinical teams in the Trust against a number of key workforce, financial, operational and quality metrics to provide an overall risk score and early indicator of wider operational or quality issues. An example is set out below. We will develop this report to include metrics and tolerances, as well as additional measures including quality assessment tool, peer review, SIRIs, Team changes in leadership, pressure ulcers and falls. The maps will provide additional intelligence in identifying areas that require additional support as part of the Trust Oversight process. Currently Adult Mental Health Teams who are provided intensive support are:

- Antelope House (Trinity Ward)
- Southampton East Community Mental Health Team
- Southampton Central Community Mental Health Team
- Winchester Community Mental Health Team
- ICTs in Totton and Waterside, Romsey
- Health Visiting Teams in Eastleigh Southern Parishes, Fareham and Andover
- Radiology
- Lymington New Forest Hospital Admin.
- Anstey Ward

Example hot spot report:
3. Detailed Analysis
3.1 Safe: All Incidents

Analysis

- Trust-identified priority highlighting the total number of incidents reported each month and the % of those of moderate or above severity. Incidents are reviewed by cause groups.
- Data is subject to further validation, following manager review of incidents.
- Increase in incident reporting since April 2017 which has been outside Statistical Process Controls (SPC) since March. Increase in the % incidents classed as moderate or above.
- This is representative of a positive reporting culture, where teams are actively encouraged to report incidents.
- The top-three cause groups for incidents in the last 12 months were:
  - assault, abuse or threat to staff
  - self-harm or self-injurious behaviour
  - slips, trips or falls

Actions / Developments in the last month
- Quality review of data undertaken which has affected the reported incident numbers in last month's report.
- This has identified that:
  - Learning Disability division saw an overall increase in reported incidents between March and April. This relates to a new admission and to the change in habits of another patient.
  - Specialised Services saw increases in the number of reported incidents at Bluebird House due to patient acuity on the ward.
  - One community care team reported a rise in numbers of pressure ulcers which deteriorated under our care from 3 in March to 14 in April but there were no other significant rises in other teams.

Summary
- Trust-identified priority highlighting the total number of incidents reported each month and the % of those of moderate or above severity. Incidents are reviewed by cause groups.
- Data is subject to further validation, following manager review of incidents.
- Increase in incident reporting since April 2017 which has been outside Statistical Process Controls (SPC) since March. Increase in the % incidents classed as moderate or above.
- This is representative of a positive reporting culture, where teams are actively encouraged to report incidents.
- The top-three cause groups for incidents in the last 12 months were:
  - assault, abuse or threat to staff
  - self-harm or self-injurious behaviour
  - slips, trips or falls

Trajectory and planned actions for next month
- In Learning Disabilities there are care plans in place to address challenges; these are reviewed weekly.
- The Bluebird House incidents are discussed at the monthly ‘Learning from Incidents’ meeting and the recent spikes are analysed per patient and theme.
- There is focused work on pressure ulcers and a Trust-wide review to understand the trends. See the next section for more detailed narrative on planned actions.
3.2 Safe: Pressure Ulcers

Analysis

<table>
<thead>
<tr>
<th>Metric</th>
<th>1 month</th>
<th>24 month trend (incidents &amp; % &gt;= moderate severity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcers Grade 3</td>
<td>30</td>
<td>10.0%</td>
</tr>
<tr>
<td>Pressure Ulcers Grade 4</td>
<td>25</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

Summary
- Trust-identified priority highlighting the total number of Pressure Ulcers (grade 3 and 4), and the % of those of moderate or above.
- Identified as a key priority for the Quality Account and will be the first work stream within the Quality Improvement Initiative.
- The data is subject to further validation, following completion of manager reviews of incidents.
- A technical issue was found which resulted in over-reporting. This has fixed, and the numbers reported are in line with actual incidents.
- Acuity of patients has increased pressure on the teams and impacted on their responsiveness leading to an increase in pressure ulcers.

Actions / Developments in the last month
- A meeting occurred to focus upon the actions required to address the increase in pressure ulcers across the ISD as part of the Quality Account.
- Plan drafted and shared with Director, with areas requiring education, training and updates identified.
- The approach to reporting has been standardised and shared with the teams.
- All pressure ulcers are reviewed and the Trust identifies which pressure ulcers were preventable. For April, four grade 3 and two grade 2 pressure ulcers were classed as preventable, and of those one met Serious Incident criteria.

Trajectory and planned actions for next month
- To hold standardised panels across the ISD, to be reviewed weekly at Head of Nursing-level.
- Mapping of goals of improvement on a 3-monthly basis using current data and planning for the future.
3.3 Responsive: Mental Health Risk Assessments

Analysis

Summary
- Trust-identified priority linked to ensuring patients have a regular review of the risk to their mental health in terms of management of Self Harm, Violence and Aggression and other risk factors.
- The metric remains non-compliant despite an improving trajectory at a Trust-level.
- There are sustained levels of excellent performance within Learning Disabilities and Specialised Services, but there continues to be concerns in relation to a small number of teams within Adult Mental Health (AMH), and Older People’s Mental Health (OPMH).

Actions / Developments in the last month
- A performance manager has been dedicated to data triangulation using the Tableau ‘i’ report to highlight and work with individuals where teams are non-compliant.
- This has highlighted significant variation in approach and processes which is being addressed.

Trajectory and planned actions for next month
- Data quality review of the definition and recording of assessments.
- Due to the variation in approach and processes to mental health risk assessments, revision to the Standard Operating Procedure is required.
3.4 Responsive: Out-of-Area Placements

**Analysis**

<table>
<thead>
<tr>
<th>Metric</th>
<th>1 month</th>
<th>3 months</th>
<th>24 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out Of Area placements (CBDs)</td>
<td>1,534</td>
<td>3,033</td>
<td></td>
</tr>
</tbody>
</table>

- Trust-identified priority recording the number of out-of-area placements for Southern Health patients whilst in the Trust’s care.
- Priority area for NHS England as part of the Five Year Forward View.
- The majority of the out-of-area placements are within AMH.
- Out-of-area placements peaked at 62 in April; actions summarised below have supported the decrease to 36 at time of reporting.
- Executive lead identified to support Quality Improvement programme to reduce dependence.

**Actions / Developments in the last month**

- Right care Right Place workshop held in April
- Review of the Standard Operating Procedure for the Acute Care Pathway to ensure the over-arching principles for effective patient flow and capacity management are included and/or referenced.
- Re-base of the nominal bed allocation per area to acknowledge more recent Clinical Commissioning Group (CCG) population, weighting and available commissioned bed stock
- Reconsider the proposal to implement an ‘area-model’ of bed management and flow
- Additionally, it has been agreed to have very senior, clinically-led oversight regarding key principles of the bed management model within the AMH Services to realign bed allocation, escalation and accountability to those able to directly affect change.

**Summary**

- Work is planned to develop BI tools to better understand demand and hotspots and enable management of predicted demand to become proactive in planning capacity.
- There will be a focus on managing the internal bed capacity and development of an Area bed management model to prevent the need for Out-of-Area admissions. This will increase the local accountability for demand.
- Current Out-of-Area Placements will be reviewed by senior clinical staff and discharges planned appropriately.
- It is anticipated that the introduction of more local accountability structures resolve this and the position continues to improve
- The elimination of all Out of Area Placements at a rate of 20% reduction per month will take until October 2018.

**Trajectory and planned actions for next month**

- Work is planned to develop BI tools to better understand demand and hotspots and enable management of predicted demand to become proactive in planning capacity.
- There will be a focus on managing the internal bed capacity and development of an Area bed management model to prevent the need for Out-of-Area admissions. This will increase the local accountability for demand.
- Current Out-of-Area Placements will be reviewed by senior clinical staff and discharges planned appropriately.
- It is anticipated that the introduction of more local accountability structures resolve this and the position continues to improve
- The elimination of all Out of Area Placements at a rate of 20% reduction per month will take until October 2018.
### 3.5 Responsive: ISD Delayed Transfers of Care

#### Analysis

<table>
<thead>
<tr>
<th>ISD DTOC</th>
<th>Clinical Commissioning Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISD - Mid and Upper North Hampshire</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>ISD - South East Hampshire</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>ISD - South West and Southampton</td>
<td>23%</td>
<td></td>
</tr>
</tbody>
</table>

#### Summary
- CCG-identified priority comparing the number of delayed days for medically-fit patients versus occupied bed days.
- An action plan and trajectory to reduce DTOCs across the ISD to 13.5% by March was implemented in the autumn. The target was not met by all wards.
- The metric is currently non-compliant at 16.7%; with wards in both South East and South West Hampshire having higher levels of delays. Petersfield is now compliant.
- The level of delays in Alton has increased following a recent improvement in reporting accuracy of short-term delays.

#### Actions / Developments in the last month
- ISD Programmes Manager has reviewed reporting to ensure there is accurate recording of DTOCs and actions are being implemented.
- Implementation of SAFER, revised DTOC policy and SOP, Choice Policy, training and patient flow operational standards.
- A recording issue was identified at Alton, which has been rectified.
- Review sessions, with leads as detailed, to identify next steps. Work will continue to support teams in the interim.
- Developments with Hampshire County Council and Continuing Healthcare (CHC) to include roll out a Discharge to Assess (D2A) pathway for community hospitals. This will continue into May
- Project report submitted to Strategic Management Committee for review and consideration of recommendations in June meeting.

#### Trajectory and planned actions for next month
- Embedding actions, weekly validation meetings and monthly compliance checks.
- Development of “why not home today” to engage patients and families
- E-learning training for DTOC, Choice Policy training, intranet page
- Further development of the D2A pathways and process
- Consider standardising this approach across AMH and OPMH
- Identify opportunities to review pharmacy model and therapy support offer
- A review of the trajectory, a benchmark against other Trusts, and impact of seasonal variances will be undertaken.
- The trajectory is to be set over the next couple of weeks and timescales will then be determined.
### 3.6 Well Led: Vacancy Rate and Leavers with less than 12 months service

#### Analysis

- **Summary**
  - Trust-identified priorities linked to vacancies within the Trust and ensuring retention of staff, particularly those newly-recruited.
  - Both metrics are currently non-compliant. The Trust-wide vacancy rate increased in April, from 9.2% to 11.4%. Divisionally, it shows a 5.1% vacancy rate in the Integrated Services division (114.3 wte) and 15.3% in Mental Health/Learning Disabilities.
  - Rolling turnover in the ISD has reduced slightly this month to 16%, which mirrors the reduction Trust-wide. The number of staff leaving within the first 12 months of employment remains high at 26.5%
  - ISD Nursing vacancies remain the major area of risk; both registered and unregistered (70.1wte and 15.8wte respectively).
  - The vacancy rate saw a marked increase due to additional posts being included as a result of potential growth in contracts expected to occur in 2018/19.

#### Actions / Developments in the last month

- A number of schemes for ISD inpatients have generated some success including open days, a film and Facebook campaign.
- AMH community vacancies have reduced below the Trust vacancy target (5%); however, the CMHT Acuity and Dependency outcomes suggest staffing pressures due to caseloads.
- A number of AMH medical locums successfully converted to substantive contracts.
- A focused report on reasons for leaving cited lack of flexible working, poor management/leadership, and pressure of work. These themes are addressed in Workforce Strategy and work has begun to generate projects.
- Sickness absence has been steadily decreasing from 5.7% in January to 4% in April in Mental Health Division, similar to last year.
- The level of sporadic sickness is increasing; a third more staff with 3 episodes of sickness absence in 6 months in 8 months, anxiety and stress remain the highest report reason for absence.
- Increasing numbers of staff are being actively supported during periods of sickness (42%).

#### Trajectory and planned actions for next month

- Team development of action plans as a result of the staff survey
- Targeted ‘Care to Join Us’ recruitment campaigns and open days continue.
- National advertising campaigns are due to start 2nd June 18.
- Nurse rotation pilots continue at Lymington Hospital to create learning opportunities for newly-qualified staff, and a similar pilot at Petersfield Hospital is being developed which will provide an opportunity to work for 6 months in each of the following areas: primary care, minor injury unit, wards, and integrated care teams.
- A focus on sickness absence/staff wellbeing continues to ensure staff are being supported. The Trust Sickness Absence policy and procedure is currently being updated to strengthen links to supporting staff wellbeing in the workplace.
3.7 Well Led: Finance

3.7.1 I&E Surplus/ (Deficit) in month and YTD

Analysis

- The control total for the year is a £3.4m surplus which includes Provider Sustainability Fund (PSF), previously known as Sustainability Transformation Funding, income of £4.1m.
- The Trust has delivered a £1.2m deficit against a control total of £0.6m, an adverse variance of £0.6m.
- The income target has not been achieved this month due to a prudent assumption of not including growth and investment income until contracts have been signed.
- The favourable variance for pay is mainly due to the contra for the growth and investments income not yet included in the plan, £0.4m.

Actions / Developments in the last month

- The financial recovery plan continues to be a focus for the organisation with the aim of earning all PSF for 2018/19.
- The Divisional CIPs continue to be a focus for the teams and the May priority is to ensure that all QIAs for known schemes are signed off and paperwork for schemes developed. There is still a significant gap in the Adult Mental Health teams and Estates Services. The Executive will continue to have oversight of the position.
- The contract negotiations are due to complete in May which will confirm income levels and services developments.
- The CQUIN schemes are being finalised with teams and the work

Trajectory and planned actions for next month

- The financial recovery plan continues to be a focus for the organisation with the aim of earning all PSF for 2018/19.
- The Divisional CIPs continue to be a focus for the teams and the May priority is to ensure that all QIAs for known schemes are signed off and paperwork for schemes developed. There is still a significant gap in the Adult Mental Health teams and Estates Services. The Executive will continue to have oversight of the position.
- The contract negotiations are due to complete in May which will confirm income levels and services developments.
- The CQUIN schemes are being finalised with teams and the work

Summary

<table>
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<tr>
<th>Description</th>
<th>Plan 18/19</th>
<th>Actual 18/19</th>
<th>Budget</th>
<th>Actual</th>
<th>Var F(A)</th>
<th>Plan 18/19</th>
<th>Actual 18/19</th>
<th>Budget</th>
<th>Actual</th>
<th>Var F(A)</th>
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<tr>
<td>EBITDA</td>
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<td>(0.6)</td>
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<td>Control Total Adjustments:</td>
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<tr>
<td>Impairment</td>
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<td>0.0</td>
<td>0.0</td>
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<td>Depreciation of donated assets</td>
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<td>Gain / (Losses) from transfers by absorption</td>
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<td>Capital donations / grants</td>
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<td>0.0</td>
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<tr>
<td>Performance against control total</td>
<td>(0.6)</td>
<td>(1.2)</td>
<td>(0.6)</td>
<td>(1.2)</td>
<td>(0.6)</td>
<td>(1.2)</td>
<td></td>
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</tr>
</tbody>
</table>

INTEGRATED SERVICES DIVISION

MENTAL HEALTH

OLDER PERSONS MENTAL HEALTH SERVICE

LEARNING DISABILITIES

ESTATES SERVICES

CORPORATE

EXECUTIVE SERVICES

CONTRACT INCOME

YTD Variance

Trust Financial Performance against Plan and Agreed Control Total

In Month and YTD Variances
centrally-held reserves which are evenly profiled but spend was low in month 1 (£0.2m), contingency £0.1m, and vacancies in registered nursing £0.6m and admin & clerical £0.2m offset by unfound CIPs (£0.6m).

- The non-pay overspend is due to out-of-area mental health placements (with the average number out of area (OOA) mental health beds for the month increasing 28 to 51.5, £0.2m overspend.), £0.2m unmet CIP targets, premises £0.1m overspent and other smaller overspends on drugs and clinical supplies of £0.1m

- Non-contracted activity is lower than plan by £0.1m and other operating income has under-recovered by £0.1m.

- Agency costs £0.6m, (£0.7m last month) which is £0.1m lower than the internal plan and only £7k higher than the monthly ceiling set by NHS Improvement.

plans being put in place to ensure maximum CQUIN recovery in 2018/19.
4. National Performance Benchmarking Summary

4.1 How to interpret the benchmarking analysis

<table>
<thead>
<tr>
<th>How to interpret the benchmarking analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 month comparison</td>
</tr>
<tr>
<td>SHFT</td>
</tr>
<tr>
<td>Wessex</td>
</tr>
<tr>
<td>National</td>
</tr>
</tbody>
</table>

12 month comparison shows how we have performed when compared to all the individual Trusts over the last 12 months and compares this to performance locally and nationally.

12 month Trust benchmarking shows how we have performed compared to the mean of Wessex performance. The purple bar shows SHFT performance, the pink bar shows the mean of Wessex performance. All the rest, in blue, mark individual Trust performance.

Trend comparison shows the trend of Trust performance over the previous 24 months where possible and compares this to how others have performed, using the same colour scheme described previously. The shaded area of the chart shows the control limit of one standard deviation from the mean of Trust performance over this period, so any time it goes out of this control limit, it is usually worth noting.

Supporting narrative gives a brief summary of the current situation.
4.2 Mental Health Metrics

Proportion of admissions to Adult Mental Health Acute Wards receiving a prior Gatekeeping review | National target 95% | Sourced from NHS England | Updated quarterly

<table>
<thead>
<tr>
<th>SHFT</th>
<th>99.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wessex</td>
<td>98.9%</td>
</tr>
<tr>
<td>National</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

Proportion of patients receiving a follow-up within 7 days of discharge from a Mental Health Ward | National target 95% | Sourced from NHS England | Updated quarterly

<table>
<thead>
<tr>
<th>SHFT</th>
<th>96.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wessex</td>
<td>96.5%</td>
</tr>
<tr>
<td>National</td>
<td>96.3%</td>
</tr>
</tbody>
</table>

Waiting times for patients started treatment for Early Intervention in Psychosis | National target 50% | Sourced from NHS England | Updated monthly

<table>
<thead>
<tr>
<th>SHFT</th>
<th>87.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wessex</td>
<td>83.7%</td>
</tr>
<tr>
<td>National</td>
<td>74.8%</td>
</tr>
</tbody>
</table>

Waiting times for incomplete pathways for Early Intervention in Psychosis | National target 50% | Sourced from NHS England | Updated monthly

<table>
<thead>
<tr>
<th>SHFT</th>
<th>83.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wessex</td>
<td>49.3%</td>
</tr>
<tr>
<td>National</td>
<td>43.8%</td>
</tr>
</tbody>
</table>
4.2 Improving Access to Psychological Therapies (IAPT) Metrics

### Improving Access to Psycholgical Therapies (IAPT) metrics

<table>
<thead>
<tr>
<th></th>
<th>12 month comparison</th>
<th>12 month Trust benchmarking</th>
<th>Trend comparison</th>
<th>Supporting narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improvement Rate</strong></td>
<td>SHFT: 62.5%</td>
<td>Wessex: 66.0%</td>
<td></td>
<td>Data up to and including: January 2018</td>
</tr>
<tr>
<td></td>
<td>National: 66.5%</td>
<td></td>
<td></td>
<td>The Trust scored in the third quartile over the last 12 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Consistently being outscored by local Trusts over the previous 6 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The Trust scored 3.5% below National average in the most recent results.</td>
</tr>
</tbody>
</table>

### Recovery Rate

|                      | SHFT: 48.7%         | Wessex: 50.2%                | National: 51.3% | Data up to and including: January 2018 |
|                      |                     |                              |                 | Latest Trust Score: 46% |
|                      |                     |                              |                 | The Trust scored in the third quartile over the last 12 months. |
|                      |                     |                              |                 | Largely scoring in line with local Trusts over the last 6 months, until the last two months where it has dropped below. |
|                      |                     |                              |                 | The Trust scored 5% below National average in the most recent results. |

### First Treatment within 6 Weeks

|                      | SHFT: 89.2%         | Wessex: 90.4%                | National: 88.0% | Data up to and including: January 2018 |
|                      |                     |                              |                 | Latest Trust Score: 93% |
|                      |                     |                              |                 | The Trust scored in the third quartile over the last 12 months but has consistently improved over this time. |
|                      |                     |                              |                 | SHFT has outperformed local trusts for the last three 3 months. |
|                      |                     |                              |                 | The Trust scored almost 5% above National average in the most recent results. |

### First Treatment within 18 Weeks

|                      | SHFT: 99.6%         | Wessex: 99.7%                | National: 98.4% | Data up to and including: January 2018 |
|                      |                     |                              |                 | Latest Trust Score: 99% |
|                      |                     |                              |                 | The Trust scored in the top quartile over the last 12 months. |
|                      |                     |                              |                 | Consistently scoring well and has outperformed local Trusts over the last 12 months. |
|                      |                     |                              |                 | The Trust scored 1% above National average in the most recent results. |
5. Appendices

Appendix 1.1 – Charts Explained

A. Services
Which Services and Service Lines do the metrics apply to? In some sections this is replaced by theme of the metric (for example Workforce).

B. Metric
The name of the metric. For a full definition of metrics please refer to the definitions appendix of the Integrated Performance Report which will include:
- Definition and rationale for the metric
- Organisation setting the metric
- Internal stretch target and minimum national compliance level (if applicable)
- Numerator and Denominator
- Data Quality kitemark

C. 1 month
Performance for the metric over the most recent 1 month period.

D. 3 months
Performance for the metric over the most recent 3 month period.

F. 24 month trend
Trend analysis, for the last 24 months, is presented using Statistical Process Control.

The Upper and Lower Control Limits (red lines) represent natural limits of variation; the range of performance that would be deemed normal for the measure to perform within based on historical performance. The Control Limits are calculated using 1 standard deviation above and below the mean (represented by the green dotted line) and as such are reflective of 68% of expected performance.

This method of analysing trends is useful as it encourages an improvement culture, identifying genuine change, as opposed to natural monthly variation. Rules are used to identify change (https://www.aquanw.nhs.uk/resources/mental-health/restrain-yourself/Understanding%20SPC%20Charts.pdf).

Any performance point that breaches one of the rules would be formally reviewed with service commentary requested to understand the variance and identify any actions taken as a result from the learning achieved.

Colours explained:
- Complaint - Achieving standard
- Non compliant - Failing standard
- No standard set

Appendix 1.2 – Performance Dashboards (Safe)
180605 TB 10.1 Integrated Performance Report
Appendix 1.3 – Performance Dashboards (Caring)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Metric</th>
<th>1 month</th>
<th>24 month trend (% likely or extremely likely &amp; received)</th>
<th>Theme</th>
<th>Metric</th>
<th>1 month</th>
<th>24 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients - Physical Health</td>
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<tr>
<td></td>
<td>Average score (1 to 5 with 5 the best) 4.8</td>
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<td>Surveys received 1,736</td>
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<td>Experience surveys</td>
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<tr>
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<td>Average score (1 to 5 with 5 the best) 4.6</td>
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<td>Surveys received 53</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Colours explained:
- Complaint Achieving standard
- Non compliant - Failing standard
- No standard set
### Appendix 1.4 – Performance Dashboards (Effective)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Metric</th>
<th>1 month</th>
<th>3 months</th>
<th>24 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>% Reviewed</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Numbers reported</td>
<td>31</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>% Reviewed</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Numbers reported</td>
<td>20</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Out of Area</td>
<td>Out Of Area placements (ODDs)</td>
<td>1,534</td>
<td>3,033</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td>Mixed Sex Accomodation</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Colours explained:**

- **Complaint - Achieving standard**
- **Non compliant - Failing standard**
- **No standard set**
### Appendix 1.5 – Performance Dashboards (Responsive)

<table>
<thead>
<tr>
<th>Services</th>
<th>Metric</th>
<th>1 month</th>
<th>3 months</th>
<th>24 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gatekeeping</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MH LD Inpatient - Delayed Transfers of Care</td>
<td>5.1%</td>
<td>6.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPA 7 Day Follow Up</td>
<td>98.1%</td>
<td>97.4%</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>EIP 2 week wait</td>
<td>85.7%</td>
<td>85.8%</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>IAPT waiting times - 6 weeks</td>
<td>96.8%</td>
<td>95.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IAPT waiting times - 18 weeks</td>
<td>100.0%</td>
<td>99.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waiting Times - External Referral Clock Stops</td>
<td>90.6%</td>
<td>91.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPA 12 Month Reviews</td>
<td>99.2%</td>
<td>99.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MHSDS Identifiers</td>
<td>99.7%</td>
<td>99.7%</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>MHSDS Outcomes</td>
<td>76.9%</td>
<td>78.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Risk Assessments</td>
<td>64.8%</td>
<td>83.6%</td>
<td></td>
</tr>
</tbody>
</table>

#### Colours explained:

- **Complaint**: Achieving standard
- **Non compliant**: Failing standard
- **No standard set**
Appendix 1.6 – Performance Dashboards (Well-Led)

Values shown in Financial tables and charts are variance from plan as opposed to actual values. The 3 month variance quotes the average variance over the 3 month period.

Financial metric themes explained:
A - Income and Expenditure
B - Cash and Capital
C - Efficiencies
D - Use of Resources

Colours explained: Complaint - Achieving standard  Non compliant - Failing standard  No standard set
Appendix 2 – Trust Performance Definitions and Data Quality Kite-marks

The following table defines all of the Key Performance Indicators that are referenced within the Trust Integrated Performance Report. In addition to definition, targets and data source, a Data Quality Kite-Mark is provided for each Responsive domain indicator to assess how reliable and valid the quoted performance is.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition / Rationale</th>
<th>Priority for</th>
<th>Internal stretch target</th>
<th>Numerator Denominator</th>
<th>Data Quality Kite-Mark</th>
<th>Electronic Source System?</th>
<th>Standard Operating Procedure exists?</th>
<th>Validation reporting in place via Tableau?</th>
<th>Current Data Quality error rate (if applicable)</th>
<th>Has a Data Quality audit been completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsive Domain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gatekeeping</td>
<td>It is clinically important to ensure every patient admitted to an Adult Mental Health Ward is assessed by a Crisis Team to ensure the admission is clinically appropriate for the patient.</td>
<td>NHS Improvement</td>
<td>97%</td>
<td>Patients receiving gatekeeping contact prior to admission</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
<td>Number of patients admitted to an Adult Mental Health ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPA 7 Day Follow-Up</td>
<td>Patients should be discharged in a safe and supported way; ensuring they receive a dedicated follow-up appointment within 7 days of a discharge from a Mental Health hospital.</td>
<td>NHS Improvement</td>
<td>97%</td>
<td>Discharged patients receiving a follow-up within 7 days</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
<td>Discharged patients from any Mental Health ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for</td>
<td>Internal stretch target</td>
<td>Numerator Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Electronic Source System?</td>
<td>Standard Operating Procedure exists?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Current Data Quality error rate (if applicable)</td>
<td>Has a Data Quality audit</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
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<td>----------------------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>MH LD Inpatient Delayed Transfers of Care*</td>
<td>The percentage of beds used by mental health service users who are medically fit to be discharged from hospital, but are unable to be discharged due to non-medical reasons</td>
<td>NHS Improvement</td>
<td>5%</td>
<td>Days lost to delayed transfers of care</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>CPA 12 Month Reviews</td>
<td>The percentage of all service users on Care Programme Approach (CPA) who have had their care plan reviewed within the last 12 months and who have been on Care Programme Approach (CPA) for 12 months or more</td>
<td>NHS Improvement</td>
<td>97%</td>
<td>Patients with a CPA review within the last 12 months</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>IAPT waiting times (6 weeks)</td>
<td>People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral</td>
<td>NHS Improvement</td>
<td>80%</td>
<td>Patients beginning treatment within 6 weeks of referral</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for Internal stretch target</td>
<td>Numerator Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Electronic Source System?</td>
<td>Standard Operating Procedure exists?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Has a Data Quality audit been completed?</td>
<td></td>
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</tr>
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<td>--------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>IAPT waiting times (18 weeks)</strong></td>
<td>People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral</td>
<td>NHS Improvement</td>
<td>97% Patients beginning treatment within 18 weeks of referral</td>
<td>3 3 3 3</td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EIP 2 week wait</strong></td>
<td>People with a first episode of psychosis to begin treatment with a NICE-recommended package of care within 2 weeks of referral</td>
<td>NHS Improvement</td>
<td>60% Patients beginning treatment within 2 weeks of referral</td>
<td>3 3 3 3</td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MHSDS Identifiers</strong></td>
<td>Compliance of identifier elements in the data set of the monthly Mental Health Services Data Set submission to NHS Digital</td>
<td>NHS Improvement</td>
<td>98% Valid entries for each of the selected data items</td>
<td>3 3 3 3</td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for Internal stretch target</td>
<td>Internal stretch target Required target to achieve minimum compliance</td>
<td>Numerator Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Electronic Source System?</td>
<td>Standard Operating Procedure exists?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Current Data Quality error rate (if applicable)</td>
<td>Has a Data Quality audit been completed?</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
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<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>MHSDS Outcomes</td>
<td>Compliance of outcome elements in the data set of the monthly Mental Health Services Data Set submission to NHS Digital</td>
<td>NHS Improvement</td>
<td>60%</td>
<td>Valid entries for each of the selected data items</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50%</td>
<td>Total number of entries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Risk Assessments</td>
<td>Risk Assessment compliance for current patients</td>
<td>Trust (Mental Health)</td>
<td>n/a</td>
<td>Current patients with Risk Assessments completed</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>95%</td>
<td>All current patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting Times: Referral to 1st Attended Appointment</td>
<td>The percentage of people receiving their first attending appointment and have waited less than the agreed waiting time standard for the service.</td>
<td>Commissioner</td>
<td>n/a</td>
<td>Patients receiving first attended treatment from referral</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%</td>
<td>Total patients waiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for</td>
<td>Internal stretch target</td>
<td>Numerator Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Electronic Source System?</td>
<td>Standard Operating Procedure exists?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Current Data Quality error rate (if applicable)</td>
<td>Has a Data Quality audit been completed?</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Physical Health Delayed Transfers of Care</td>
<td>The percentage of service users who are medically fit to be discharged from hospital, but are unable to be discharged due to non-medical reasons</td>
<td>Commissioner</td>
<td>7.5%</td>
<td>Days lost to delayed transfers of care during the reporting period</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Referral To Treatment: Incomplete Waiters</td>
<td>Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway</td>
<td>NHS Improvement</td>
<td>94%</td>
<td>Patients receiving first definitive treatment within 18 weeks of referral</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Diagnostics: 6-week waits</td>
<td>Maximum 6-week wait for diagnostic procedures</td>
<td>NHS Improvement</td>
<td>99.5%</td>
<td>Patients receiving a diagnostic procedure within 6 weeks of referral</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>99%</td>
<td>Patients referred for diagnostic procedures</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Each element is scored 1-3, with 3 being the highest level of assurance.
<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition / Rationale</th>
<th>Priority for</th>
<th>Internal stretch target</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Quality Kitemark</th>
<th>Electronic Source System?</th>
<th>Standard Operating Procedure exists?</th>
<th>Validation reporting in place via Tableau?</th>
<th>Current Data Quality error rate (if applicable)</th>
<th>Has a Data Quality audit been completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIU – 4 hour waits</td>
<td>A&amp;E maximum waiting time of 4 hours from arrival to admission/transfer/discharge</td>
<td>NHS Improvement</td>
<td>99%</td>
<td>Patients waiting 4 hours or less from arrival to admission/transfer/discharge</td>
<td>2 3 2 2</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95%</td>
<td>Patients arriving in A&amp;E during the time period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Information Data Set Compliance</td>
<td>Data completeness: community services (T), comprising: RTT information referral information treatment activity information</td>
<td>NHS Improvement</td>
<td>60%</td>
<td>Valid entries for each of the selected data items</td>
<td>3 3 3 3</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>Total number of entries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid Response: % Seen within 2 hours</td>
<td>The percentage of patients seen within 2 hours of the referral being received</td>
<td>Trust</td>
<td>n/a</td>
<td>Rapid response contacts seen within 2 hours</td>
<td>3 3 3 2</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80%</td>
<td>Rapid response contacts (excluding data quality errors)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life: Patients dying in preferred location</td>
<td>The percentage of patients dying in their preferred location of care</td>
<td>Trust</td>
<td>n/a</td>
<td>Patients dying in their preferred location of care during the reporting period</td>
<td>3 3 3 2</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80%</td>
<td>Total deceased end of life patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

MH LD Inpatient Delayed Transfers of Care
The Trust’s internal data quality audit identified concerns that not all staff understood the definition of a Delayed Transfer of Care and as such there a risk was identified that Mental Health Delayed Transfer of Care data may, in the minority of records, not accurately reflect the national definition of a delay. Work is being undertaken within the Division to improve understanding within clinical staff and to promote the Trust’s new discharge standard operating procedure.

**CPA 12 Month Reviews**

Whilst the Trust is confident it is reporting CPA review compliance accurately, there remains a concern that not all review documentation is being correctly recorded within the CPA module of the Trust’s Electronic Patient Record system, RiO. It is important that review documentation is recorded correctly to ensure clinicians have access to a complete and accurate patient record that supports the delivery of high-quality patient care. **Action:** The divisional performance team will complete a randomly selected audit of the CPA caseload to review whether the CPA Review form contains quality patient-focused care and is not just ticking the box to meet compliance. The audit and review will be split equally across all locality areas.

**EIP 2 week wait**

The EIP 2 week wait standard has 2 elements to it; one being that a patient receives commencement of treatment within 2 weeks, and the other being the treatment is compliant with NICE guidelines. At present the Trust is able to demonstrate commencement of treatment within 2 weeks however there are concerns services are not able to evidence NICE compliance and as such this constitutes a data quality risk in terms of the reliability of EIP reported performance.

**Action:** It is recognised that the recording of NICE interventions is a data quality risk. There are actions that have already taken place to progress this from a manual data collection to a standardised recording on RiO.

- To date, manual data collection validated via submissions to national EIP specific audits: EIP Matrix, EIPN.
- All interventions are now available on RiO to record via intended activities against a scheduled appointment, and interventions can be counted via appointment outcomes

Further action to be completed

- The Information team is in discussion with EIP to develop a Tableau report to measure interventions against NICE guidelines. An initial report is available, but further work is taking place to develop it, alongside data quality checks by the teams, to ensure RiO is being used correctly to record the data

**Physical Health Delayed Transfers of Care**
At present the Trust does not record Physical Health Delayed Transfers of Care data as part of a patient’s Electronic Record; as such reporting is based upon monthly submissions provided by Inpatient Wards. Whilst a recent internal data quality audit identified these manual submissions to be reliable, it did identify concerns that it was not possible to easily audit records due to the lack of daily electronic patient data.

**Action:** There is an action plan in existence that identifies the issue of the daily bed state tool not reflecting a validated position. The teams are receiving training to improve the accurateness and there is a pilot in to use RiO as the main EPR.

**MIU 4 hour wait**

The Trust is confident 4-hour wait times are being reported accurately, however the data for this metric is not currently recorded in an electronic system within Petersfield MIU. The service does not have an Electronic Patient Record and as such only monthly performance monitoring is possible; whereas at Lymington, the Trust’s other MIU, full real-time electronic data is available.

**Action:** There are early discussions taking place between Operational Leads and Technology team to scope the moving of the service onto RiO.

**Rapid Response 2 hour performance**

Data relating to Rapid Response is recorded within the Trust’s Electronic Patient Record, RiO, and as such is fully auditable with clinical documentation being available to evidence the quality of care provided. The data quality concern relates to clinicians validating the request and actual seen times of Rapid Response visits which are required to calculate the 2 hour performance. Whilst this validation has improved over recent months, there remain a small number of errors every month which are not being validated by clinical staff.

**Action:** Validation of data quality errors remains a continuous process and is often one per team with no pattern to this. It will be highlighted to teams to ensure any errors are rectified in a timely way.

**End of Life**

A similar situation to Rapid Response where electronic data is captured within RiO however a small number of errors relating to the data required to calculate End of Life performance are not being validated by clinical staff on a monthly basis. The errors relate to palliative patients not having a recorded place of death and as such the Trust not being able to assess if the patient died in their preferred location of care.

**Action:** This will be an area of focus for teams to ensure they have a process to collect and record place of death (where it is appropriate to get it).
<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition / Rationale</th>
<th>Priority for</th>
<th>No thresholds are applied to incident analysis. The Trust is committed to an active reporting culture, encouraging reporting whilst reducing severity</th>
<th>Numerator Denominator</th>
<th>Data Quality Kite-Mark</th>
<th>Electronic Source System?</th>
<th>Standard Operating Procedure exists?</th>
<th>Validation reporting in place via Tableau?</th>
<th>Any additional concerns (i.e. through an audit)?</th>
<th>Current Data Quality error rate (if applicable)</th>
</tr>
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<tr>
<td><strong>Safe Domain</strong></td>
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<tr>
<td>Incidents</td>
<td>Total Number of incidents reported on Ulysses in the month. There are separate categories for Abscond, Ligature, Management for Violence and Aggression, Medicines Management, Pressure Ulcers, Self Harm.</td>
<td>Trust</td>
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<tr>
<td>Restraint</td>
<td>Number for restraint interventions / patients</td>
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<td>Seclusion</td>
<td>Number of Seclusion interventions / patients / holds</td>
<td>Trust</td>
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<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for</td>
<td>No thresholds are applied to incident analysis. The Trust is committed to an active reporting culture, encouraging reporting whilst reducing severity</td>
<td>Numerator Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Electronic Source System?</td>
<td>Standard Operating Procedure exists?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Current Data Quality error rate (if applicable)</td>
<td>Any additional concerns (i.e. through an audit)?</td>
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<td>Effective Domain</td>
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<tr>
<td>Mortality</td>
<td>Number of deaths reported as requiring a review in line with the Trust Mortality policy and % undergoing a Mortality Panel Review</td>
<td>Trust</td>
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<tr>
<td>Mixed Sex Accommodation</td>
<td>Number of incidents reported</td>
<td>Trust</td>
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<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for</td>
<td>No thresholds are applied to patient experience analysis. The Trust is committed to listening to patients and learning from their experience</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Electronic Source System?</td>
<td>Standard Operating Procedure exists?</td>
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<td><strong>Caring Domain</strong></td>
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<tr>
<td>Patient Experience – Friends and Family Test</td>
<td>A nationally-used measure to record patient satisfaction. It looks at the percentage of people responding 'extremely likely' or 'likely' to the question 'How likely are you to recommend our services to friends and family if they needed similar care or treatment?'</td>
<td>NHS Improvement</td>
<td>% of responses 'extremely likely' or 'Likely'</td>
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<tr>
<td>Customer Experience (Complaints/Concerns / Compliments)</td>
<td>Number of complaints, concerns and compliments received and recorded on Ulysses</td>
<td>Trust</td>
<td>Total number of responses</td>
<td></td>
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<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for</td>
<td>Internal stretch target</td>
<td>Numerator Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Standard Operating Procedure exists?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Current Data Quality error rate (if applicable)</td>
<td>Any additional concerns (i.e. through an audit)?</td>
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<td><strong>Well Led Domain</strong></td>
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<tr>
<td>Leavers with less than 12 months service</td>
<td>% of people who left, who had joined the Trust within the last 12 months</td>
<td>Trust</td>
<td>15%</td>
<td>Number of staff leaving who joined in the last 12 months</td>
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<td>20%</td>
<td>Total staff leaving</td>
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<tr>
<td>Vacancies</td>
<td>%r of vacant posts versus planned establishment</td>
<td>Trust</td>
<td>5.0%</td>
<td>Number of vacant posts</td>
<td></td>
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<td>Total funded establishment</td>
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<tr>
<td>Rolling 12 month Bank and Agency</td>
<td>% of Bank and Agency spend</td>
<td>Trust</td>
<td>3.5%</td>
<td>Bank and agency spend</td>
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<td>5.0%</td>
<td>Total pay bill</td>
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<tr>
<td>Sickness Absence</td>
<td>% of people absent due to sickness</td>
<td>Trust</td>
<td>3.5%</td>
<td>Number of staff off sick</td>
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<td>5.0%</td>
<td>Total number of staff</td>
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<tr>
<td>Turnover</td>
<td>% of staff who have left the Trust</td>
<td>Trust</td>
<td>12%</td>
<td>Number of leavers</td>
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<td>20%</td>
<td>Total number of staff</td>
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<tr>
<td>Appraisal Compliance</td>
<td>% of staff having an appraisal since April. Appraisals provide opportunities for staff to discuss concerns and to set objectives with their manager, which improve individual practice and care provided to patients.</td>
<td>Trust</td>
<td>95%</td>
<td>Number of staff having an appraisal</td>
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<td>90%</td>
<td>Total number of staff</td>
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<tr>
<td>Metric</td>
<td>Definition / Rationale</td>
<td>Priority for</td>
<td>Internal stretch target</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Quality Kite-Mark</td>
<td>Standard Operating Procedure exists?</td>
<td>Electronic Source System?</td>
<td>Validation reporting in place via Tableau?</td>
<td>Current Data Quality error rate (if applicable)?</td>
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<td><strong>Well Led Domain</strong></td>
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<tr>
<td>LEaD Training compliance</td>
<td>% of staff having completed all statutory and mandatory training</td>
<td>Trust</td>
<td>95%</td>
<td>Number of staff compliant with training</td>
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<td>90%</td>
<td>Total number of staff</td>
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<td>Capital YTD</td>
<td>Taken from the ledger</td>
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<td>Cost Improvement YTD</td>
<td>Financial Year to date % variance (Planned vs Actual), taken from the ledger</td>
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<tr>
<td>I&amp;E Surplus/(Deficit) in month</td>
<td>Financial month £'000 Variance (Planned vs Actual). Taken from the ledger</td>
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<tr>
<td>I&amp;E Surplus/(Deficit) YTD</td>
<td>Financial Year To Date £'000 Variance (Planned vs Actual). Taken from the ledger</td>
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<td>Agency Spend YTD</td>
<td>Taken from ledger</td>
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<td>Cash Balance month end</td>
<td>Taken from the ledger</td>
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<tr>
<td>Use of Resources YTD</td>
<td>The Use of Resources rating is to assess whether the Trust is well managed financially. It measures 5 elements: Capital Service Cover, Liquidity, I&amp;E Margin, I&amp;E Variance, Agency</td>
<td>NHS Improvement</td>
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Costs, with each element accounting for 20% of the score.

| Note: if any element scores a 4, an override mechanism is applied and the overall score cannot be better than a 3. |   |   |   |   |
### Appendix 3 – Trust Operating Plan Priorities

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>2018/19 DELIVERABLES</th>
<th>MEASURES OF DELIVERY</th>
</tr>
</thead>
</table>
| Provide good quality care | - Achieve a minimum rating of ‘good’ from our regulator the Care Quality Commission (CQC). [Q3]  
- Achieve our quality priorities as set out in our quality accounts and our contracts. [Monthly]  
- Removal of NHS Improvement restrictions on our operating licence, relating to quality of care.[Q3] |  
| Single approach to improving quality adopted across the whole trust | - 6 QI champion coaches in place, 60 trained Quality improvement implementers, 600 staff actively involved in Quality improvement based transformation projects. [Q4]  
- Measurable improvement against key trust priorities as a direct result of QI work [Q4] |  
| Patients, families and the public are more involved in decisions about their care and their local services | - 97% of people completing monthly ‘Friends and Family’ test would ‘Recommend’ or ‘Highly Recommend’ care. [Q4]  
- Achieve objectives of the Experience, Involvement and Partnership Strategy. [Q4]  
- Evidence of increased patient, carer and family involvement in care, in line with principles of the Triangle of Care. [Monthly]  
- Within top 20% similar NHS Trusts nationwide for engagement of people who use or rely on our services. [Q4]  
- NHS Improvement lifts restrictions to operating licence relating to service user engagement. [Q3] |  
| People are able to access the care they need, when they need it | - All nationally mandated targets met. [Monthly]  
- Significantly reduce the number of people receiving mental health care in beds outside Hampshire with the number of beds reduced to no more than 4. [By the end of Q2] |  
| Increased recruitment and retention of staff, leading to a more stable workforce | - Vacancy rate of 6% or lower. [Q4]  
- Only 3.2% of the total pay costs are spent on agency workers by the end of the year. [Monthly] |  
| Strong leadership throughout the organisation | - Achieve a rating of ‘good’ from the Care Quality Commission in the ‘well-led’ category. [Q3]  
- NHS Improvement regulatory undertakings relating to Board governance lifted. [Q3] |  
| Staff feel involved, motivated and proud to work at Southern Health | - 2018 Staff survey engagement scores in ‘top 3rd':  
- Advocacy increased from 3.63 towards 3.73  
- Motivation increased from 3.93 to 3.95 or above  
- Involvement sustained at 75% (already top 3rd)  
- Staff survey overall response rate increased to 66%. [Q4] |  
| The size, shape and skills of our workforce can meet current and future needs | - People and Organisational Development Strategy approved by Trust Board. [Q1] |
### Patients have better access, experience and outcomes as a result of transformed, joined-up services

- Improvements to services in line with our clinical services strategy and Hampshire health and care plans. [Q4]
- Complete redesign of access to South East Hampshire mental health services and agree implementation plan with partner organisations. [Q2]
- Launch second major service redesign programme supported by Northumberland, Tyne and Wear NHS Trust. [Q1]
- Implement Extended Primary Care Teams (EPCT) and closer working with primary, acute, social care and voluntary sector partners. [Q4]
- Joint management structure in place to deliver integrated intermediate care with Hampshire County Council. [Q3]
- Discharge to assess pathway in place in our community hospitals. Increased patient and family involvement in discharge planning. [Q4]
- Specialist services review completed across Hampshire with CCGs, to ensure provision of safe, high quality long term condition hubs and specialist services that meet the needs of localities. [Q4]
- Children’s public health 0-19 care model designed in partnership with Hampshire County Council. [Q4]

### Expansion and improvement of specialised mental health services for adults and young people underway

- Board approval of plans to expand secure services for young people. [Q1]
- Support from board and key stakeholders for improvements to the adult secure services pathway. [Q4]

### Make every penny count towards patient care and service improvements

- Services delivered within the 2018/19 financial targets. [Q4]
- Delivery of control total surplus each quarter. [Monitored throughout the year]
- Fully deliver CIP target, of which at least 75% is recurrent in year and 100% recurrently including full year effect. [Monthly]
- Cash balance in line with financial plan. [Q4]
- NHS Improvement Use of Resources Rating of 3 Q1/Q2 and 2 Q3/Q4

### Future delivery and improvements to care safeguarded through sound financial planning

- Medium term commissioning strategy for community services agreed. [Q2]
- 3 year financial plan developed, including efficiency plans. [Q4]
1. **Purpose**

   1.1. The purpose of this report is to provide Trust Board members with the exception report for May 2018 (April 2018 data) presented within the overall data submissions for safer staffing in line with national reporting requirements.

2. **Background**


   2.2. This report details the rolling 4 months comparison data to enable identification of trends and monitoring of inpatient wards breaching Safer Staffing recommendations.

   2.3. Narrative has been provided to inform Trust Board members where professional judgement decisions have been applied to improve staffing levels in inpatient units as required for this period where staffing levels have fallen below 80% establishment.

   2.4. From April 2018 a new monthly reporting metric of Care Hours Per Patient Day (CHPPD) has been introduced by NHSL for all Community, Mental Health and Learning Disability Trusts. CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is now included within our monthly data submissions and within Appendix 2 of this report.

   2.5. Reporting on NQB Compliance Status based upon updated Safer Staffing Guidance Appendix 5 will no longer be reported within this report as all work streams have now been completed or now business as usual. Updates regarding SafeCare will continue to be provided throughout the year on an exception basis.

3. **Exception report for the period 1st April 2018 to 30th April 2018**

   3.1. The full data return for this period can be found in Appendix 1.

   3.2. Off framework agency use is not included within the below data.

   3.3. 5 sites will be reported in the national publication data set as red this month;-

   3.4. 4 out of 5 sites total staffing levels were over 94.9% when combining actual Registered Nursing and unregistered nursing hours and reviewing against planned combined staffing level fill rates for the site*. One site - Leigh House staffing remained at 68.8%. Further narrative pertaining to Leigh House is detailed in section 4.

   **Antelope House – Registered Nurse day shifts – 79.8%**

   When combining actual Registered Nursing and unregistered nursing hours for the site, total staffing levels were 107.9% of total planned hours*.

   **Leigh House – Registered Nurse day shifts – 50.7%**
When combining actual Registered Nursing and unregistered nursing hours for the site, total staffing levels were 68.8% of total planned hours*.

**Bluebird House – Registered Nurse day shifts – 73.8%**
When combining actual Registered Nursing and unregistered nursing hours for the site, total staffing levels were 94.9% of total planned hours*

**Elmleigh – Registered Nurse day shifts – 71.2%, Unregistered nurse night shifts 66%**
When combining actual Registered Nursing and unregistered nursing hours for the site, total staffing levels were 99.4% for day shifts and 103% for night shifts of total planned hours*.

**Melbury Lodge– Registered Nurse night shifts – 73.7%**
When combining actual Registered Nursing and unregistered nursing hours for the site, total staffing levels were 97.2% of total planned hours*.

*Where Registered Nurse staffing levels are reduced, in order to maintain safe services, unregistered staffing levels may be increased where it is deemed that this is appropriate to do so. This is carefully managed on a shift by shift basis by Senior Clinician’s.


4.1. Ward level safer staffing data for the last 4 months on a rolling basis which reflects submitted information is contained within Appendix 3.

4.2. 15 wards have had staffing under-establishment fill rate challenges for at least 3 out of the past 4 rolling months. These are monitored on a shift by shift/daily/weekly basis and staff redeployed flexibly across units/wards where able to ensure wards are staffed appropriately.

**Stefano Oliveri Unit – Registered Nurse day and night shifts**
This is due to vacancy. There has been no impact to patients due to the reduced staffing levels, nor has the team flagged within data triangulation. It is planned to review the staffing model and skill mix at the acuity and dependency validation meeting next month and also as part of wider discussions within OPMH.

**Hawthorns 2 – Registered Nurse day shifts**
This is due to band 5 vacancies. Pro-active recruitment to vacancies continues together with support from long term temporary staffing placements. A number of new members of staff will commence in September and October.

**Elmwood and Beechwood Ward – Registered Nurse night shifts**
This is due to vacancy. Cross unit working on each shift as necessary to ensure that safe staffing levels were maintained and staffing evenly distributed, with senior level support as required. Elmwood Ward did not flag within April data as average fill rate was 89.3%.

**Saxon Ward, Trinity Ward and Hamtun Ward– Registered Nurse day shifts**
This is due to ongoing vacancy and unavailability. Cross unit working, together with the use of temporary staff, including some non-framework agency, and senior level support to ensure that safe staffing levels are maintained. A daily Matron led staffing meeting is in place, together with oversight from both the Director and Deputy Director of Nursing.
Appendix 1

Hamtun Ward did not flag within April data as reported Registered Nurse day shift fill was 90.5%.

April data for Saxon and Trinity Ward does not include off framework agency hours so actual day shift fill for Registered Nursing was higher than 90.5%.

**Kingsley Ward – Registered Nurse night shifts**

This is due to vacancy and unavailability. Risk is mitigated through the use of regular temporary staff and increased levels of unregistered staff, together with senior clinician support as required. Registered Nurse fill rates for night shifts have improved each month for the last four months.

**Beaulieu Ward and Berrywood Ward – Registered Nurse day shifts**

This is due to ongoing vacancies and unavailability. Support and patient care is also provided by utilisation of temporary staff including long term placements and other Professional groups including Therapy staff and Practice Educators as appropriate. Neither ward flagged for Registered Nurse day shifts within April data, with Berrywood fill rate at 80.7% and Beaulieu at 91.8%.

**Stewart Ward - Registered Nurse day shifts and Moss Ward unregistered nurse day and night shifts**

This is due to vacancy and unavailability. Staffing is reviewed daily on a cross unit basis which means that staff will be moved fluidly between wards at the start of shift if required, in order to ensure appropriate skill mix and staffing levels. Utilisation of temporary staff on long lines of work to offset vacancy levels, together with senior level support as required. Recruitment continues to be ongoing with planning in progress for an open day in June.

**Leigh House – Registered Nurse day shifts**

This is due to vacancy and unavailability, but recent recruitment success will improve this position in this next quarter. At times, staffing levels have proved challenging with respect to continuity and quality of care delivery to the young people, however staffing has remained safe. The board is requested to note that a number of the young people access Section 17 leave or home leave at weekends, which means staffing numbers will be reduced accordingly. Additionally, other members of the multidisciplinary team – including teaching staff who are not captured within this data also contribute to care.

Successful recruitment to full establishment levels has been achieved for Band 6 and Band 2 posts. Successful candidates will now proceed through the recruitment process.

**Elmleigh - Registered Nurse day shifts**

This is due to vacancy and unavailability. There has been no impact to care as a result of this reduction in Registered Nurse shift fill. The creation of a number of Band 4 roles who have received specialist training and development within this unit has released Registered Nursing time resulting in increased patient contact, and improved quality of care. This is monitored on a weekly basis by the unit Matron.

**Ark Royal Ward - Registered Nurse day shifts**

This is due to vacancy and unavailability. There has been no impact to patient care as a result of these reduced staffing levels, however the position continues to be monitored and work is ongoing in order to recruit to vacancies.
5. Acuity and dependency re-measure updates and community safer staffing

5.1. Acuity and dependency re-measurement within Community Mental Health teams has commenced as part of an ongoing rolling program using the Hurst Tool. A further two teams detailed reports have now returned from Professor Hurst which following validation of the data has identified a gap of 13 whole time equivalents (WTE’s). Business cases are currently being prepared for submission through internal process. Full detailed reporting on all teams’ results will be included within this report once all results have returned.

5.2. Implementation of the Benson Winter staffing model within Children’s Services and subsequent establishment setting has enabled reporting with respect to planned versus actual staffing levels on a monthly basis. Data for the month of April for Health Visiting is available below.

5.3. The Board is requested to note that percentage fill rates for unregistered staff are based upon small planned numbers of hours – as the majority of the workforce is Registered staffing. This can mean that if there are only three whole time equivalents (WTE’s) of unregistered staff in a team, a cumulative loss of one WTE due to unavailability over the month would result in a 33% reduction in fill rate. Further detail relating to any impact of staffing levels to service will be detailed within the Children’s Services Divisional Quality report.

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<thead>
<tr>
<th>Team</th>
<th>Registered</th>
<th>Unregistered</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Fill Rate</td>
<td>Fill Rate</td>
</tr>
<tr>
<td>Aldershot HV S00616</td>
<td>89.56%</td>
<td>119.05%</td>
</tr>
<tr>
<td>Alton and Odiham HV S00602</td>
<td>107.95%</td>
<td>93.33%</td>
</tr>
<tr>
<td>Alver and Lee HV S00618</td>
<td>118.94%</td>
<td>43.49%</td>
</tr>
<tr>
<td>Andover HV S00600</td>
<td>97.53%</td>
<td>46.82%</td>
</tr>
<tr>
<td>Basingstoke and Tadley HV S00617</td>
<td>103.72%</td>
<td>80.00%</td>
</tr>
<tr>
<td>Basingstoke North and Rural HV S00596</td>
<td>85.99%</td>
<td>85.71%</td>
</tr>
<tr>
<td>Basingstoke South and Rural HV S00595</td>
<td>111.34%</td>
<td>10.00%</td>
</tr>
<tr>
<td>Bordon and Petersfield HV S00597</td>
<td>92.38%</td>
<td>91.75%</td>
</tr>
<tr>
<td>Eastleigh North &amp; Romsey HV S00612</td>
<td>110.46%</td>
<td>87.07%</td>
</tr>
<tr>
<td>Eastleigh South HV S00620</td>
<td>65.08%</td>
<td>95.95%</td>
</tr>
<tr>
<td>Fareham HV S00607</td>
<td>104.83%</td>
<td>88.36%</td>
</tr>
<tr>
<td>Farnborough HV S00598</td>
<td>101.37%</td>
<td>95.24%</td>
</tr>
<tr>
<td>Fleet and Yateley HV S00615</td>
<td>103.63%</td>
<td>66.19%</td>
</tr>
<tr>
<td>Gosport Central HV S00608</td>
<td>122.88%</td>
<td>87.11%</td>
</tr>
<tr>
<td>Havant HV S00604</td>
<td>87.67%</td>
<td>99.58%</td>
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<tr>
<td>New Forest East HV S00619</td>
<td>109.52%</td>
<td>75.40%</td>
</tr>
<tr>
<td>New Forest West HV S00611</td>
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<td>Waterlooville HV S00605</td>
<td>102.36%</td>
<td>117.14%</td>
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<td>Winchester HV S00601</td>
<td>94.27%</td>
<td>55.77%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>98.56%</td>
<td>80.82%</td>
</tr>
</tbody>
</table>
6. Incident reporting

6.1. SHFT staff are encouraged to report staffing related incidents via our Ulysses system. The graph below shows the number and grade of staffing cause group incident forms submitted each month for the past 12 months.

6.2. The Board are requested to note that we have revised the process which allows staff to identify issues as red flag incidents related to staffing at the point of reporting. This means that staffing issues may not have been identified as a cause group and therefore would not be included in the graph below.

6.3. 47 staffing related incidents were submitted in April 2018. 0 were graded as level 4 major harm (aqua) or level 3 moderate harm (purple), 7 level 2 low harm (green), with the remaining 40 incidents graded as level 1a near miss or 1 no harm.

6.4. All staffing incidents – irrespective of level of grading have been reviewed in accordance with the safer staffing policy descriptors as nursing red flag incidents in addition to the incidents flagged by the reporters which may have differing cause groups. This has resulted in 25 incidents being identified as red flag incidents.

6.5. Within this report, red flag information is detailed at a level that provides an overview. Additional information relating to any impact to patients will be detailed within Quarterly Divisional Quality and Governance reports.

6.6. Red flag incidents identified for April are:

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Number of Incidents</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bluebird House - Moss Ward</td>
<td>2</td>
<td>Reduced staffing levels, and levels not matched to patient acuity. Delay in care delivery. Delay in review completion.</td>
</tr>
<tr>
<td>North Area - AMHT</td>
<td>1</td>
<td>Inability to deliver AMHT out of hour’s service to Basingstoke ED due to staff sickness.</td>
</tr>
<tr>
<td>Leigh House</td>
<td>2</td>
<td>Inability to complete managers hearing in identified timescales due to workload. Delay in delivery of care.</td>
</tr>
<tr>
<td>Melbury Lodge - Mother and Baby Unit</td>
<td>2</td>
<td>Staffing levels not matched to patient clinical requirement.</td>
</tr>
<tr>
<td>Bluebird House - Hill Ward</td>
<td>3</td>
<td>Staffing levels not matched to patient clinical</td>
</tr>
</tbody>
</table>
Appendix 1

<table>
<thead>
<tr>
<th>Location</th>
<th>Incident Count</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural East CCT (North)</td>
<td>1</td>
<td>Patient visits rescheduled due to staffing. Staffing not matched to clinical need.</td>
</tr>
<tr>
<td>Antelope House - Trinity Ward</td>
<td>1</td>
<td>Staffing levels not matched to patient clinical requirement.</td>
</tr>
<tr>
<td>Gosport Therapy (Community and Inpatient)</td>
<td>1</td>
<td>Staffing unavailability resulting in a delay in patient assessments</td>
</tr>
<tr>
<td>Romsey ICT</td>
<td>1</td>
<td>Delay in administration of medication.</td>
</tr>
<tr>
<td>Ravenswood Ashurst Ward</td>
<td>1</td>
<td>Inability to facilitate community leave.</td>
</tr>
<tr>
<td>Health Visiting - Eastleigh South</td>
<td>2</td>
<td>Inability to deliver all universal contacts and postnatal visits.</td>
</tr>
<tr>
<td>Melbury Lodge - Kingsley Unit</td>
<td>1</td>
<td>Delay in tribunal referral</td>
</tr>
<tr>
<td>Rural West CCT (North)</td>
<td>1</td>
<td>Patient visits rescheduled due to staffing. Delay in completion of documentation.</td>
</tr>
<tr>
<td>Petersfield Hospital - Cedar Ward</td>
<td>1</td>
<td>Delay in delivery of care</td>
</tr>
<tr>
<td>Lymington Radiology</td>
<td>3</td>
<td>Reduced staffing levels resulting in the closure of Hythe X-ray department</td>
</tr>
<tr>
<td>Petersfield and Bordon Therapy</td>
<td>1</td>
<td>Delay in delivery of occupational therapy to Cedar ward inpatients</td>
</tr>
<tr>
<td>Parklands Hospital - Beechwood Ward</td>
<td>1</td>
<td>Staffing levels not matched to patient clinical requirement, delay in delivery of care.</td>
</tr>
</tbody>
</table>

6.6.1. Actions identified will be monitored within Divisions to ensure themes reported within red flag incidents are addressed.

7. Bank and Agency – Safer Staffing risk

7.1. Fill rates by ‘type of worker’ have been analysed this month with the breakdown available in Appendix 4. The table identifies the split between substantive, multi-post holder, bank only and agency temporary workers within the fill rates reported.

7.2. A SHFT internally agreed Red Flag is to highlight any inpatient unit utilising more than 50% temporary workers to meet their fill requirement as this represents a potential safer staffing risk, for April this was 604 shifts over 29 shift types across the whole Trust.

7.2.1. 28 out of the 29 shift types were night shifts that were covered with over 50% temporary workers.

7.2.2. 3 of the 29 shift types involved using more than 50% agency only temporary workers. These shifts were worked within;

- Saxon Ward
- Beaulieu Ward
- Stewart Ward

7.2.3. In all locations the majority of these shifts were worked by staff who were either on specific long lines of work or who regularly work within these locations.
8. **Risks and issues**

8.1. Continuing to source appropriate staffing to meet the requirements of SHFT inpatient units and community teams in line with workforce plans, and the national climate of reduced Registered Nurse availability.

8.2. Managing the financial and skills challenges associated with workforce establishment changes in line with national guidance.

8.3. Under the leadership of the Director and Deputy Director of Nursing to reduce temporary staffing and eliminate non-framework agency use whilst maintaining safer staffing levels and complying with NHS Improvement (NHSI) rules.

9. **Next Steps and Priorities for 2018**

9.1. Continued focus on effective rostering to improve staffing utilisation and productivity in line with Lord Carter’s recommendations has now commenced. It is anticipated that this project will run until November 2018

9.2. Further refine the acuity and dependency measurement process within community settings.

9.3. Implementation of SafeCare within SHFT within all inpatient areas and operationalise for community use. The phased roll out has commenced, and it is anticipated that this will be completed by November 2018 for inpatient areas.

9.4. Eliminate all non-framework agency spend, reduce reliance on bank and agency staff and reduce agency expenditure in line with NHSI target.

9.5. Continue to embed Safer Staffing within SHFT and ensure continued alignment to the latest National Quality Board guidance.

10. **Recommendation**

10.1. The board are asked to receive the action report for Safer Staffing for May 2018 (April 2018 data).

11. **Appendices**
Appendix 1

Appendix 1 – Safer Staffing Monthly Board Report – May 2018 (April 2018 data)

- The table below shows ward level average nursing fill rates during day and night shifts for the reporting period above.
- Data is extracted from e-roster (showing the planned positions) and NHS Professionals bank and agency reports.
- An Internally developed RAG rating has been applied consistently as per last month’s reporting. Wards highlighted in ‘GREEN’ are reported as having staffing levels between 80% and 150% planned levels (in line with NHS England’s primary baseline triggers). ‘RED’ wards are reported as having less than 80% average fill rate (NICE 2014 recommended 75% as the trigger for RED). ‘BLUE’ are reported as having more than 150% fill rate.

- Staffing levels across hospital sites and across each ward are operationally managed each shift through the transfer of staffing resource, as indicated, to meet the changing acuity and dependency of patient needs. This enables a ‘RED’ ward to become a ‘GREEN’ in terms of safer staffing levels, but the transfer is not made electronically on e-roster as it often is not a requirement to be a whole shift movement often providing changing cover during peaks in acuity and dependency throughout periods of a day. In order to show the effect of this flexibility and movement throughout shifts, the right hand column on the chart below, shows the resulting average staffing levels across the whole site. With this exercise being completed for this monthly reporting period.

- Data is for nursing only and does not include any other staff working substantively on the wards with patients, such as Psychology and Therapy. Data also does not include student nurses on placement within inpatient areas.
## Appendix 1

Appendix 1 – Safer Staffing Monthly Board report – May 2018 (April 2018 data). When interpreting this dataset, Trust Board members should consider that some of the Southern Health NHS Foundation Trust inpatient wards are very small with less than 10 beds.

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Hospital Site name</th>
<th>Ward Name</th>
<th>Average fill rate RN Staff (%)</th>
<th>Average fill rate CSW staff (%)</th>
<th>Average fill rate RN staff (%)</th>
<th>Average fill rate CSW staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>Moorgreen Hospital</td>
<td>Willow Ward</td>
<td>141.9%</td>
<td>116.0%</td>
<td>96.7%</td>
<td>121.9%</td>
</tr>
<tr>
<td>SS</td>
<td>Woodhaven</td>
<td>Ashford Unit</td>
<td>105.2%</td>
<td>86.2%</td>
<td>106.9%</td>
<td>95.6%</td>
</tr>
<tr>
<td>AMH</td>
<td>Antelope House</td>
<td>Saxon Ward</td>
<td>77.2%</td>
<td>131.7%</td>
<td>146.3%</td>
<td>134.2%</td>
</tr>
<tr>
<td>AMH</td>
<td>Antelope House</td>
<td>Trinity Ward</td>
<td>72.4%</td>
<td>129.6%</td>
<td>160.3%</td>
<td>140.6%</td>
</tr>
<tr>
<td>AMH</td>
<td>Antelope House</td>
<td>Hamtun Ward PICU</td>
<td>90.5%</td>
<td>120.5%</td>
<td>137.4%</td>
<td>127.2%</td>
</tr>
<tr>
<td>AMH</td>
<td>Elmleigh</td>
<td>Elmleigh Inpatient</td>
<td>71.2%</td>
<td>118.0%</td>
<td>66.0%</td>
<td>137.7%</td>
</tr>
<tr>
<td>AMH</td>
<td>Forest Lodge</td>
<td>Forest Lodge</td>
<td>113.3%</td>
<td>87.3%</td>
<td>100.0%</td>
<td>101.7%</td>
</tr>
<tr>
<td>AMH</td>
<td>Hollybank</td>
<td>Hollybank</td>
<td>99.3%</td>
<td>97.6%</td>
<td>100.4%</td>
<td>101.6%</td>
</tr>
<tr>
<td>AMH</td>
<td>Melbury Lodge</td>
<td>Kingsley Ward</td>
<td>104.9%</td>
<td>102.6%</td>
<td>76.2%</td>
<td>136.2%</td>
</tr>
<tr>
<td>AMH</td>
<td>Melbury Lodge</td>
<td>Mother &amp; Baby Unit</td>
<td>87.4%</td>
<td>92.0%</td>
<td>100.0%</td>
<td>87.7%</td>
</tr>
</tbody>
</table>

Average RN fill rate as a site

Average CSW fill rate as a site
### Appendix 1

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Hospital Site name</th>
<th>Ward Name</th>
<th>Average fill rate RN Staff (%)</th>
<th>Average fill rate CSW staff (%)</th>
<th>Average fill rate RN staff (%)</th>
<th>Average fill rate CSW staff (%)</th>
<th>Average RN fill rate (%) as a site</th>
<th>Average CSW fill rate (%) as a site</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Parklands Hospital</td>
<td>Hawthorns 1</td>
<td>78.6%</td>
<td>129.3%</td>
<td>120.7%</td>
<td>155.7%</td>
<td>81.7%</td>
<td>111.5%</td>
</tr>
<tr>
<td>AMH</td>
<td>Parklands Hospital</td>
<td>Hawthorns 2</td>
<td>74.4%</td>
<td>128.6%</td>
<td>100.0%</td>
<td>116.7%</td>
<td>81.7%</td>
<td>111.5%</td>
</tr>
<tr>
<td>SS</td>
<td>Ravenswood House</td>
<td>Ashurst Ward</td>
<td>82.5%</td>
<td>105.2%</td>
<td>86.6%</td>
<td>100.0%</td>
<td>90.0%</td>
<td>90.9%</td>
</tr>
<tr>
<td>SS</td>
<td>Ravenswood House</td>
<td>Lyndhurst Ward</td>
<td>99.0%</td>
<td>75.7%</td>
<td>100.0%</td>
<td>100.2%</td>
<td>90.0%</td>
<td>90.9%</td>
</tr>
<tr>
<td>SS</td>
<td>Ravenswood House</td>
<td>Malcolm Faulk Ward</td>
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<td>94.9%</td>
<td>161.3%</td>
<td>98.6%</td>
<td>90.0%</td>
<td>90.9%</td>
</tr>
<tr>
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<td>Mary Graham Ward</td>
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<td>96.3%</td>
<td>96.9%</td>
<td>98.6%</td>
<td>90.0%</td>
<td>90.9%</td>
</tr>
<tr>
<td>SS</td>
<td>Southfield</td>
<td>Beech Ward</td>
<td>105.8%</td>
<td>113.5%</td>
<td>100.8%</td>
<td>98.9%</td>
<td>102.9%</td>
<td>105.3%</td>
</tr>
<tr>
<td>SS</td>
<td>Southfield</td>
<td>Cedar Ward</td>
<td>108.4%</td>
<td>101.4%</td>
<td>97.5%</td>
<td>101.3%</td>
<td>102.9%</td>
<td>105.3%</td>
</tr>
<tr>
<td>SS</td>
<td>Southfield</td>
<td>Oak Ward</td>
<td>94.7%</td>
<td>102.8%</td>
<td>100.0%</td>
<td>101.7%</td>
<td>102.9%</td>
<td>105.3%</td>
</tr>
<tr>
<td>SS</td>
<td>Bluebird House</td>
<td>Moss Ward</td>
<td>80.9%</td>
<td>86.8%</td>
<td>143.8%</td>
<td>79.5%</td>
<td>73.8%</td>
<td>109.5%</td>
</tr>
<tr>
<td>SS</td>
<td>Bluebird House</td>
<td>Stewart Ward</td>
<td>58.7%</td>
<td>121.4%</td>
<td>88.5%</td>
<td>103.3%</td>
<td>73.8%</td>
<td>109.5%</td>
</tr>
<tr>
<td>SS</td>
<td>Bluebird House</td>
<td>Hill Ward</td>
<td>93.6%</td>
<td>139.2%</td>
<td>75.4%</td>
<td>145.5%</td>
<td>73.8%</td>
<td>109.5%</td>
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<tr>
<td>SS</td>
<td>Leigh House</td>
<td>Leigh House</td>
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<td>83.4%</td>
<td>92.4%</td>
<td>103.1%</td>
<td>50.7%</td>
<td>83.4%</td>
</tr>
</tbody>
</table>
## Appendix 1

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Hospital Site name</th>
<th>Ward Name</th>
<th>Average fill rate RN Staff (%)</th>
<th>Average fill rate CSW staff (%)</th>
<th>Average fill rate RN as a site (%)</th>
<th>Average fill rate CSW as a site (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BU1</td>
<td>Gosport War Memorial Hospital</td>
<td>Ark Royal Ward</td>
<td>75.2%</td>
<td>101.5%</td>
<td>91.7%</td>
<td>163.8%</td>
</tr>
<tr>
<td>BU1</td>
<td>Gosport War Memorial Hospital</td>
<td>Sultan Ward</td>
<td>101.2%</td>
<td>101.7%</td>
<td>100.6%</td>
<td>103.8%</td>
</tr>
<tr>
<td>BU1</td>
<td>Petersfield Hospital</td>
<td>Cedar Ward (Petersfield)</td>
<td>83.0%</td>
<td>95.3%</td>
<td>100.0%</td>
<td>103.4%</td>
</tr>
<tr>
<td>BU1</td>
<td>Petersfield Hospital</td>
<td>Rowan Ward</td>
<td>92.6%</td>
<td>91.7%</td>
<td>98.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>BU2</td>
<td>Fordingbridge Hospital</td>
<td>Ford Ward</td>
<td>88.9%</td>
<td>86.0%</td>
<td>100.3%</td>
<td>99.5%</td>
</tr>
<tr>
<td>BU2</td>
<td>Lymington New Forest Hospital</td>
<td>Deerleap Ward</td>
<td>97.9%</td>
<td>111.7%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>BU2</td>
<td>Lymington New Forest Hospital</td>
<td>Longbeech Ward</td>
<td>86.3%</td>
<td>163.7%</td>
<td>101.7%</td>
<td>168.7%</td>
</tr>
<tr>
<td>BU2</td>
<td>Lymington New Forest Hospital</td>
<td>Medical Admissions Unit</td>
<td>87.6%</td>
<td>93.5%</td>
<td>96.7%</td>
<td>96.7%</td>
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<tr>
<td>BU2</td>
<td>Lymington New Forest Hospital</td>
<td>Wilverley Ward</td>
<td>84.6%</td>
<td>204.6%</td>
<td>100.0%</td>
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</tr>
<tr>
<td>BU2</td>
<td>Romsey Hospital</td>
<td>Chichester/Nightingale Ward</td>
<td>101.3%</td>
<td>96.7%</td>
<td>98.8%</td>
<td>140.3%</td>
</tr>
<tr>
<td>BU3</td>
<td>Alton Community Hospital</td>
<td>Anstey Ward</td>
<td>110.6%</td>
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<td>100.6%</td>
<td>164.4%</td>
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<tr>
<td>Directorate</td>
<td>Hospital Site name</td>
<td>Ward Name</td>
<td>DAY RN Staff (%)</td>
<td>DAY CSW Staff (%)</td>
<td>NIGHT RN Staff (%)</td>
<td>NIGHT CSW Staff (%)</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>OPMH</td>
<td>Gosport War Memorial Hospital</td>
<td>Daedalus Ward</td>
<td>87.5%</td>
<td>98.8%</td>
<td>79.8%</td>
<td>114.9%</td>
</tr>
<tr>
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<td>Gosport War Memorial Hospital</td>
<td>Dryad Ward</td>
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<td>125.3%</td>
<td>85.1%</td>
<td>176.6%</td>
</tr>
<tr>
<td>OPMH</td>
<td>Melbury Lodge</td>
<td>Stefano Oliveri Unit</td>
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<td>110.0%</td>
<td>57.5%</td>
<td>177.9%</td>
</tr>
<tr>
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<td>Parklands Hospital</td>
<td>Beechwood Ward</td>
<td>92.0%</td>
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<td>51.7%</td>
<td>224.9%</td>
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<td>Elmwood Ward</td>
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<td>98.5%</td>
<td>89.3%</td>
<td>141.4%</td>
</tr>
<tr>
<td>OPMH</td>
<td>Western Community Hospital</td>
<td>Berrywood Ward</td>
<td>80.7%</td>
<td>121.8%</td>
<td>96.7%</td>
<td>106.7%</td>
</tr>
<tr>
<td>OPMH</td>
<td>Western Community Hospital</td>
<td>Beaulieu Ward</td>
<td>91.8%</td>
<td>127.6%</td>
<td>98.6%</td>
<td>176.0%</td>
</tr>
</tbody>
</table>
Appendix 1

Appendix 2 – CHPPD – Comparison of data – February, March, April
### Appendix 1

### Appendix 3 – Comparison of data – January 2018, February, March, April

<table>
<thead>
<tr>
<th>Division</th>
<th>Hospital Site name</th>
<th>Ward name</th>
<th>Jan-18 Day</th>
<th>Jan-18 Night</th>
<th>Feb-18 Day</th>
<th>Feb-18 Night</th>
<th>Mar-18 Day</th>
<th>Mar-18 Night</th>
<th>Apr-18 Day</th>
<th>Apr-18 Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD</td>
<td>Moorgreen Hospital</td>
<td>Willow Ward</td>
<td>126.1%</td>
<td>107.2%</td>
<td>98.7%</td>
<td>104.7%</td>
<td>136.9%</td>
<td>118.5%</td>
<td>96.5%</td>
<td>117.9%</td>
</tr>
<tr>
<td>SS</td>
<td>Woodhaven</td>
<td>Ashford Unit</td>
<td>85.6%</td>
<td>89.4%</td>
<td>100.0%</td>
<td>102.2%</td>
<td>120.7%</td>
<td>86.4%</td>
<td>100.0%</td>
<td>97.7%</td>
</tr>
<tr>
<td>AMH</td>
<td>Antelope House</td>
<td>Saxon Ward</td>
<td>31.2%</td>
<td>131.7%</td>
<td>132.8%</td>
<td>131.5%</td>
<td>117.1%</td>
<td>120.5%</td>
<td>133.0%</td>
<td>131.7%</td>
</tr>
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<td>Antelope House</td>
<td>Trinity Ward</td>
<td>71.4%</td>
<td>130.7%</td>
<td>135.5%</td>
<td>134.7%</td>
<td>149.0%</td>
<td>140.3%</td>
<td>143.3%</td>
<td>139.0%</td>
</tr>
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<td>Antelope House</td>
<td>Hamtun Ward PICU</td>
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<td>146.5%</td>
<td>119.9%</td>
<td>111.7%</td>
<td>126.3%</td>
<td>128.6%</td>
<td>117.9%</td>
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<td>Elmleigh</td>
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<td>92.1%</td>
<td>128.0%</td>
<td>117.8%</td>
<td>98.9%</td>
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<td>117.9%</td>
</tr>
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<td>95.7%</td>
<td>100.0%</td>
<td>101.6%</td>
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<td>94.8%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
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<td>Hollybank</td>
<td>Hollybank</td>
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<td>100.4%</td>
<td>101.5%</td>
<td>102.8%</td>
<td>98.2%</td>
<td>100.5%</td>
<td>101.5%</td>
</tr>
<tr>
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<td>Melbury Lodge</td>
<td>Kingsley Ward</td>
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<td>100.3%</td>
<td>85.6%</td>
<td>157.5%</td>
<td>95.6%</td>
<td>104.9%</td>
<td>146.5%</td>
<td>151.0%</td>
</tr>
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<td>AMH</td>
<td>Melbury Lodge</td>
<td>Mother &amp; Baby Unit</td>
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<td>97.0%</td>
<td>100.3%</td>
<td>101.5%</td>
<td>90.5%</td>
<td>72.3%</td>
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<td>76.8%</td>
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<td>AMH</td>
<td>Parklands Hospital</td>
<td>Hawthorns 1</td>
<td>86.2%</td>
<td>116.3%</td>
<td>112.9%</td>
<td>139.3%</td>
<td>124.3%</td>
<td>118.0%</td>
<td>134.6%</td>
<td>117.9%</td>
</tr>
<tr>
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<td>Parklands Hospital</td>
<td>Hawthorns 2</td>
<td>96.8%</td>
<td>120.5%</td>
<td>96.8%</td>
<td>98.7%</td>
<td>131.5%</td>
<td>100.0%</td>
<td>110.8%</td>
<td>115.9%</td>
</tr>
<tr>
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<td>Ravenswood House</td>
<td>Ashurst Ward</td>
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<td>85.1%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>118.3%</td>
<td>85.8%</td>
<td>96.2%</td>
<td>101.4%</td>
</tr>
<tr>
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<td>Ravenswood House</td>
<td>Lyndhurst Ward</td>
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<td>155.7%</td>
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<td>157.0%</td>
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<td>151.1%</td>
</tr>
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<td>137.1%</td>
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<td>88.7%</td>
<td>100.3%</td>
<td>99.6%</td>
</tr>
<tr>
<td>SS</td>
<td>Southfield</td>
<td>Beech Ward</td>
<td>93.5%</td>
<td>119.7%</td>
<td>100.0%</td>
<td>103.5%</td>
<td>93.9%</td>
<td>105.9%</td>
<td>100.6%</td>
<td>102.0%</td>
</tr>
<tr>
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<td>Southfield</td>
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<td>93.1%</td>
<td>99.9%</td>
<td>109.7%</td>
<td>102.3%</td>
<td>89.9%</td>
<td>98.4%</td>
<td>100.0%</td>
<td>98.4%</td>
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<td>Southfield</td>
<td>Oak Ward</td>
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<td>117.5%</td>
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<td>100.0%</td>
<td>92.1%</td>
<td>100.7%</td>
<td>100.4%</td>
<td>100.0%</td>
</tr>
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<td>Division</td>
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<td>Ward name</td>
<td>Jan-18 Day</td>
<td>Jan-18 Night</td>
<td>Feb-18 Day</td>
<td>Feb-18 Night</td>
<td>Mar-18 Day</td>
<td>Mar-18 Night</td>
<td>Apr-18 Day</td>
<td>Apr-18 Night</td>
</tr>
<tr>
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<tr>
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<td>96.2%</td>
<td>94.5%</td>
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<td>84.7%</td>
<td>102.1%</td>
<td>96.6%</td>
<td>86.8%</td>
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<td>Hill Ward</td>
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<td>95.9%</td>
<td>93.6%</td>
<td>121.4%</td>
</tr>
<tr>
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<td>Leigh House</td>
<td>Leigh House</td>
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<td>97.4%</td>
<td>84.2%</td>
<td>116.5%</td>
<td>84.8%</td>
<td>87.6%</td>
<td>93.6%</td>
<td>121.4%</td>
</tr>
<tr>
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<td>Gosport War Memorial Hospital</td>
<td>Ark Royal Ward</td>
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<td>96.0%</td>
<td>91.4%</td>
<td>96.0%</td>
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<td>88.8%</td>
</tr>
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<td>Gosport War Memorial Hospital</td>
<td>Sultan Ward</td>
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<td>124.0%</td>
<td>104.3%</td>
<td>124.1%</td>
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<td>109.4%</td>
<td>100.1%</td>
<td>87.9%</td>
</tr>
<tr>
<td>BU1</td>
<td>Petersfield Hospital</td>
<td>Cedar Ward (Petersfield)</td>
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<td>102.3%</td>
<td>84.2%</td>
<td>102.4%</td>
<td>90.9%</td>
<td>100.0%</td>
<td>92.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>BU1</td>
<td>Petersfield Hospital</td>
<td>Rowan Ward</td>
<td>94.5%</td>
<td>104.8%</td>
<td>84.6%</td>
<td>100.0%</td>
<td>90.9%</td>
<td>100.0%</td>
<td>92.1%</td>
<td>100.0%</td>
</tr>
<tr>
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<td>Fordingbridge Hospital</td>
<td>Ford Ward</td>
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<td>84.9%</td>
<td>91.5%</td>
<td>88.6%</td>
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<td>100.0%</td>
<td>98.5%</td>
<td>106.7%</td>
<td>97.9%</td>
<td>111.7%</td>
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<tr>
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<td>Lymington New Forest Hospital</td>
<td>Longbeech Ward</td>
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<td>141.8%</td>
<td>87.7%</td>
<td>150.1%</td>
<td>84.9%</td>
<td>155.6%</td>
<td>86.3%</td>
<td>163.7%</td>
</tr>
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<td>Medical Admissions Unit</td>
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<td>81.0%</td>
<td>110.0%</td>
<td>86.9%</td>
<td>105.3%</td>
<td>87.6%</td>
<td>95.3%</td>
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<tr>
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<td>Lymington New Forest Hospital</td>
<td>Witterley Ward</td>
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<td>100.0%</td>
<td>93.9%</td>
<td>100.0%</td>
<td>93.0%</td>
<td>100.0%</td>
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<td>100.0%</td>
</tr>
<tr>
<td>BU2</td>
<td>Ramsey Hospital</td>
<td>Chichester/Nightingale Ward</td>
<td>97.6%</td>
<td>92.4%</td>
<td>97.5%</td>
<td>91.7%</td>
<td>98.8%</td>
<td>90.9%</td>
<td>102.2%</td>
<td>101.3%</td>
</tr>
<tr>
<td>BU3</td>
<td>Alton Community Hospital</td>
<td>Anstey Ward</td>
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<td>89.3%</td>
<td>74.8%</td>
<td>72.7%</td>
<td>98.8%</td>
<td>72.0%</td>
<td>110.6%</td>
<td>124.1%</td>
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<td>Gosport War Memorial Hospital</td>
<td>Daedalus Ward</td>
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<td>93.0%</td>
<td>95.3%</td>
<td>88.7%</td>
<td>98.4%</td>
<td>86.3%</td>
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<td>98.8%</td>
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<td>Gosport War Memorial Hospital</td>
<td>Dryad Ward</td>
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<td>122.8%</td>
<td>90.9%</td>
<td>123.1%</td>
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<td>98.8%</td>
<td>80.0%</td>
<td>108.1%</td>
<td>83.6%</td>
<td>103.1%</td>
<td>92.0%</td>
<td>103.6%</td>
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<tr>
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<td>Parklands Hospital</td>
<td>Elmwood Ward</td>
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<td>121.1%</td>
<td>91.6%</td>
<td>106.8%</td>
<td>96.1%</td>
<td>108.1%</td>
<td>87.7%</td>
<td>105.9%</td>
</tr>
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<td>71.6%</td>
<td>115.0%</td>
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<td>80.7%</td>
<td>121.8%</td>
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<td>Western Community Hospital</td>
<td>Beaulieu Ward</td>
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<td>90.7%</td>
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<td>71.5%</td>
<td>127.0%</td>
<td>91.8%</td>
<td>127.6%</td>
</tr>
</tbody>
</table>
### Appendix 1

### Appendix 4 – Bank and Agency Safer Staffing Risk – using over 50% fill rate as temporary workers.

<table>
<thead>
<tr>
<th>Division</th>
<th>Site</th>
<th>Unit</th>
<th>Staff Group</th>
<th>Shift</th>
<th>Substantive*</th>
<th>Bank MPH*</th>
<th>Bank BO*</th>
<th>Agency*</th>
<th>Total Filled</th>
<th>Total Filled Non</th>
<th>Total Temp Fill Rate</th>
<th>No Shifts affected (out of 31)</th>
</tr>
</thead>
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<td>AMH</td>
<td>Antelope House</td>
<td>Hamtun Ward PICU</td>
<td>Unregistered</td>
<td>Night</td>
<td>22.2%</td>
<td>0.9%</td>
<td>76.9%</td>
<td>0.0%</td>
<td>23.1%</td>
<td>76.9%</td>
<td>78%</td>
<td>25</td>
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<td>Antelope House</td>
<td>Saxon Ward</td>
<td>Registered</td>
<td>Night</td>
<td>26.5%</td>
<td>4.4%</td>
<td>0.0%</td>
<td>69.0%</td>
<td>31.0%</td>
<td>69.0%</td>
<td>73%</td>
<td>18</td>
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<td>Antelope House</td>
<td>Trinity Ward</td>
<td>Registered</td>
<td>Night</td>
<td>44.2%</td>
<td>19.8%</td>
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<td>36.0%</td>
<td>64.0%</td>
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<td>Trinity Ward</td>
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<td>6.2%</td>
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<td>42.3%</td>
<td>57.7%</td>
<td>64%</td>
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</tr>
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<td>Registered</td>
<td>Night</td>
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<td>12.8%</td>
<td>25.8%</td>
<td>25.3%</td>
<td>48.9%</td>
<td>51.1%</td>
<td>64%</td>
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<td>Parklands Hospital</td>
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<td>Night</td>
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<td>11.7%</td>
<td>45.3%</td>
<td>0.0%</td>
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<td>45.3%</td>
<td>57%</td>
<td>20</td>
</tr>
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<td>BU2</td>
<td>Lyminster New Forest Hospital</td>
<td>Wilverley Ward</td>
<td>Registered</td>
<td>Night</td>
<td>46.0%</td>
<td>0.0%</td>
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<td>46.0%</td>
<td>54.0%</td>
<td>54%</td>
<td>19</td>
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<td>Alton Community Hospital</td>
<td>Anstey Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>38.8%</td>
<td>6.4%</td>
<td>48.6%</td>
<td>6.1%</td>
<td>45.3%</td>
<td>54.7%</td>
<td>61%</td>
<td>20</td>
</tr>
<tr>
<td>LD</td>
<td>Moorgreen Hospital</td>
<td>Willow Ward</td>
<td>Registered</td>
<td>Night</td>
<td>6.8%</td>
<td>8.4%</td>
<td>1.7%</td>
<td>83.2%</td>
<td>15.1%</td>
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<td>93%</td>
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</tr>
<tr>
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<td>Western Community Hospital</td>
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<td>Registered</td>
<td>Night</td>
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<td>4.7%</td>
<td>52.8%</td>
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<td>20</td>
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<td>Beaulieu Ward</td>
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<td>Night</td>
<td>27.3%</td>
<td>17.2%</td>
<td>28.0%</td>
<td>27.6%</td>
<td>44.5%</td>
<td>55.5%</td>
<td>73%</td>
<td>26</td>
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<td>Night</td>
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<td>3.2%</td>
<td>71.8%</td>
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<td>28.2%</td>
<td>71.8%</td>
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<td>OPMH</td>
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<td>Elmwood Ward</td>
<td>Registered</td>
<td>Day</td>
<td>45.5%</td>
<td>3.4%</td>
<td>42.4%</td>
<td>8.7%</td>
<td>48.9%</td>
<td>51.1%</td>
<td>55%</td>
<td>20</td>
</tr>
<tr>
<td>OPMH</td>
<td>Parklands Hospital</td>
<td>Elmwood Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>45.9%</td>
<td>22.8%</td>
<td>12.3%</td>
<td>19.0%</td>
<td>68.7%</td>
<td>31.3%</td>
<td>54%</td>
<td>24</td>
</tr>
<tr>
<td>OPMH</td>
<td>Parklands Hospital</td>
<td>Elmwood Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>32.4%</td>
<td>6.1%</td>
<td>61.5%</td>
<td>0.0%</td>
<td>38.5%</td>
<td>61.5%</td>
<td>68%</td>
<td>25</td>
</tr>
<tr>
<td>OPMH</td>
<td>Gosport War Memorial Hospital</td>
<td>Daedalus Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>36.6%</td>
<td>9.4%</td>
<td>50.4%</td>
<td>3.6%</td>
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<td>63%</td>
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</tr>
<tr>
<td>OPMH</td>
<td>Gosport War Memorial Hospital</td>
<td>Dryad Ward</td>
<td>Registered</td>
<td>Night</td>
<td>48.9%</td>
<td>11.7%</td>
<td>23.3%</td>
<td>16.1%</td>
<td>60.6%</td>
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</tr>
<tr>
<td>OPMH</td>
<td>Gosport War Memorial Hospital</td>
<td>Dryad Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>29.8%</td>
<td>0.0%</td>
<td>64.6%</td>
<td>5.6%</td>
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<td>24</td>
</tr>
<tr>
<td>SS</td>
<td>Bluebird House</td>
<td>Hill Ward</td>
<td>Registered</td>
<td>Night</td>
<td>44.7%</td>
<td>6.6%</td>
<td>6.7%</td>
<td>42.0%</td>
<td>51.3%</td>
<td>48.7%</td>
<td>55%</td>
<td>17</td>
</tr>
<tr>
<td>SS</td>
<td>Bluebird House</td>
<td>Hill Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>40.9%</td>
<td>7.0%</td>
<td>25.7%</td>
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<td>52.1%</td>
<td>59%</td>
<td>18</td>
</tr>
<tr>
<td>SS</td>
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<td>Moss Ward</td>
<td>Unregistered</td>
<td>Night</td>
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<td>2.1%</td>
<td>42.8%</td>
<td>8.3%</td>
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<td>51.1%</td>
<td>53%</td>
<td>19</td>
</tr>
<tr>
<td>SS</td>
<td>Bluebird House</td>
<td>Stewart Ward</td>
<td>Registered</td>
<td>Night</td>
<td>33.9%</td>
<td>3.9%</td>
<td>0.0%</td>
<td>62.2%</td>
<td>37.8%</td>
<td>62.2%</td>
<td>66%</td>
<td>23</td>
</tr>
<tr>
<td>SS</td>
<td>Leigh House</td>
<td>Leigh House</td>
<td>Registered</td>
<td>Night</td>
<td>20.4%</td>
<td>8.8%</td>
<td>35.2%</td>
<td>35.6%</td>
<td>29.2%</td>
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<td>80%</td>
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<tr>
<td>SS</td>
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<td>Ashurst Ward</td>
<td>Registered</td>
<td>Night</td>
<td>27.0%</td>
<td>30.6%</td>
<td>11.6%</td>
<td>30.9%</td>
<td>57.6%</td>
<td>42.4%</td>
<td>73%</td>
<td>18</td>
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<td>SS</td>
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<td>Lyndhurst Ward</td>
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<td>43.3%</td>
<td>4.4%</td>
<td>51.2%</td>
<td>1.1%</td>
<td>47.7%</td>
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<td>57%</td>
<td>17</td>
</tr>
<tr>
<td>SS</td>
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<td>Mary Graham Ward</td>
<td>Registered</td>
<td>Night</td>
<td>27.4%</td>
<td>6.8%</td>
<td>27.8%</td>
<td>37.9%</td>
<td>34.2%</td>
<td>65.8%</td>
<td>73%</td>
<td>19</td>
</tr>
<tr>
<td>SS</td>
<td>Ravenswood House</td>
<td>Mary Graham Ward</td>
<td>Unregistered</td>
<td>Night</td>
<td>49.0%</td>
<td>5.2%</td>
<td>45.8%</td>
<td>0.0%</td>
<td>54.2%</td>
<td>45.8%</td>
<td>51%</td>
<td>19</td>
</tr>
<tr>
<td>SS</td>
<td>Southfield</td>
<td>Beech Ward</td>
<td>Registered</td>
<td>Night</td>
<td>42.9%</td>
<td>0.0%</td>
<td>57.1%</td>
<td>0.0%</td>
<td>42.9%</td>
<td>57.1%</td>
<td>57%</td>
<td>17</td>
</tr>
</tbody>
</table>

*Substantive - SHFT Staff
*Bank MPH - SHFT staff working additional shifts via the NHSP bank
*Bank BO - NHSP bank only staff
*Agency - Agency only staff
REPORT TO THE TRUST BOARD

Date | 05.06.2018
---|---
Agenda Item | 11
Title | Trust Operating Plan
Author(s) | Sue Damarell-Kewell, Associate Director Planning, Performance, Business Development and Contracting
Sponsoring Director | Paula Anderson, Director of Finance

Purpose & Action Required

The 2018/19 Operating Plan is presented to the Board for approval. The Operating Plan is the narrative document that summarises the priorities and deliverables for the 2018/19 financial year.

The Trust Board is asked to approve the updated Operating Plan.

Executive Director Overview

In March 2017, we published a two year operating which set out the strategic, operational and financial framework for 2017/18 and 2018/19. That document set out the Trust’s key priorities and how we would go about delivering them. For year two, the Trust remains committed to the principles set out in the original plan, and therefore the purpose of this document is to refresh the priorities and deliverables for 2018/19 for the year ahead.

The plan has been updated to reflect the current priorities of the trust and will be a simple, public facing document that will give any reader a clear view of the focus for the next 12 months.

A ‘plan on a page’ visualisation has been updated and is available for staff and service users as a clear summary of the priorities.

The plan has been reviewed and supported by the Service Performance and Transformation Committee prior to its submission to NHS Improvement of 30th April.

This plan sits alongside the detailed divisional operational and financial plan documentation.
### Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>X</td>
</tr>
<tr>
<td>People</td>
<td>X</td>
</tr>
<tr>
<td>Transformation</td>
<td>X</td>
</tr>
<tr>
<td>Money</td>
<td>X</td>
</tr>
</tbody>
</table>

The Operating Plan sets out the strategic priorities for 2018/19 for the Trust. It describes the measures by which success will be monitored.

### Does this impact any Board Assurance Framework / Corporate Risks?

The Operating Plan sets out the risks to delivery of the Trust Priorities and these will shape the BAF.
Southern Health NHS Foundation Trust

2018/19
Operating Plan

Our Vision at Southern Health is to provide high quality, safe services which improve the health, wellbeing and independence of the people we serve.
Index

Contents
Introduction ............................................................................................................................................ 3
About our Trust....................................................................................................................................... 3
Our priorities for 2018/19....................................................................................................................... 4
Quality ..................................................................................................................................................... 5
Achieving a CQC rating of ‘Good’ ........................................................................................................ 5
Implementing a Trust wide Quality Improvement (QI) programme .................................................. 5
Patient, family and public engagement .............................................................................................. 6
Meeting all access targets ................................................................................................................... 6
People ..................................................................................................................................................... 7
Workforce strategy ............................................................................................................................. 7
Workforce stability .............................................................................................................................. 7
Staff engagement ................................................................................................................................ 8
Well Led rating .................................................................................................................................... 8
Transformation ....................................................................................................................................... 9
Adult Mental Health ............................................................................................................................ 9
Specialised Services ............................................................................................................................. 9
Integrated Services ............................................................................................................................ 10
Money ................................................................................................................................................... 10
Financial Plan ....................................................................................................................................... Error! Bookmark not defined.
Contracts & Income .......................................................................................................................... 11
Use of Resources ............................................................................................................................... 11
Risk ...................................................................................................................................................... 12
Appendix 1: Strategic Priorities and Measures of Delivery 2018/19 .................................................... 13
Introduction
In March 2017, we published a two year operating which set out the strategic, operational and financial framework for 2017/18 and 2018/19. That document set out the Trust’s key priorities and how we would go about delivering them. For year two, the Trust remains committed to the principles set out in the original plan, and therefore the purpose of this document is to refresh the priorities and deliverables for 2018/19.

During 2017/18 we have been largely successful in delivering against our strategic priorities, making improvements in quality and driving forwards with our transformation agenda through both developing Extended Primary Care Teams working in local communities, and in launching our first service change projects through a new Quality Improvement methodology with our partners at Northumberland Tyne & Wear NHS Foundation Trust. Our staff engagement activity is beginning to show positive results, our bank and agency expenditure has significantly reduced and our staff turnover levels have reduced, but vacancy rates and turnover are still a significant concern and higher than our targets. Similarly, whilst we achieved our control total financial targets for the first three quarters of the year, despite all efforts it was not possible to fully mitigate the impact of fines arising from the prosecutions and subsequently we failed to earn the STF for quarter 4 but we did receive a similar sum as a general distribution to all providers that signed up to a control total for 2017/18. We successfully mitigated other in year costs pressures relating to adult mental health beds (with subsequent out of area placements,) higher than planned levels of locum doctors and unfound CIPs by a range of one-off benefits, but most of these costs are ongoing and as such both staffing levels and finance will be key pressures going into 2018/19.

Despite these challenges, 2018/19 will be a really exciting year for our staff, everyone we care for and our partners. We appointed a new Chair, new Non-Executive Directors and a new Chief Executive during 2017, and under this new Board leadership we are refreshing our vision and strategy, focusing on delivering the highest possible quality of care and transforming our services through a major programme of Quality Improvement built on engagement and co-production. During 2018/19 we will develop this long term vision to give much greater clarity on how our services will be provided in the years to come and the value we will give to people across Hampshire.

About our Trust
We provide community health, specialist mental health and learning disability services for people across the south of England.

Covering Hampshire we are one of the largest providers of these types of service in the UK. We employ around 6,000 staff who work from 200 sites, including community hospitals, health centres, inpatient units and social care services.

Our vision is: to provide high quality, safe services which improve the health and wellbeing, independence and confidence of the people we serve.

We might be large, but our service users and patients are still at the centre of everything we do and this is reflected in our three values which have been developed by our staff:
• *Patients and people first*
• *Partnership*
• *Respect*

Our services cover:

**Mental health services** - we provide treatment and support to adults and older people experiencing mental illness. We also provide treatment to adults and young people, in secure and specialised settings.

**Community services** - our diverse range of community health services provide support and treatment to both adults and children. We deliver this care in community hospitals, health centres, GP surgeries and in our patients’ homes. We also provide a stop smoking service (Quit4Life).

**Learning disabilities services** - our community learning disability teams work in partnership with local councils to provide assessment and support for adults with learning disabilities. We also provide specialist inpatient services.

**Our priorities for 2018/19**

For this second year of our two year plan we continue to work to four key strategic priorities that will allow us to deliver our vision:

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>Deliver high quality, safe services that command the confidence of people who use or rely on them</td>
</tr>
<tr>
<td><strong>People</strong></td>
</tr>
<tr>
<td>Develop a strong and sustainable workforce, with the culture and stability to deliver the Trust’s objectives</td>
</tr>
<tr>
<td><strong>Transformation</strong></td>
</tr>
<tr>
<td>Implement our Clinical Services Strategy, transforming our care models to deliver great outcomes for the people who use or rely on our services</td>
</tr>
<tr>
<td><strong>Money</strong></td>
</tr>
<tr>
<td>Focus on eliminating waste, improving efficiency, and increasing productivity and effectiveness, to create the financial flexibility and resilience needed to invest in the future of our services</td>
</tr>
</tbody>
</table>

This plan summarises our key activities for 2018/19 for each of these priority areas. Further, in order that we track our delivery, the table at appendix 1 sets the key deliverables and related measures of delivery against which we will assess our success during the year.
QUALITY

Achieving a CQC rating of ‘Good’

During 2017 we made significant improvements to our structures and processes for ensuring we deliver the highest quality of care, and this was set out in our 5 year quality strategy published in 2016. We refresh our priorities under this strategy each year in consultation with our board, Council of Governors and our stakeholders. This process allows us to identify our specific Quality Account Priorities which are reported formally and publically each year as part of the annual accounts process. For 2018/19 these priorities are:

<table>
<thead>
<tr>
<th>Patient Safety</th>
<th>Patient Experience</th>
<th>Clinical Outcomes</th>
</tr>
</thead>
</table>

We have been working very closely with our colleagues at the Care Quality Commission throughout 2017/18 and have been addressing areas of significant regulatory concerns raised in previous inspections. Building on this we are preparing for a full inspection during 2018. All teams have their own quality plans in place to support this aim, and we continue to operate a rolling programme of ‘Peer Review’ to highlight areas of good practice, and areas we can improve on.

In addition to these priorities, we have also committed to deliver a range of quality related performance targets with our commissioners, which result in additional payments to our Trust. These targets, known as ‘CQUINs’, vary in detail from flu jab uptake to healthy eating to specific service requirements, and will be monitored through regular review meetings with our commissioners.

Implementing a Trust wide Quality Improvement (QI) programme

We recognise the importance of bringing about systematic, sustainable improvements in quality, through implementation of a recognised quality improvement methodology, which staff are well supported to deliver. The need to develop such a methodology has been highlighted through our clinical service strategy, and it is recognised that this is a consistent theme within trusts rated ‘Outstanding’ by the CQC.

As part of our wider transformation plans, we have partnered with Northumberland, Tyne & Wear NHS Foundation Trust (NTW) to support us in the implementation of a QI methodology that will underpin all of our quality improvement and service transformation projects. The programme was
launched during March 2018 and is being overseen by a Transformation Programme Board which is made up of staff, service users, experts by experience and system stakeholders. This board is overseeing all of our transformation activity, for which QI is the underpinning approach. During the year we expect to have trained c.60 staff in the skills and techniques to act as trainers and facilitators across our services, and are aiming for at least 10% of our staff (c.600) to have been involved in a structured project.

**Patient, family and public engagement plans which lead to more engagement and involvement in clinical and care decisions and better understanding of our work**

In 2017/18 we launched our Experience, Involvement and Partnership Strategy which details our commitment to working together with service users, patients, families and carers so that they have a say in their care and treatment, and helping us to understand how services can be improved.

The first year of this plan focused on putting in place the systems, networks and standards that will support our staff to work more closely with people who use our services, involving people in their own care and treatment, and routinely offering opportunities to participate meaningfully in the planning, delivery and monitoring of our services.

During Q1 of 2018/19 we will be reflecting on the progress made to date and setting out the programme of work for the next two years to fully embed this culture of involvement and partnership throughout all our services.

Further to this, and as part of our quality account priorities, we will revisit and further develop the work achieved in the roll out of the Triangle of Care in the Mental Health Division. This will build on principles for involving families in the care of the patient, and work on information sharing and 'common sense confidentiality'.

The Triangle of Care emphasises the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health. It promotes a therapeutic alliance between service user, carer and clinicians to ensure that a positive, honest and open relationship is created from the first point of contact.

**Meeting all access targets**

During 2017/18, we have performed well against our regulatory and contractual targets for operational delivery (access to care). There are a small number of areas where focussed improvement activity is required, and specific improvement plans are in place to deliver these.

Ensuring people have the right access to our services will always be a core priority for us, but we know our teams are facing increasing pressures on services as activity continues to increase within an economic environment where funding for new or increased services is limited.

Of particular concern during 2017/18 has been the high levels of need for adult mental health inpatient beds. This has resulted in an increased use of ‘Out of Area Beds’ which reflects a poor experience for those in need of a bed and their families/carers, and also carries a significant financial penalty for our Trust. There is a significant programme of work underway to reduce this pressure during 2018/19 and improve the pathways through our inpatient units to minimise the number of Out of Area Beds required.
Further, reflecting the increased demand being experienced across all of our services, we will be working with our commissioners to provide much more detailed demand and capacity information that will drive our contracting and business planning approach for 2019/20 and beyond.

**PEOPLE**

**Workforce strategy**

During the second half of 2017/18 we have been reviewing and refreshing our People and Organisational Development (OD) strategy to ensure it reflects the vision of the trust and our strategic priorities. We expect to finalise and publish this strategy during Q1 of 2018/19. It will set out the plans and actions we are undertaking in five key areas:

- Collective leadership, devolution and engagement
- Well being, inclusion and diversity
- Learning and education
- Workforce development
- Partnership and system working

The actions across this strategy will ensure we meet our overall aim from the People and OD strategy which is to: *Attract and retain people to pursue a relentless focus on improving and providing quality services to enable people to reach their full potential (patients and staff)*.

The strategy will be closely linked to our transformation plans. In particular, it will reflect the significant cultural shifts required across our organisation to support the QI agenda (which requires a shift from directing staff to supporting staff and patient led change) and to develop a clinically led and management supported leadership structure. Included within our plans for the year are a bespoke clinical leadership development programme that has been co-developed with our senior clinicians to meet their needs in these leadership roles.

Further, we will be working closely with our system partners in the Hampshire & Isle of Wight Sustainable Transformation Partnership (H&IoW STP) to develop more flexible workforce options across organisational boundaries, and develop roles which support the transformation agenda across the county.

**Workforce stability**

Recruitment and, in particular, retention remains our biggest challenge for 2018/19. Whilst our turnover rates have reduced over the last year, they remain high at c.15% and our vacancy rate is c.9%.

We have done a lot of work in 2017/18 to stabilise our workforce, and in particular have been successful in significantly reducing our agency and locum usage over the year where our levels are now below the national average. However, given the turnover rates we have developed a retention plan which has been agreed with NHS Improvement. The key areas of delivery within this plan are:

- Greater use of data and analytics for accurate workforce planning
- Giving greater flexibility to move roles within our trust and with our local partners
- Improving our induction processes and early career experience
- Better rostering and planning
- Improving our reward and recognition programmes
- Continuing our staff engagement programme
These activities are expected to further reduce turnover and vacancy rates by the end of 2018/19 and our aim is to reduce vacancy rates to 6% and our turnover to 13% respectively. In addition, we continue to work with teams that are experiencing specific local challenges due to turnover, sickness and other absence and monitor these closely.

<table>
<thead>
<tr>
<th>Workforce Plan 2018/19</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall workforce as at 1 April 2018</td>
<td>5,416.4</td>
</tr>
<tr>
<td>Assumed recruitment to vacancies to align to budgeted staffing levels from April 2018’</td>
<td>188.8</td>
</tr>
<tr>
<td>CIP/efficiencies</td>
<td>(86.5)</td>
</tr>
<tr>
<td>Service developments and 5YFV investments funded by commissioners*</td>
<td>108.2</td>
</tr>
<tr>
<td>Overall workforce as at 31 March 2019</td>
<td>5,626.9</td>
</tr>
</tbody>
</table>

*some at risk as still under negotiation with Commissioners

Staff engagement

During 2017/18 we launched a comprehensive programme of staff engagement, led by the Interim Chief Executive and shaped by a Staff Engagement Group representing staff and roles from across the breadth of our trust. The aim is for staff to feel truly empowered so that they feel safe to raise issues, make changes happen and recommend it as a place to work and to have care and treatment.

This programme will continue in 2018/19 led by the Director of Workforce, OD and Communications. It will shape it activity from feedback from engagement sessions with our staff, and through key data such as the staff survey.

The 2017 staff survey showed that across all key findings we had improved in 5 and declined in 1 since 2016. Overall 6 are better than average, 16 average and 10 worse than average. This was positive given the very public challenges the trust has faced over the last two years, however, the data shows that whilst our staff are confident about local services, and our overall engagement scores are in line with national peers, our staff do not feel connected with the trust as a whole. Building a strong sense of joint ownership for our services will be a key aim for the engagement programme.

Well Led rating

As the new Board further establishes itself during 2018/19 it is important it establishes a leadership culture, and sound governance, to shape the transformation agenda whilst ensuring we deliver against our regulatory requirements.

A programme of work will be delivered reviewing all aspects of the CQC ‘Well-Led’ domain in preparation for the CQC inspection. Ensuring we can demonstrate the Trust is well led, alongside
demonstrating we have good staff and stakeholder engagement plans in place and have delivered against our CQC action plans will be required to lift our regulatory undertakings with NHS Improvement.

**TRANSFORMATION**

The Transformation agenda is significant for our Trust. Over the last two years, alongside addressing the quality issues identified by external reviews and regulators, we have been pushing ahead with reshaping our services to meet future demand. We continue to work closely with our system partners via the Hampshire & Isle of Wight Sustainability and Transformation Partnership (H&IoW STP), in particular key work streams such as the Mental Health Alliance and the New Models of Care Programmes (community services), but as we go into 2018/19 we will be taking a much more structured approach to driving transformation across all of our services.

We have established a Transformation Programme Board, chaired by the Trust Chief Executive, to oversee the range of programmes we are going to deliver this year. This Programme Board will simultaneously oversee the implementation of the QI methodology with our partners Northumberland Tyne & Wear NHS Foundation Trust (NTW), and all of our major transformation programmes. This will ensure that we have a structured and consistent approach to transformation which is centred on the people we care for and is shaped from the knowledge of our front line staff, who know first-hand how care can be improved.

The key programmes for 2018/19 are summarised below:

**Mental Health**

- Working with our partners NTW to complete the transformation of access to mental health services in South East Hampshire started in 2017, and roll out at least one further major project during 2018.
- Improve crisis care, leading to more efficient use of in-patient beds and a reduction in out of area placements.
- Integrate Older Persons Mental Health (OPMH) services with our Adult services ensuring needs-led rather than age-led care.
- Continue to work with our commissioners to identify and implement new services to meet the requirements of the Mental Health Five Year Forward View.
- Further developments in Improving Access to Psychological Therapies services to deliver better access through digital solutions, enhanced pathways for people with long term conditions and older people, and new approaches to engage with primary care.

**Specialised Services**

- Develop and submit for Board approval a business case to improve forensic care for adults with mental health issues, covering male Medium Secure and both male and female Low Secure services, and addressing the estate challenges posed by our Ravenswood Medium Secure unit.
- Develop and submit for Board approval a business case for investment in new Low Secure Child and Adolescent Mental Health Services (CAMHS) and begin the programme of capital works.
**Integrated Services**

- Working with Primary Care and our commissioners, deliver improved integration under an Extended Primary Care Team model (building on the learning from the Better Local Care vanguard, funding for which finished at the end of 2017/18).
- Working with Hampshire County Council, design and deliver an integrated intermediate health and social care service for the county.
- Working with Hampshire County Council, design a children’s public health 0-19 care model bringing together our existing services, building on our successful relationship with Barnardo’s.
- Increased focus on self-care and prevention agenda moving towards a more proactive model of care and ensuring we make every contact count, whilst strengthening partnership arrangements and community relationships in localities/natural communities.
- Continued focus on timely access to services and delays for people whilst in services to support the redesign of care pathways using patient and staff feedback and data analysis.
- Develop closer relationships with local university’s to create new roles and career pathways that meet the needs of the new generation of workforce, and further develop our research roles and opportunities for conducting research locally.
- Integration of Physical and Mental Health services to ensure a holistic approach to care Trustwide.

**MONEY**

The following table shows the key financial headlines for 2017/18 and 2018/19.

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Plan £m</th>
<th>2017/18 Draft Accounts £m</th>
<th>2018/19 Plan £m</th>
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<tbody>
<tr>
<td><strong>Income</strong></td>
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<td>309.4</td>
<td>309.4</td>
</tr>
<tr>
<td>Of which, STF</td>
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<td>2.9</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Operating Expenses</strong></td>
<td></td>
<td>(280.4)</td>
<td>(294.0)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>17.9</td>
<td>15.4</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Non-operating Expenses</strong></td>
<td></td>
<td>(16.2)</td>
<td>(24.2)</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit)</strong></td>
<td>1.7</td>
<td>(8.8)</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Adjustments for the Control Total:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairment</td>
<td>1.2</td>
<td>6.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Gain / (Loss) on Transfers by Absorption</td>
<td>0.0</td>
<td>3.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Donated assets</td>
<td>0.0</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Control Total Surplus</strong></td>
<td></td>
<td>2.9</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Despite all efforts, the only significant financial pressure the Trust did not fully mitigate in 2017/18 was the impact of the fines and legal costs from the prosecution hearings in March 2018. Although other pressures, such as out of area placements, high medical locum usage and unfound efficiency
savings were offset by range of one-off in year benefits, these costs are ongoing and will be continue to be significant risks for the Trust in 2018/19.

However the plan for 2018/19 is to meet the agreed control total surplus of 3.4m (after receipt of £4.1m STF) and this assumes the following:

- Securing additional income for activity growth and Five Year Forward View Investment from our Commissioners, although no margin has been assumed in the plan;
- Significantly reducing the out of area placements to minimal levels by the end of quarter 2;
- Reducing the current high costs of medical locum agency by 26%;
- Delivery of a £13.1m (4.5%) Cost Improvement Plan (CIP) which is at a higher level than the national efficiency target of 2%; and
- The cost of the new pay deal will be fully funded.

Capital investment of £17.3m has been included in the plan, which is higher than recent years’ plans due to the business case for the development of a CAMHS / Secure Services Investment and a new ‘Invest to Save’ programme. This development will require a business case to be submitted to NHS Improvement. Priority has been given to ensuring that our services are delivered from safe and compliant premises and, for this reason, enabling works to address environmental concerns will continue to be prioritised.

The forecast closing cash balance for 2017/18 of £28.3m is an increase in year of £3.0m. This will support the increased capital programme along with other sources such as external funding from NHSE for the CAMHS/ Secure Services Investment, further in year asset disposals and depreciation. The planned closing cash balance for 2018/19 is £23.5m.

**Contracts & income**

We have contractual agreements in place with each of our commissioners for 2018/19 based on the 2 year contracts signed in 2017/18, however revised finance schedules have been negotiated although the majority of these are finalised there are some Five Year Forward View for Mental Health and growth funding which will take a little time in to the new financial year to resolve. Our assumptions within the plan are neutral, ie all new income will be matched by new expenditure.

Throughout 2018/19, we will continue working closely with South East Hampshire and Fareham and Gosport CCG’s to consider different contracting arrangements, as part of the Portsmouth & South East Hampshire Integrated Care System.

**Use of resources**

The Use of Resources rating assesses how well the Trust is financially managed with an overall score of ‘1’ being the best and ‘4’ the worst. The forecast outturn for 2017/18 is an overall score of ‘2’ which is expected to deteriorate to ‘3’ for quarters 1 and 2 of 2018/19 and then improve to ‘2’ and ‘1’ for quarters 3 and 4 respectively. The improvement during the year is due to the profiling of the receipt of the Provide Sustainability Fund (PSF), lower out of area beds spend, reduced agency run rate and CIP delivery.
Risk

We face a number of risks which have not been factored into the plan as it is assumed there will be a successful mitigation. Whilst the majority of agreements have been reached in contract negotiations, there remains a level of risk around the detail of the investments being made by commissioners and in particular the ability to deliver the Mental Health Five Year Forward View in full. A small level of QIPP savings have been agreed and work continues to jointly develop deliverable schemes with commissioners.

Until CIP schemes are fully developed there is a level of CIP risk within the programme and there is a moderate assumption around revenue generation.

High use of out of area mental health placements remains a significant pressure for the Trust. Although discussions have commenced with our local Commissioners about future contracting and risk sharing arrangements, it is likely that this will continue to be an unfunded cost during 2018/19. For the purposes of the 2018/19 plan we have identified non recurrent resources to cover a level of spend on out of area beds with ambitious internal plans to reduce these significantly over the year.

It is assumed that the cost for the NHS pay deal will be fully funded and therefore any shortfall will be a financial risk for the Trust.
## Appendix 1: Strategic Priorities and Measures of Delivery 2018/19

<table>
<thead>
<tr>
<th>PRIORITIES</th>
<th>2018/19 DELIVERABLES</th>
<th>MEASURES OF DELIVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide good quality care</td>
<td>Achieve a minimum rating of ‘good’ from our regulator the Care Quality Commission (CQC). [Q3]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve our quality priorities as set out in our quality accounts and our contracts. [<em>Monitored throughout the year</em>]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Removal of NHS Improvement restrictions on our operating licence, relating to quality of care. [Q3]</td>
<td></td>
</tr>
<tr>
<td>Single approach to improving quality adopted across the whole trust</td>
<td>6 QI champion coaches in place, 60 trained Quality improvement implementers, 600 staff actively involved in Quality improvement based transformation projects. [Q4]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measurable improvement against key trust priorities as a direct result of Quality Improvement work. [Q4]</td>
<td></td>
</tr>
<tr>
<td>Patients, families and the public are more involved in decisions about their care and their local services</td>
<td>97% of people completing monthly ‘Friends and Family’ test would ‘Recommend’ or ‘Highly Recommend’ care. [Q4]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve objectives of the Experience, Involvement and Partnership Strategy. <em>(To be agreed Q1 2018/19)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evidence of increased patient, carer and family involvement in care, in line with principles of the Triangle of Care. [<em>Monitored throughout the year</em>]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within top 20% similar NHS Trusts nationwide for engagement of people who use or rely on our services. [Q4]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NHS Improvement lift restrictions to operating licence relating to service user engagement. [Q3]</td>
<td></td>
</tr>
<tr>
<td>People are able to access the care they need, when they need it</td>
<td>All nationally mandated targets met. [<em>Monitored throughout the year</em>]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Significantly reduce the number of people receiving mental health care in beds outside Hampshire with the number of beds reduced to no more than 4. <em>[By the end of Q2]</em></td>
<td></td>
</tr>
<tr>
<td>Priority: People</td>
<td>Increased recruitment and retention of staff, leading to a more stable workforce</td>
<td>Vacancy rate of 6% or lower. [Q4]</td>
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<td>----------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Only 3.2% of the total pay costs are spent on agency workers by the end of the year. [Monitored throughout the year]</td>
<td></td>
</tr>
<tr>
<td>Priority: People</td>
<td>Strong leadership throughout the organisation</td>
<td>Achieve a rating of ‘good’ from the Care Quality Commission in the ‘well-led’ category. [Q3]</td>
</tr>
<tr>
<td></td>
<td>NHS Improvement regulatory undertakings relating to Board governance lifted. [Q3]</td>
<td></td>
</tr>
<tr>
<td>Priority: People</td>
<td>Staff feel involved, motivated and proud to work at Southern Health</td>
<td>2018 Staff survey engagement scores in ‘top 3rd’: Advocacy increased from 3.63 towards 3.73</td>
</tr>
<tr>
<td></td>
<td>Motivation increased from 3.93 to 3.95 or above</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involvement sustained at 75% (already top 3rd)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff survey overall response rate increased to 66%. [Q4]</td>
<td></td>
</tr>
<tr>
<td>Priority: People</td>
<td>The size, shape and skills of our workforce can meet current and future needs</td>
<td>People and Organisational Development Strategy approved by Trust Board. [Q1]</td>
</tr>
<tr>
<td>Priority: Transformation</td>
<td>Patients have better access, experience and outcomes as a result of transformed, joined-up services</td>
<td>Improvements to services in line with our clinical services strategy and Hampshire health and care plans. [Q4]</td>
</tr>
<tr>
<td></td>
<td>Complete redesign of access to South East Hampshire mental health services and agree implementation plan with partner organisations. [Q2]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Launch second major service redesign programme supported by Northumberland, Tyne and Wear NHS Trust. [Q1]</td>
<td></td>
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<tr>
<td></td>
<td>Implement Extended Primary Care Teams (EPCT) and closer working with primary, acute, social care and voluntary sector partners. [Q4]</td>
<td></td>
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<tr>
<td></td>
<td>Joint management structure in place to deliver integrated intermediate care with Hampshire County Council. [Q3]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharge to assess pathway in place in our community hospitals. Increased patient and family involvement in discharge planning. [Q4]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist services review completed across Hampshire with CCGs, to ensure provision of safe, high quality long term condition hubs and specialist</td>
<td></td>
</tr>
<tr>
<td>Priority</td>
<td>Description</td>
<td>Details</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Money</strong></td>
<td>Future delivery and improvements to care safeguarded through sound financial planning</td>
<td>Medium term commissioning strategy for community services agreed [Q2] 3 year financial plan developed, including efficiency plans [Q4]</td>
</tr>
<tr>
<td></td>
<td>Expansion and improvement of specialised mental health services for adults and young people underway</td>
<td>Board approval of plans to expand secure services for young people. [Q1] Support from board and key stakeholders for improvements to the adult secure services pathway. [Q4]</td>
</tr>
<tr>
<td></td>
<td>Make every penny count towards patient care and service improvements</td>
<td>Services delivered within the 2018/19 financial targets. [Q4] Delivery of control total surplus each quarter. [<strong>Monitor throughout the year</strong>] Fully deliver CIP target, of which at least 75% is recurrent in year and 100% recurrently including full year effect. [<strong>Monitor throughout the year</strong>] Cash balance in line with financial plan. [Q4] NHS Improvement Use of Resources Rating of 3 (Q1/Q2) and 2 (Q3/Q4) [Q4]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services that meet the needs of localities. [Q4] Children’s public health 0-19 care model designed in partnership with Hampshire County Council. [Q4]</td>
</tr>
</tbody>
</table>
Our vision:
To provide high quality, safe services which improve the health and wellbeing, independence and confidence of the people we serve*

Quality
- Provide good quality care
- People are able to access the care they need, when they need it
- Patients, families and the public are more involved in decisions about their care and their local services
- A single, proven approach to improving quality adopted across the whole trust

Transformation
- Patients have better access, experience, and outcomes as a result of transformed, joined up services
- Expansion and improvement of specialised mental health services for adults and young people are well underway

People
- Increased recruitment and retention of staff, leading to a more stable workforce
- Strong leadership throughout the organisation
- Staff feel involved, motivated and proud to work at Southern Health
- The size, shape and skills of our workforce can meet current and future care needs of the people we serve

Money
- Make every penny count towards patient care and service improvement
- Future delivery and improvements to care safeguarded through sound financial planning

*Please note, we will be refreshing our vision in 2018/19, in partnership with staff, patients and carers, to better reflect the aspirations we have for the future.
## REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>12</td>
</tr>
<tr>
<td>Title</td>
<td>Infection Prevention &amp; Control Annual Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Jacky Hunt, Lead Nurse IP&amp;C</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Julie Dawes, Director of Nursing &amp; AHPs</td>
</tr>
</tbody>
</table>

### Purpose & Action Required

The report is for assurance

### Executive Director Overview

- There has been 9 cases of *Clostridium difficile* toxin positive patients post 72hrs of admission into inpatient areas (all not preventable)

- There have been 5 E coli, 1 Pseudomonas and zero MRSA, MSSA and Klebsiella blood stream infection post 48hrs of admission.

- There have been 36 MRSA new positive swab results (34 within 48hrs of admission and 2 post 48hrs of admission.

- The IPC Team have provided advice to in-patient areas on:
  - 10 outbreaks of D&V
  - 7 outbreaks of flu
  - 59 cases of individual flu
  - 1 ward closure (5 bay closures)
  - Overall 20 bed days lost due to infection.

- There have been a total of 47 sharps incidents (plus 4 clean incidents).

- The team have delivered 22 mandatory IPC training session.

- 93% of Trust staff are in date with their Annual IPC training and 98% in date with 3 yearly IPC training.

- The IPC team have supported teams to undertake 12
<table>
<thead>
<tr>
<th>Strategic Priorities this paper supports:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>✗</td>
</tr>
<tr>
<td>People</td>
<td>✗</td>
</tr>
<tr>
<td>Transformation</td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
</tr>
<tr>
<td>Does this impact any Board Assurance Framework / Corporate Risks</td>
<td></td>
</tr>
</tbody>
</table>

audits in addition to monthly and quarterly hand hygiene audits

Previously considered by: IP&C Group 8.5.18
                          Quality & Safety meeting 8.5.18
Executive Summary

Welcome to the 2017.18 Annual Report for Infection Prevention & Control and Decontamination for Southern Health Foundation Trust (SHFT). SHFT is a large provider of community care, covering a wide range of disciplines including physical health, mental health, learning disabilities and children’s across Hampshire. As the Director of Infection, Prevention and Control (DIPC), I have been privileged to lead the IPC agenda over the last year.

This report clearly demonstrates how SHFT has embraced the Infection Prevention and Control (IPC) agenda, deploying audit, education and clinical leadership and support, so all SHFT understand and maintain their personal accountability in preventing and controlling infection.

SHFT has established clearly defined standards for maintaining patient safety and ensuring high quality outcomes for patients. There have been no Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infections reported this year.

There have been 9 patients who were identified as C.difficle toxin positive more than 72 hours after admission, in Physical Health wards. Seven of these cases were deemed not preventable at RCA (2 are in progress). No cases of C.difficile infection were identified in mental health wards.

Significant efforts have been made to ensure SHFT remains compliant with the Health and Social Care Act (2015). This year the Trust has been delighted to welcome a new Antimicrobial Pharmacist to advance the antimicrobial strategy. This is a shared post between this Trust and Solent NHS Trust.

This year the Trust has focused on water safety by improving plumbing at Melbury Lodge and Gosport War Memorial Hospital, strengthening the Trust’s Water Safety Group membership and providing more ‘Legionella Awareness Training’ for Water Safety Group members.

This year the flu season was particularly busy across the country. The Trust successfully established a system of ‘Flu Peer Vaccinators’ for the first time. Thanks to the dedicated work of these staff and Occupational Health, staff flu vaccination rates were increased from 34 % in 2016.2017 to 50.5% this year. In addition, 4 ‘flu ward hubs’ were set up to ensure the adequate provisions were available to safely manage flu, across the county. Another new successful initiative was the use of Southern Health staff to support Public Health England in the collection of flu swabs from residents in Care Homes during outbreaks.

A further focus this year has been on Sepsis management, the Trust has been working together with the Patient Safety Wessex Collaborative to rollout the National Early Warning System (NEWS) to our community hospitals.

IPC has remained a top Board priority during 2017.18 and this will continue to be reported and monitored as new infection control challenges emerge that SHFT will focus on throughout 2018.19.
1. Purpose

1.1 This report represents the Annual Report for the Infection Prevention and Control Team (IPCT) 2017.18. The purpose of this report is to:

- Provide assurance that there are robust policies and procedures in place to demonstrate compliance with the Health and Social Care Act 2008 – Code of practice on the prevention and control of infections and related guidance (DH 2015)
- Demonstrate that Infection prevention and control is embedded into the organisation and the responsibility for IPC is effectively devolved to all members of the staff regardless of discipline or grade

This report also provides a summary of Trust wide outbreaks, incidents and learning which has emerged from events that occurred in SHFT.
This report covers the period 1\textsuperscript{st} April 2017 – 31\textsuperscript{st} March 2018.

2. Context/Background

2.1 Under the Health and Social Care Act (2008) Code of Practice, each provider of health and social care must meet the required infection prevention standards – see table listed below.

<table>
<thead>
<tr>
<th>Compliance Criterion</th>
<th>What the registered provider will need to demonstrate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them</td>
</tr>
<tr>
<td>2</td>
<td>Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections</td>
</tr>
<tr>
<td>3</td>
<td>Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance</td>
</tr>
<tr>
<td>4</td>
<td>Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion</td>
</tr>
<tr>
<td>5</td>
<td>Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people</td>
</tr>
<tr>
<td>6</td>
<td>Systems to ensure that all care workers (including contractors and</td>
</tr>
</tbody>
</table>
What the registered provider will need to demonstrate

<table>
<thead>
<tr>
<th>Compliance Criterion</th>
<th>Volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Provide or secure adequate isolation facilities</td>
</tr>
<tr>
<td>8</td>
<td>Secure adequate access to laboratory support as appropriate</td>
</tr>
<tr>
<td>9</td>
<td>Have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections</td>
</tr>
<tr>
<td>10</td>
<td>Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection</td>
</tr>
</tbody>
</table>

2.2 The Infection Prevention and Control and Decontamination Group will be responsible for ensuring that the Trust continues to remain compliant with the Code and this is reported via Quarterly Reporting. The priority for this Group is to continue to develop the Annual Work Programme which includes detailed plans regarding training, policies and procedures and audit.

2.3 It is an expectation within the Code of Practice, that the assurance framework in place includes a regular review of the statistics on the incidences of alert organisms eg MRSA, outbreaks of infection and serious untoward incidences.

3. Report

3.1 Governance Arrangements

Board level responsibility for IP&C is clearly defined and there are clear lines of accountability for IP&C throughout the organisation. The Chief Executive (CEO) is responsible for the prevention and control of infection. The Director of Infection Prevention and Control (DIPC), who also holds the position of Deputy Director of Nursing and is the lead executive for IP&C and is directly reportable to the CEO and Trust Board. The Patient Safety Group receives quarterly updates from IP&C. The DIPC receives a monthly report detailing incidents by exception, which is circulated to the Trust Board.

3.2 The Infection Prevention and Control and Decontamination Group is chaired by the DIPC and meets quarterly. The Group is represented by all Divisions in the organisation. Prior to the meeting the IPC Lead submits a quarterly report on IPC activity for the previous quarter to group members. This report is reviewed, discussed and approved at each meeting. In quarter 4 the Group receive an Annual Report for approval. The IPC Group is also responsible for approving IPC policies and procedures.

3.3 The Infection Prevention and Control Team (IPCT)

The operational management of the IPCT sits with the Deputy Director of Nursing and AHP. The team consists of:

- Director of Infection Prevention and Control (DIPC). The DIPC post is held by the Deputy Director of Nursing
0.1 WTE Consultant Microbiologist
1.0 WTE Band 8A Lead Nurse IPC
1.0 WTE Band 7 IPC Nurse
1.00 WTE Band 7 vacancy
1.00 WTE Band 6 IPC Nurse (to Band 7 on completion of training September 2018)
0.7 WTE Band 3 IP&C Team Secretary (banding under review)

Theresa Lewis (Band 8b) moved to an infection prevention post outside the Trust in September 2017. The Trust wish to formally thank Theresa for her hard work and dedication over the 9 years she was in post. Jacky Hunt was appointed Lead IPC Nurse (Band 8a) February 2018. The role of the Team Secretary has been expanded to include data management and audit co-ordination. Application to uplift this post band from a 3 to a 4 is in progress.

When fully staffed the workload for the team is defined into three geographical areas: North, East and West. Within each area the band 6/7 IPC nurse provide the operational service within the Divisions whilst the band 8 IPC nurse provides the strategic overview for the team.

Service Delivery
The IPCT work with all staff throughout the organisation to engender an infection prevention culture within the Trust. IPC is represented through a number of forums – see Appendix A: Annual Programme 2017.18 for full details.

All policies and procedures are reviewed every four years or sooner if required, to ensure compliance with national guidelines or following learning identified through IPC incidents. Once approved, policies and procedures are available to staff via the Trust intranet and to the public via the Trust internet site. The IPCT also reviews other Trust policies, on request to ensure they comply with IPC standards.

3.4 IPC Annual Programme
The Annual Programme (Appendix A) is mapped to the structure of the Health and Social Care Act, Code of practice. This Code sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with cleanliness and infection control requirements set out in the regulation. Compliance with the Code is a legal requirement and it is the duty of the CQC to monitor and enforce compliance.

All elements of the Health Act, Code of practice are in place.

4. Surveillance and IPC Incidents

4.1 Surveillance
As part of mandatory surveillance reporting the Trust monitors data on *Clostridium difficile* infections (occurring at least 48 hours after admission), E coli, MRSA and MSSA blood stream infections. The team also monitor new cases of MRSA positive swab results which occur post 48hrs of admission to an inpatient area. In addition to
mandatory surveillance, the team will also provide advice on the management of a wide range of communicable diseases such as chicken pox, scabies, Group A streptococcus and patients who are known MRSA carriers.

4.2 Clostridium difficile

The target set by WHCCG for Clostridium difficile infections for 2017.18 (preventable C.difficile toxin positive cases occurring more than 72 hours after admission) is 4 cases in physical health and 2 cases in mental health (including OPMH).

During 2017.2018 there have been 9 Clostridium difficile toxin positive cases (post 72hr of admission) in physical health community hospitals.

All of the incidents have been thoroughly investigated with a Root Cause Analysis (RCA) to identify any learning. Of the 9 incidents investigated, all were considered to be unavoidable. The root cause was due to patient factors eg antibiotic history, recent hospitalisation, patient's age and co-morbidities. Please see common themes of learning from the 9 cases summarized in the table below.

There have been no preventable C.difficile toxin positive cases occurring more than 72 hours after admission within mental health inpatient areas.

Clostridium difficile: Community Hospitals
Common Themes for Learning from *Clostridium difficile* cases

<table>
<thead>
<tr>
<th>1</th>
<th>Training/Practice Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢</td>
<td>Urinary tract infection in the elderly or catheterized patients should be diagnosed based on recorded symptoms of infection. Dip stick testing in these groups is not a good indicator of infection and should be avoided.</td>
</tr>
<tr>
<td>➢</td>
<td>Full antibiotic history is rarely handed over by Acute Trusts when they transfer a patient in a physical health/OPMH in-patient ward so staff are asked to consider any patient who is transferred from an acute trust as vulnerable to <em>C. difficile</em> infection particularly if they have had a history of infection requiring antibiotics or if they are over 65 years old and frail and</td>
</tr>
<tr>
<td>T.H.I.N.K +ve</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>take a specimen <strong>as soon</strong> as the first type 7 stool is passed, please don’t wait</td>
</tr>
<tr>
<td>H</td>
<td>hand hygiene</td>
</tr>
<tr>
<td>I</td>
<td>isolate patient on the first type 7 stool</td>
</tr>
<tr>
<td>N</td>
<td>note ‘CDT risk’ on your handover sheet/board</td>
</tr>
<tr>
<td>K</td>
<td>keep any antibiotics and PPIs (e.g. omeprazole) under review</td>
</tr>
<tr>
<td>➢</td>
<td>Staff should treat even the first episode of diarrhea as infectious until proven otherwise.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Communication and Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢</td>
<td>Medirest Porters at G.W.M.H should check the specimen fridge each day, to ensure timely delivery to the lab (1 occurrence).</td>
</tr>
<tr>
<td>➢</td>
<td>All <em>C. difficile</em> toxin positive cases occurring more than 72 hours after admission should be recorded as ‘moderate harm’ to trigger a 48hour panel. If necessary they can be downgraded after panel.</td>
</tr>
</tbody>
</table>

### 4.3 Blood Stream Infections

Over the course of the year there have been a total of:

- 0 MRSA blood stream infections – post 48hrs of admission
- 0 MSSA blood stream infections – post 48hrs of admission
- 5 *E coli* blood stream infections – post 48hrs of admission
0 Klebsiella – post 48hr of admission
1 Pseudomonas – post 48hr of admission

All of these incidents have been thoroughly investigated with a Root Cause Analysis (RCA) to identify any learning. Please see common themes of learning from all 5 cases summarized in the table below.

### SHFT Blood Stream Infections 2017.18

<table>
<thead>
<tr>
<th>Month</th>
<th>MRSA</th>
<th>MSSA</th>
<th>E coli</th>
<th>Klebsiella</th>
<th>Pseudomonas</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dec</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Learning from E Coli Bloodstream infections**

Four of the 5 cases were not deemed preventable at 48hour panel (one is in progress). No common themes of learning identified.

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.04.17</td>
<td>Longbeech 2 - Ward LNFH went to 48 hour panel downgraded (not avoidable) patient recovered quickly, source urine, catheter in situ and in retention.</td>
</tr>
<tr>
<td>26.6.17</td>
<td>Longbeech 2 - LNFH Downgraded at 48 hour panel downgraded (not avoidable). Most likely cause a chest infection.</td>
</tr>
<tr>
<td>6.8.17</td>
<td>Deerleap Ward LNFH -Patient previously treated for a UTI whilst at UHS prior to transfer to LNFH. Patient positive to E coli in urine from a sample taken on admission to LNFH. Spiked a temp 3 days post admission - highly likely patient incubating infection on admission.</td>
</tr>
<tr>
<td>28.2.18</td>
<td>Wilverly 2, LNFH This lady had a history of retention of urine and was catheterized twice prior to the e-coli bacteremia. The urinary catheter was removed but she went into chronic retention which is thought to have pre-</td>
</tr>
</tbody>
</table>
4.4 MRSA (positive swab results)

The number of MRSA positive swab results (new cases) is monitored in inpatient areas, and their cause investigated as indicated. Over the course of the year there have been a total of 36 new cases of MRSA identified (34 pre 48hr and 2 post 48hr). All incidents occurring post 48hrs of admission are thoroughly investigated with a Root Cause Analysis (RCA) to identify any learning. Please see common themes of learning from these cases summarized below.

For completeness in reporting, cases testing positive within mental health wards are also included but these are identified as part of clinical screening and not as part of routine admission screening. In line with Department of Health guidelines, MRSA screening within mental health settings is targeted at ‘At Risk’ groups rather than universal screening for all admissions. Within the Mental Health Division there has been one new case of MRSA identified.

NEW MRSA results: Community Hospitals:

- April: 0
- May: 1
- June: 2
- July: 3
- August: 4
- September: 10
- October: 5
- November: 4
- December: 3
- January: 2
- February: 1
- March: 1

*new cases
Common Themes for Learning from MRSA cases

<table>
<thead>
<tr>
<th>Training/Practice Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Delay from the microbiology laboratory in receiving the results (5 days); needed to be escalated (1 case)</td>
</tr>
<tr>
<td>➢ It is important for alerts on the PAS system for known carriers of MRSA are also transferred to any RIO notes.</td>
</tr>
</tbody>
</table>

All the learning identified above will be shared with the Trust via:

➢ Trust Board via IPC monthly exception reporting
➢ IPC quarterly reporting
➢ IPC quarterly learning updates
➢ IPC link network
➢ The ward team involved at team meetings

4.5 Ward/Unit closures due to suspected infection (Serious Incidents)

During 2017/2018 there was one ward closure due to Flu which occurred on Malcolm Faulk ward, Ravenswood.

4.7 Outbreaks, Ward Closures and Bay Closures

In addition to the incidents noted above, the team have monitor for increased infection in inpatient areas. These were due to diarrhoea and vomiting and flu and where patients could be isolated effectively, bays were closed on affected wards if required. During a bay closure or infection incident, the IPC team maintain daily contact with wards to monitor the situation, support staff and assess if further measures are needed.

The IPC Team have provided advice to in-patient areas on:

➢ 10 outbreaks of D&V
➢ 7 outbreaks of flu
➢ 1 ward closure (5 bay closures)
➢ Overall 20 bed days lost due to infection.

4.8 Occupational Health and Sharps Incidents

Sharps Incidents

Details on needle stick injury (NSI)/sharps incidents and other incidents are recorded on the Trusts internal incident reporting system (Ulysses) and also by the Trusts Occupational Health provider (PAM). Data is reviewed from both sources, cross matched to remove duplicates, and reported each quarter. In 2017.18 there were a total of 51 NSI/sharps and other incidents reported (including 4 clean incidents). In comparison during 2016.17 there were 68 incidents reported (including 4 clean incidents).
A review of the common cause of sharps injuries reported include:

- Injuries sustained from bites, scratches and bodyfluid exposure: 11
- Injuries sustained after use and before disposal: 17
- Injuries sustained on disposal: 4
- Injuries sustained from insulin needles / insulin pens: 12
- Other: 3

The table below shows the number of sharps incidents reported by injury type:

<table>
<thead>
<tr>
<th>Number of Incidents</th>
<th>Sharps &amp; Body Fluid Incidents reported via Ulysses &amp; PAM</th>
<th>April 2017 - March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>Bites &amp; Scratches</td>
<td>NSI/Sharp (clean)*</td>
</tr>
<tr>
<td>May</td>
<td>Sharp</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Body Fluids</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SHFT is compliant with the EU directive for introducing safer sharps in the workplace and a catalogue of safety products is available for staff to access.

5. **IP&C Training**

5.1 **Mandatory Training**

The IP&C team provide ‘face to face’ training for Annual and 3 yearly training. Alternatively staff can complete their training on-line by completing either e-assessment or e-learning which has integral e-assessment questions. During the year the team have delivered a total of 22 training sessions:

- 14 clinical update training sessions
- 5 non-clinical updated training sessions
- 3 training sessions for OCS staff at Lymington hospital

The table below provides a summary of staff who are compliant with IPC training by each Division. Managers are responsible for ensuring their teams are compliant with all statutory and mandatory training which is monitored through annual staff appraisal.
### IP&C Training compliance 2017/2018 – taken from Tableau on 3.4.18

<table>
<thead>
<tr>
<th>Directorate</th>
<th>IP&amp;C Training – Annual %</th>
<th>IP&amp;C Training – 3 yearly %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>N/A</td>
<td>87</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>N/A</td>
<td>100</td>
</tr>
<tr>
<td>Property &amp; Estates</td>
<td>N/A</td>
<td>99</td>
</tr>
<tr>
<td>Development Director</td>
<td>N/A</td>
<td>100</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>N/A</td>
<td>99</td>
</tr>
<tr>
<td>Medical Director</td>
<td>N/A</td>
<td>100</td>
</tr>
<tr>
<td>People &amp; Communications</td>
<td>N/A</td>
<td>97</td>
</tr>
<tr>
<td>Strategy Director Summary</td>
<td>N/A</td>
<td>100</td>
</tr>
<tr>
<td>ISD East – BU 1</td>
<td>93</td>
<td>98</td>
</tr>
<tr>
<td>ISD West – BU 2</td>
<td>90</td>
<td>99</td>
</tr>
<tr>
<td>ISD North – BU 3</td>
<td>93</td>
<td>99</td>
</tr>
<tr>
<td>Childrens – BU 4</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>OPMH – BU 5</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>ISD Central Management – BU 6</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Mental Health</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>93</td>
<td>98</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>Overall Compliance</td>
<td>93%</td>
<td>98%</td>
</tr>
</tbody>
</table>

The Trust aims for an attendance of 95% or higher to score Green for all statutory and mandatory training. Attendance at IPC training is monitored via quarterly IPC reports, and discussed at IPC Group meetings. Team performance is also now available via the Tableau reporting system, which allows all staff to view performance metrics on a number of areas including attendance at statutory and mandatory training.

#### 5.2 IP&C Link Training

IPC Link Advisors play an important role in promoting good IPC standards in clinical teams. The IPC Team have given considerable thought as to how best support this group of staff in their role. Historically IPC Link Meetings had been well attended but in this year, attendance fell significantly so after November 2017 it was decided that face to face educational meetings were no longer an effective means of support for the IPC Links. The exception to this were the Children’s IPC Links as they had good meeting attendance and so wished to continue with an annual Children’s IPC Meeting.

A full day IPC Link Forum is planned for October 19th 2018 with 60 places for Physical Health and Mental Health (adults) IPC Links to receive an update on key initiatives and issues in infection prevention and control.

Selective ward visits were made this year by IPC Nurses to use the ‘walk around’ tool with the respective IPC Link, on their ward. Next year the IPC Team plan to build on this, working directly with the IPC Links in their workplace, once the IPC Team is fully staffed.
Topics discussed at IPC link sessions this year include:

**MH, LD and SS:**
- Audit feedback
- A quiz on diarrhoea and vomiting
- Learning from past IPC incidents
- Managing MRSA in MH settings
- News section – updated policies, IPC Matters newsletter, flu vaccination reminder

**Physical Health and OPMH:**
- Audit feedback
- Exploring IPC incidents from 2016.17 – discussion common themes of learning
- Gram negative blood stream infections
- Flu immunisation reminder
- News section – updated policies, CQC learning and checklist, diabetic pen safety, infection alerts on RIO, agency and bank staff IP&C induction checklist

**Children’s:**
- Audit feedback
- Childhood infections and quiz
- Sepsis
- PVL Staph. aureus
- PHE Measles updated guidance
- Group B streptococcus updated guidance
- News section – parvovirus (slapped cheek), flu immunisation reminder

**Summary of Attendance by IPC Links**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Service</th>
<th>Number of teams</th>
<th>Gaps</th>
<th>Total minus gaps</th>
<th>Attendance at Link meetings</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting 1</td>
<td>ISD</td>
<td>100</td>
<td>1</td>
<td>99</td>
<td>40</td>
<td>40%</td>
</tr>
<tr>
<td>(7 sessions)</td>
<td>OPMH</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>Meeting 2</td>
<td>ISD</td>
<td>99</td>
<td>1</td>
<td>98</td>
<td>46</td>
<td>47%</td>
</tr>
<tr>
<td>(7 sessions)</td>
<td>OPMH</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>Meeting 1</td>
<td>Mental Health/ Specialised Services &amp; LD</td>
<td>41</td>
<td>1</td>
<td>40</td>
<td>9</td>
<td>22%</td>
</tr>
<tr>
<td>(3 sessions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting 1</td>
<td>Childrens</td>
<td>30</td>
<td>0</td>
<td>30</td>
<td>20</td>
<td>67%</td>
</tr>
<tr>
<td>(3 sessions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting 2</td>
<td>Childrens</td>
<td>31</td>
<td>0</td>
<td>31</td>
<td>18</td>
<td>58%</td>
</tr>
<tr>
<td>(3 sessions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Training of new IP&C Links**

In 2017-2018 the IP&C Team introduced 3 half day training courses spread out over the course of the year for IP&C Links new to the role. These half day courses replace the
annual 2 day course and enable our new Links to gain attendance to training more quickly.

45 new IP&C Links have received training via the new ½ day course in 2017/2018 – see table below:

<table>
<thead>
<tr>
<th>Date of meeting</th>
<th>Location</th>
<th>Number of Links who attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 May 2017</td>
<td>Tatchbury Mount, Calmore</td>
<td>12</td>
</tr>
<tr>
<td>6 July 2017</td>
<td>Parklands Hospital, Basingstoke</td>
<td>14</td>
</tr>
<tr>
<td>8 November 2017</td>
<td>Fareham Community Hospital, Fareham</td>
<td>19</td>
</tr>
</tbody>
</table>

5.3 Additional IPC Training For Trust Staff

Additional IPC Training other than mandatory training of staff is summarised in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Delivered where / who</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5.17</td>
<td>Bed bugs</td>
<td>To the staff at College Keep AMH community team</td>
</tr>
<tr>
<td>15.6.17</td>
<td>C.difficile</td>
<td>To staff on Deerleap ward at LNFH</td>
</tr>
<tr>
<td>24.7.17</td>
<td>Local induction of staff member at ward managers request</td>
<td>Jacky Hunt at Alton Community Hospital</td>
</tr>
<tr>
<td>22.11.17</td>
<td>IP&amp;C update</td>
<td>MBU by Joanne Williams</td>
</tr>
</tbody>
</table>

6. Audit

6.1 The IPC team co-ordinate a programme of audits across all specialities. The audit team within Corporate Governance support the IPC team with the audit process. Managers are responsible for ensuring that audits are completed and any actions identified are addressed in an action plan. Action plans are monitored via the Teams Divisional Quality Improvement Plan (monitored by Heads of Nursing).

Audit results are shared:
- With all teams
- With IP&C Links at Link meetings until October 2017 when the meetings were discontinued in favour of a yearly study day (except Children’s IPC Links who will continue with an annual meeting)
- Via the quarterly IP&C Report which is discussed at quarterly IPC Group meetings
For the majority of the audits completed there is no overall score as standards are reported separately. However when an overall score is generated this is included in the table below.
### IPC audits completed 2017-18

<table>
<thead>
<tr>
<th>Month</th>
<th>Area to be audited</th>
<th>Team</th>
<th>Participation</th>
</tr>
</thead>
</table>
| April | Endoscopy                | Lymington                 | Participation - 100%  
Result – 100%                                                               |
| May   | Urinary Catheter – Epic 3| ISD Inpatients            | Participation 92% (12/13 teams participated)  
44 patients with a urinary catheter were audited  
11 standards were audited  
5 standards scored 88% or above |
| June  | Urinary Catheter- Epic 3 | ISD community teams       | Participation 81% (26/33 teams of ICTs participated)  
209 catheter insertions were audited  
16 standards were audited  
13 standards scored 95% or higher |
| June  | MRSA Screening           | Physical health inpatient teams | Participation 92% (12/13 of wards participated.  
145 patients were assessed during the audit week and all were eligible for MRSA admission screening |
|       | Compliance                | MH, SS&LD inpatient teams | Participation 86% (24/28 of wards participated.  
44 service users were assessed during the audit week for eligibility for MRSA admission screening and 59% (26/44) met this criteria. |
| July  | Nasoendoscopes           | ISD OPD teams              | 100% participation (3/3)  
68 standards were measured as part of this audit  
67 standards scored 100%  
1 standard (Decontamination takes place in a separate, dedicated decontamination room) scored 67% |
| July  | Daniels sharps container | All teams                 | 313 sharps bins were examined  
• 312/313 containers did not have protruding sharps  
• 312/313 container were less than ¾ full  
• 302/313 containers were sited off the floor at a suitable height or place  
• 311/313 containers had appropriate content  
• All staff understood that the label on the sharps bin was to be completed at assembly and closure |
| September | IP&C standards | MCP’s East ISD | Participation 100%  
• Brune Road 27/27 – 100%  
• Stoke Road 24/27 – 89% |
<table>
<thead>
<tr>
<th>Month</th>
<th>Area to be audited</th>
<th>Team</th>
<th>Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>September – Dec</td>
<td>Immunisation clinic</td>
<td>School nursing teams</td>
<td>Participation 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17 standards were measured</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 elements scored 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 standards scored 96% or above</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 standard scored 59% (sharps box transported with temporary lock on)</td>
</tr>
<tr>
<td>October</td>
<td>Endoscopy</td>
<td>Lymington</td>
<td>Participation 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Result 100%</td>
</tr>
<tr>
<td>November</td>
<td>Standard Precautions &amp; Sharps</td>
<td>All Inpatients and physical health community teams</td>
<td>Participation 78% (102/131 team)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>91% (67) staff wore an apron when performing wound care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>93% (25) staff wore an apron when there was a low risk of splash.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95% (21) staff wore an apron when performing personal care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>99% (223) of staff did clean their hands after removing PPE.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100% (222) staff disposed of PPE immediately after removal into the appropriate waste stream</td>
</tr>
<tr>
<td>January</td>
<td>MRSA – Screening Compliance</td>
<td>All Inpatient areas</td>
<td>Participation 82% (33/40 teams)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>79% patients met the criteria for MRSA screening (no patients in LD and SS met the criteria of requiring MRSA screening on admission).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>98% patients had their MRSA screen documented in the clinical record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>94% of patients had all of the sites screened and recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>78% (128) of results were checked, documented and actioned within 72 hours of admission across the Trust.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12% (37) of patients did not have their admission MRSA screen, checked, documented and actioned within 72 hours. The reasons given for this was result not ready, (5) patients had been admitted for less than 72 hours (15) and not checked (17)</td>
</tr>
<tr>
<td>February</td>
<td>Isolation Precautions</td>
<td>ISD Inpatients</td>
<td>Participation Environmental 67% (8/12 teams)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 of the 5 elements of the environmental audit all scored 100%, demonstrating that all physical health wards can safely</td>
</tr>
</tbody>
</table>
### 6.2 MRSA Screening Compliance Audit – January 2018

Each year as part of the IPC annual audit plan, all inpatient areas are invited to undertake a MRSA audit to assess compliance with IPC Policy: Appendix 14 MRSA

#### Results:

- 33/40 (82%) of wards participated
- Business unit 1: 3/4 (75%)
- Business unit 2: 6/7 (86%)
- Business unit 3: 1/1 (100%)
- OPMH: 5/7 (71%)
- Mental Health: 8/9 (89%)
- Learning Disabilities: 1/1 (100%)
- Specialised Services: 9/11 (82%)

#### Key findings:

- Overall, 78% (128) of results were checked, documented and actioned within 72 hours of admission.
- 12% (37) of patients did not have their admission MRSA screen, checked, documented and actioned within 72 hours. The reasons given for this was result not ready, (5) patients had been admitted for less than 72 hours (15) and not checked (17).

- 93% (43) of BU1 patients had their results checked and actioned within 72 hours, of the 2 patients who weren't, both had been in-patients for less than 72 hours
- 75% (47) of BU2 patients had their results checked and actioned within 72 hours of admission. Of the 15 that were not checked and actioned, 9 had not been admitted for more than 72 hours, 6 were not checked (4 of these were admitted to Romsey Hospital)
- 100% (45) of BU3 patients had their results checked and actioned within 72 hours
- 40% (18) of results from patients in OPMH Wards were not checked within 72 hours of admission. Of these 18 cases in OPMH wards, 5 were not ready, 4 patients had been in hospital for less than 72 hours and 9 were not checked
- 71% (34) of the patients in MH were screened for MRSA and had their results, documented and actioned within 72 hours of admission. 29% (2) of the MH patients MRSA screen results were not checked
IP&C recommendations

• Ensure there is a process in place to ensure that all MRSA screens are followed up and actioned in a timely way. Failure to follow up admission screens could potentially result in cross transmission of infection.

• Ensure that all patients who meet the MRSA screening criteria and are not screened, have a reason recorded in their clinical record eg patient refused or inappropriate due to clinical condition.

• Team Managers are asked to complete a local action plan to ensure that all patients who meet the MRSA admission screen criteria have a MRSA screen taken, documented, checked and actioned within 72 hours of admission, and if they were not screened the reason is recorded in their clinical record eg patient refused. The action plan must be submitted to the Quality Improvement Plan for your area (monitored by Heads of Nursing).

6.3 Isolation audit – February 2018

This audit is applicable to physical health inpatient wards only in order to identify areas of compliance and non-compliance with the Trust’s Isolation Procedure and to put actions in place to continuously improve practice.

Results

Good practice identified

Environmental Audit:

• 4 of the 5 elements of the environmental audit all scored 100%, demonstrating that all physical health wards can safely manage patients who need to be isolated as part of their management plan.

Observational Audit

• 10 elements were observed for in patients being cared for in isolation and 6 of these 10 elements scored 100% which is great news.

Areas for improvement

1 ward needs to ensure sufficient supplies of spare curtains are available for replacement after terminal cleaning; this was not identified as an issue last year.

Four elements of the observational audit need further attention to achieve full compliance:

• 6% (1 of 17) respondents stated they did not have hand washing facilities available within and outside of the isolation room (this is a drop from last year which was 0%)

• 12% (2 of 17) respondents did not keep the door closed whilst isolation was in progress. This was an improvement from 2017 (21%, 5 of 24 patients)

• 18% (3 of 17) respondents did not provide the patient or their relative with an information leaflet. This is a deterioration from last year (4% or 1 of 24)
6% (1 of 17) reported that the patients room had not been cleaned on the day of audit (down from 0% in 2017).

This year 100% of staff removed and disposed of personal protective clothing (PPE) in the isolation room inside the orange waste stream. In 2017, 96% (23/24) met this standard so slight improvement.

It was noted that only 5 of the responding 9 wards submitted data for the observational audit, containing the requested 3 patients per ward. The more patients in isolation that are observed, the more likely that audit will be representative of practice.

6.4 Hand Hygiene Audits

Hand hygiene audits continue to take place on a minimum of monthly basis in all inpatient areas and on a quarterly basis in community based locations and within mental health. Results of hand hygiene audits are presented as part of the quarterly report to the IPC and Decontamination Group.

See Appendix A for a full set of hand hygiene audit results for this reporting year. If teams score below 80%, they are required to re-audit within their reporting timeframe. If scores persist below 80%, the IPC nurse will contact and / or visit the team to support with the development of an action plan to improve their scores. This may involve:

- Additional hand hygiene training with the 'light box' to improve awareness
- Shadowing the IPC Link during the completion of the audit to ensure the audit tool is being completed correctly
- Increasing to weekly audits until greater compliance is demonstrated

7. Decontamination

Endoscopy dept, LNFH

The endoscopy department is reviewed each year by an independent Authorised Engineer (Decontamination). This review was completed in January 2018 and the department scored very well. Some actions were identified in line with the updated HTM 01-06 Decontamination of Flexible Endoscopes, Parts A-E (DH 2016) and these are being addressed locally by the team. This annual decontamination review is designed to assess the suitability of the decontamination facilities in readiness for further assessments on clinical competency as part of the JAG accreditation process. JAG refers to the Joint Advisory Group and provides clear nationally agreed standards for endoscopy departments. The endoscopy department at LNFH has maintained its JAG accreditation status in 2017.2018.
8. Estates & Facilities

8.1 New Builds/Refurbishments

The IPC team work collaboratively with Estate services, to ensure any new builds or refurbishments comply with IPC standards. Below is a table which summarizes IPC involvement with new builds or refurbishments during the last year.

**Summary of New Builds / Refurbishments**

<table>
<thead>
<tr>
<th>Division / Site / Location</th>
<th>Description</th>
<th>Start</th>
<th>Complete</th>
<th>IPCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISD BU 1</td>
<td>Forest Lodge</td>
<td>April 2017</td>
<td>May 2017</td>
<td>LP</td>
</tr>
<tr>
<td>ISD BU 3</td>
<td>Odiham Hospital – written advice re wound clinic</td>
<td>May 2017</td>
<td>June 207</td>
<td>JH</td>
</tr>
<tr>
<td>ISD BU 3</td>
<td>Anstey wound clinic – visit conducted in order for IP&amp;C standard to be met and still be in 5K budget – below capital bid threshold</td>
<td>July 2017</td>
<td>October 2017</td>
<td>JH</td>
</tr>
<tr>
<td>ISD West BU 2</td>
<td>Romsey Hospital – setting up new clinics</td>
<td>July 2017</td>
<td></td>
<td>JW</td>
</tr>
<tr>
<td>ISD West BU2</td>
<td>Bluebird House – visit conducted with Estates and Clinical Team re change of ward from medium secure to low secure</td>
<td>August 2017</td>
<td>September 2017</td>
<td>JW</td>
</tr>
<tr>
<td>ISD West BU2</td>
<td>Moorgreen – visited conducted with Louise Piper, IPCN &amp; Ann Catteau to review suitability of room for ENT/Audiology clinic. After discussion with staff it was found that the room was not suitable</td>
<td>August 2017</td>
<td>August 2017</td>
<td>JW</td>
</tr>
<tr>
<td>ISD East BU 1</td>
<td>Wellington Vale – moving an existing wound clinic to another room in the same building</td>
<td>September 2017</td>
<td>October 2017</td>
<td>LP</td>
</tr>
<tr>
<td>CAMHs MH</td>
<td>Redesign of Tatchbury site, alterations to existing premises for staff and patients and a new build to house an increased number of patients with mental health illness</td>
<td>December 2017</td>
<td>Ongoing</td>
<td>JW/JH</td>
</tr>
</tbody>
</table>

8.2 Medirest

The IPC team continue to work closely with the Facilities Team to monitor standards of cleanliness and support clinical teams when concerns are raised. During this year the IPCT have developed the following initiatives to support environmental cleanliness:

- Bespoke terminal check list for Mother and Baby Unit: Following the norovirus outbreaks on the Mother and Baby unit at Melbury lodge, the IPCT have worked closely with Medirest to compile a bespoke terminal clean checklist for use after an
outbreak and after an isolation room is vacated. This will address the variety of different furniture and equipment in place in this specialised unit and ensure that both clinical and housekeeping staff understand their individual responsibilities for cleaning as part of a terminal infectious clean.

8.3 **Water Safety Group (WSG)**

IPC are an integral member of the Water Safety Group which meets on a quarterly basis. The Trust Water Safety Plan has recently been reviewed by the WSG and ratified via the Health and Safety Committee. Two members of the IPCT have completed Level 3 Award in Legionella Control for Responsible Persons.

Melbury Lodge - Water quality issues were identified in October 2017 at the Melbury Lodge Site. The Estates Department have worked hard to keep the hot water at the correct temperature, flowing and the water system clean. Hot water has been sampled weekly since October 2017, when a temporary boiler was installed. The situation has been regularly reviewed and discussed with the Estates Team, the Authorising Engineer Water, Director of Infection Prevention, Consultant Microbiologist PHT and the Lead Nurse IPC. A restricted admission criteria has been applied since 1.11.17 (no babies under 1 month, no pregnant patients, only patients who are physically well).

Gosport War Memorial Hospital – Water quality issues were identified in X-ray and Out Patients of this hospital on 23.2.18. To minimise any risk from the hot water, filters were applied to the outlets concerned. The Estates Department carried out essential plumbing work to keep the hot water at the correct temperature, flowing and the water system clean. Hot water quality continues to be monitored and the situation has been regularly reviewed and discussed with the Estates Team, the Authorising Engineer Water, Director of Infection Prevention, Ass Dir Patient Safety & Infection Portsmouth Hospitals NHS Trust) and the Lead Nurse IPC.

9. **Project Work**

**Policies and Procedures**

During 2017.18 the IPCT have reviewed and updated the following policies or procedures:

- IP&C Policy (SH CP10)
- Ward closure procedure (SH CP99)
- Decontamination of Medical Devices procedure (SH CP100)
- Clostridium Difficile procedure (SH CP33)
- Care of the Deceased procedure (SH CP23)
- Decontamination of flexible endoscopes procedure (SH CP135)
- Communicable Diseases (SH CP156)

In addition IPCT have provided support to review and update 22 other Trust polices or procedures to ensure they comply with best IPC practice.
Gram negative Sepsis Prevention

a) Reporting of cases, investigation and learning
Staff are encouraged by the IPC Team to record all E.coli, Pseudomonas, Klebsiella bacteraemias that occur more than 48 hour after admission to an in-patient area on Ulysses Safeguard. The E.coli post 48hr bacteraemias from in-patient areas are each discussed at Trust 48 hour incident panel where it is determined if further investigation is warranted and completed we share learning via -

- IPC Team attend the Hampshire and IOW meetings, contribute to the E.coli BSI prevention action plan across this healthcare economy.
- IPC Quarterly Newsletters which go to IPC Links and their Managers and at Governance Meetings
- IPC Quarterly Report which is discussed at IPC Group and Patient Safety Committee

b) Sepsis 6
Lymington New Forest Hospital (LNFH) – regular audits check how quick the SEPSIS 6 are implemented. LNFH is the only hospital in our Trust where the ‘Sepsis 6‘ can be implemented

a) Early recognition and escalation to acute care – In our hospitals outside LNFH intravenous fluids and antibiotics cannot be given so the focus is on early recognition of patients with sepsis and then their prompt transfer to a hospital where the ‘Sepsis 6‘ can be implemented. Southern Health is working with the Wessex Patient Safety Collaborative to implement NEWS2 in its community hospitals outside LNFH.

b) Urinary Catheter Working Party – Clinical Trainers and IPC Nurses have started to meet 6 weekly to agree best practice standards, review policy, review formulary, implement aseptic technique training and competency

c) Correct antibiotic treatment – An Antibiotic Pharmacist post has been created which is shared with Solent. Jonathan Peters was appointed 1.10.17 to facilitate good antibiotic stewardship.

d) Education -Promotion of best practice is achieved via our Trust IPC Matters Newsletter, and clinical tools eg UTI symptom checker

10. Antimicrobial Stewardship

Jonathan Peters, Specialist Antibiotic Pharmacist (working 0.5WTE for SHFT) was welcomed to the Trust on 1.10.18.

11. Flu
This year the flu season has been particularly busy across the county.
The IPC Team have supported in-patient staff to manage 59 cases of individual patients with confirmed flu infection across the Trust.

The IPC Team have supported in-patient staff to safely contain 7 flu clusters across our wards this year.

**Staff Vaccination**

In addition to the Occupational Health provided flu clinics, the Trust successfully established a system of ‘Flu Peer Vaccinators’ for the first time. Additional vaccination opportunities were also supported via a ‘claim back’ option for staff who received their vaccination at their local pharmacy or GP.

Communication plans were put in place to support cascade of public health messages and information about clinic dates. A multi-channel approach was implemented including weekly bulletins, payslip attachments, screen savers and promotion of immunisation by IPCT at mandatory training and IPC Link Advisor system.

**As a result, staff flu vaccination rates were increased from 34% in 2016.2017 to 50.5% this year.** The lowest threshold of the CQUIN target was 50%.

**Provisions**

Following a table top exercise which took place 29.11.17 with all staff on the Director On-Call Rota, four ‘flu ward hubs’ were set up across the county to ensure an emergency supply of the provisions required to safely manage flu were available eg masks, Tamiflu, viral swabs. A “Director on Call Flu Action Card” was also agreed.

Another new successful initiative was the use of Southern Health staff to support Public Health England in the collection of flu swabs from residents in Care Homes during outbreaks.

**12. Findings/ Conclusions**

- There has been 9 cases of Clostridium difficile post 72hrs of admission into inpatient areas
- There have been 5 E coli, 1 Pseudomonas and zero MRSA, MSSA and Klebsiella blood stream infection post 48hrs of admission.
- There have been 36 MRSA new positive swab results (34 within 48hrs of admission and 2 after 48hrs of admission
- There have been a total of 47 sharps incidents (plus 4 clean incident)
- The team have delivered 22 mandatory IPC training session
- 93% of Trust staff are in date with their Annual IPC training and 98% in date with 3 yearly IPC training.
- The IPC team have supported teams to undertake 12 audits in addition to monthly and quarterly hand hygiene audits
- In in-patient areas, there have been:
  - 10 outbreaks of viral gastroenteritis
  - 7 outbreaks of flu (59 individual cases of flu were managed by the IPC Team)
  - 20 bed days were lost due to infection
  - 1 ward closure (5 bay closures)
13. **Recommendation**

The Committee are asked to approve this IPC Annual Report for 2017.2018

14. **Appendices**

Appendix A: IPC Annual Plan 2017.18

Appendix B: Summary of Hand Hygiene audit results 2017.2018

**IP&C Annual Programme 2018.19**

**Introduction**

This year’s annual programme is mapped to the structure of The Health and Social Care Act 2008: Code of Practice for the prevention and control of infections and related guidance (DH, 2015). Compliance with the Code is a legal requirement and it is the duty of the Care Quality Commission to monitor and enforce compliance.

The programme continues to address all high priority areas including
- Monitor compliance with best practice
- Review policies to ensure they meet national guidelines
- Reducing reportable bacteraemia’s eg MRSA, MSSA and E coli
- Maintaining low levels of preventable *Clostridium difficile* infection.
- Implementing measures to reduce gram negative bacteraemia with a special focus on best practice in urinary catheter management.
- Improving early recognition, escalation and management of sepsis
- Cleanliness and Decontamination
- Antimicrobial Resistance
- Involving patients with decision making on quality improvement activities to prevent and control infections
- Maximising ownership of infection prevention by Trust staff
- Work collaboratively with other agencies and partners in health and social care eg CCG’s, Occupational Health and local authorities
- Assist staff to maintain quality IPC standards and prepare them for any CQC visits

**Ongoing Activities**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Training</td>
</tr>
<tr>
<td>2</td>
<td>Maintaining a Link Advisor Programme</td>
</tr>
<tr>
<td>3</td>
<td>Audit</td>
</tr>
<tr>
<td>4</td>
<td>To review and update IP&amp;C policies. To review/contribute to other Trust policies to ensure they meet IP&amp;C requirements.</td>
</tr>
<tr>
<td>5</td>
<td>Promotion of hand hygiene</td>
</tr>
<tr>
<td>6</td>
<td>Attendance at key meetings</td>
</tr>
<tr>
<td>7</td>
<td>Specialist IP&amp;C advice on projects eg refurbishments / new builds</td>
</tr>
<tr>
<td>8</td>
<td>Risk Management and Surveillance</td>
</tr>
<tr>
<td>9</td>
<td>Meets the requirements for IP&amp;C as outlined in Local Quality Indicators</td>
</tr>
</tbody>
</table>
1. Training

The IP&C team provide ‘face to face’ training for Annual and 3 Yearly training. In addition staff are able to complete their IPC training via either E-assessment or E learning. Attendance at IPC training is monitored via quarterly IPC reports, quarterly Divisional Governance reports and discussed at IPC Group meetings. In addition training statistics can be viewed locally by teams using Tableau, the Trust reporting and analysis system.

The IP&C team will also provide bespoke training identified as a result of learning from incidents of infection. The IP&C team undertake FIT testing for staff on request.

Aseptic Technique e learning and e assessment is available to staff via the MLE system and this must be completed before undertaking a urinary catheterisation course.

2. Maintaining an IP&C Link Advisor programme

The IP&C team support a link advisor network throughout the key risk areas in the organisation. IPC Links who are new to the role are offered a half day training session, available annually in 3 locations. The ½ day course will focus on the essential elements new IPC link advisors need to know.

Schedule of meetings for Link advisors

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults – physical health and OPMH</td>
<td>IPC Link Forum Day 19.10.18</td>
</tr>
<tr>
<td>Mental Health and Learning Disabilities</td>
<td>IPC Link Forum Day 19.10.18</td>
</tr>
<tr>
<td>Children’s</td>
<td>1 meetings a year</td>
</tr>
<tr>
<td>½ day Link Advisor Training Course</td>
<td>3 (half day) courses per year. To be held at:</td>
</tr>
<tr>
<td></td>
<td>Tatchbury, Parklands and Fareham Community Hospital</td>
</tr>
</tbody>
</table>

Link Advisors and Matrons receive minutes and records of attendance / non-attendance following each meeting. Attendance is also monitored via quarterly IPC reports, and discussed at IPC Group meetings.
3. Audit

The IP&C team co-ordinate a programme of audits across all specialities. Audits will be carried out as per the plan below using the Quality Improvement Tools (Infection Prevention Society) or locally adapted tools if none nationally are available. This plan will be reviewed after 6 months and amended if necessary. Audit results are circulated to all teams once the audit is completed and a summary of the results are also reported formally via the IP&C Group. Teams are asked to develop their own actions plans, if necessary, to address any areas of non-compliance and managers are requested to submit their action plans to the Quality Improvement Plan for their area (monitored by Heads of Nursing).

Audit Plan 2018.19

<table>
<thead>
<tr>
<th>Month</th>
<th>Area to be audited</th>
<th>Who to complete the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>MRSA screening compliance</td>
<td>Inpatient areas only</td>
</tr>
<tr>
<td>February</td>
<td>Isolation</td>
<td>ISD Inpatient only</td>
</tr>
<tr>
<td>April</td>
<td>Endoscopy</td>
<td>Endoscopy Manager – ISD (Lymington)</td>
</tr>
<tr>
<td>April</td>
<td>Hand Hygiene</td>
<td>ISD &amp; OPMH inpatient areas, OPD, MIU, ECT</td>
</tr>
<tr>
<td>May</td>
<td>Urinary Catheter</td>
<td>ISD inpatient areas &amp; Community Care teams – physical health</td>
</tr>
<tr>
<td>May</td>
<td>Hand Hygiene</td>
<td>ISD &amp; OPMH inpatient areas, OPD, MIU, ECT</td>
</tr>
<tr>
<td>June</td>
<td>MRSA – Screening Compliance</td>
<td>ISD, OPMH, MH and LD inpatient areas</td>
</tr>
<tr>
<td>June</td>
<td>*Hand Hygiene</td>
<td>ISD, OPMH, MH &amp; LD inpatient areas, OPD, ECT, MIU, ISD Community Teams, MCP’s, Children’s services</td>
</tr>
<tr>
<td>July</td>
<td>Nasoendoscopes</td>
<td>OPD Managers – ISD</td>
</tr>
<tr>
<td>July</td>
<td>Hand Hygiene</td>
<td>ISD &amp; OPMH inpatient areas, OPD, MIU, ECT</td>
</tr>
<tr>
<td>August</td>
<td>Hand Hygiene</td>
<td>ISD &amp; OPMH inpatient areas, OPD, MIU, ECT</td>
</tr>
<tr>
<td>September</td>
<td>Immunisation clinics</td>
<td>Children’s services - Schools</td>
</tr>
<tr>
<td>September</td>
<td>IPC Standards</td>
<td>All MCPs East ISD</td>
</tr>
<tr>
<td>September</td>
<td>*Hand Hygiene</td>
<td>ISD, OPMH, MH &amp; LD inpatient areas, OPD, ECT, MIU, ISD Community Teams, MCP’s, Children’s services</td>
</tr>
<tr>
<td>October</td>
<td>Endoscopy</td>
<td>Endoscopy Manager – ISD (Lymington)</td>
</tr>
<tr>
<td>October</td>
<td>Urinary Catheter</td>
<td>ISD inpatient areas &amp; Community Care teams – physical health</td>
</tr>
<tr>
<td>October</td>
<td>Hand Hygiene</td>
<td>ISD &amp; OPMH inpatient areas, OPD, MIU, ECT</td>
</tr>
<tr>
<td>November</td>
<td>Standard Precautions</td>
<td>ISD, MH &amp; LD Inpatient areas, Community Teams physical health</td>
</tr>
<tr>
<td>November</td>
<td>Hand Hygiene</td>
<td>ISD &amp; OPMH inpatient areas, OPD, MIU, ECT</td>
</tr>
</tbody>
</table>
December  *Hand Hygiene*  ISD, OPMH, MH & LD inpatient areas, OPD, ECT, MIU, ISD Community Teams, MCP’s, Children’s services

January  MRSA – Screening Compliance  ISD, OPMH, MH and LD Inpatient areas

January  Hand Hygiene  ISD & OPMH inpatient areas, OPD, MIU, ECT

February  Isolation Precautions  ISD inpatient areas

February  Hand Hygiene  ISD & OPMH inpatient areas, OPD, MIU, ECT

March  *Hand Hygiene*  ISD, OPMH, MH & LD inpatient areas, OPD, ECT, MIU, ISD Community Teams, MCP’s, Children’s services

* Hand Hygiene Audits
  - **ISD in-patients, OPMH in -patients, OPD, MIU & ECT** - hand hygiene audits to be carried out on a monthly basis
  - **MH, SS & LD in patient settings** - hand hygiene audits to be carried out on a quarterly basis
  - **Community settings (physical health only)** – these take place on a quarterly basis (as a minimum) in ISD ICT’s, therapy teams, MCPs and in Children’s teams.
  - **Low Compliance** - If hand hygiene audits score less than 80%, teams will be asked to repeat the audit until scores reach above 80%
  - **Reporting** – hand hygiene audit scores will be reported quarterly in the IPC report and discussed at quarterly IPC Group meetings

4. To review and update IP&C policies and review/contribute to other Trust policies to ensure they meet IP&C requirements

The IP&C team will review all IP&C policies and procedures every 4 years or sooner if necessary to ensure they meet national requirements and the latest evidence base available. The team will also review and contribute to other trust polices via the virtual policy group and as requested from other teams to ensure all policies meet IP&C requirements.

<table>
<thead>
<tr>
<th>Appendix No</th>
<th>Policy Name</th>
<th>Version No</th>
<th>Issue No</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IP&amp;C Policy</td>
<td>3</td>
<td>SH CP10</td>
<td>Jun 21</td>
</tr>
<tr>
<td>5</td>
<td>Standard Precautions &amp; PPE</td>
<td>3</td>
<td>SH CP19</td>
<td>Nov 18</td>
</tr>
<tr>
<td>6</td>
<td>Hand Hygiene</td>
<td>3</td>
<td>SH CP12</td>
<td>Nov 18</td>
</tr>
<tr>
<td>7</td>
<td>Aseptic Technique</td>
<td>3</td>
<td>SH CP13</td>
<td>Nov 18</td>
</tr>
<tr>
<td>8</td>
<td>Outbreak of Infection / Major Outbreak</td>
<td>1</td>
<td>SH CP103</td>
<td>Jun 21</td>
</tr>
<tr>
<td>9</td>
<td>Isolation</td>
<td>2</td>
<td>SH CP32</td>
<td>Aug 18</td>
</tr>
<tr>
<td>10</td>
<td>Sharps and Inoculation Management</td>
<td>5</td>
<td>SH CP14</td>
<td>Feb 21</td>
</tr>
<tr>
<td>11</td>
<td>Ward Closure due to suspected or confirmed infection</td>
<td>1</td>
<td>SH CP99</td>
<td>Feb 21</td>
</tr>
<tr>
<td>12</td>
<td>Decontamination of Medical Devices</td>
<td>2</td>
<td>SH CP100</td>
<td>Nov 21</td>
</tr>
<tr>
<td>13</td>
<td>Diarrhoea &amp; Vomiting</td>
<td>2</td>
<td>SH CP21</td>
<td>Aug 18</td>
</tr>
<tr>
<td>14</td>
<td>MRSA Management</td>
<td>3</td>
<td>SH CP20</td>
<td>Mar 20</td>
</tr>
<tr>
<td>15</td>
<td>Clostridium Difficile</td>
<td>2</td>
<td>SH CP33</td>
<td>Sep 20</td>
</tr>
<tr>
<td>16</td>
<td>Scabies Infection Management</td>
<td>2</td>
<td>SH CP22</td>
<td>Sep 18</td>
</tr>
</tbody>
</table>
5. Promotion of hand hygiene

Hand hygiene is an integral part of the IP&C training update. Hand hygiene observational audits continue in a large number of environments.

When hand hygiene audits drop below 80% teams are asked to address corrective actions locally and repeat the audit until results demonstrate an improvement in hand hygiene standards. If scores persist below 80%, the IPC nurse will contact and / or visit the team to support with the development of an action plan to improve their scores. This may involve additional training with the ‘light box’ or shadowing the IPC Link during the completion of the audit.

Teams are asked to submit their completed audit by end of the last working day of the month/quarter depending when due. The IPC team follow up nil returns and send several reminders and this is escalated to the Manager/Matron as necessary. If audits are not received or received late they will show a nil return in the quarterly report.

Hand hygiene audit results will be reported quarterly in the IPC report and results and are discussed as part of the IPC Group meetings.

6. Key meetings attended by IP&CN’s to share expert knowledge

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPCN Team meeting</td>
<td>Fortnightly</td>
</tr>
<tr>
<td>Infection Prevention Control and Decontamination Group</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Divisional / Directorate Governance meetings</td>
<td>Attend at least Quarterly</td>
</tr>
<tr>
<td>Patient Safety Committee</td>
<td>Monthly</td>
</tr>
<tr>
<td>Capital Operations Group</td>
<td>Monthly (co-opted)</td>
</tr>
<tr>
<td>Emergency Preparedness and Planning</td>
<td>Bi monthly</td>
</tr>
<tr>
<td>Medical Devices Committee</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Medirest Contract Review Meeting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Health and Safety Committee</td>
<td>Quarterly – (co-opted)</td>
</tr>
<tr>
<td>Water Safety Group</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Statutory and Mandatory Training meeting</td>
<td>Quarterly</td>
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<tr>
<td>IP&amp;C Link Meetings (Childrens)</td>
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<tr>
<td>Root Cause Analysis and SI Panels</td>
<td>As required</td>
</tr>
<tr>
<td>New building / refurbishment planning and project meetings</td>
<td>As required</td>
</tr>
<tr>
<td>Professional regional groups eg Wessex IPS</td>
<td>3 times a year</td>
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<tr>
<td>Patient Focus Group- Lymington</td>
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### Meeting and Frequency

<table>
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<th>Meeting</th>
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<tr>
<td>Urinary Catheter Collaborative Meetings</td>
<td>6 weekly</td>
</tr>
<tr>
<td>NEWS Steering Group</td>
<td>Monthly</td>
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7. **Specialist IP&C advice on Estate projects**

The team provide specialist IP&C advice either verbally or written (reports) based on national guidance and current legislation eg refurbishments and new builds. The IP&C team will also attend meetings and undertake inspections of new builds / refurbishments when required to ensure these meet the standards required for IP&C. Project Leads are asked to engage with the IPC team at the start of any planned service to ensure any minor works can be undertaken in a timely manner and not impact on the delivery of service. The Project Lead and IPC nurse will sign off any new build / refurbishment / change of room use / new service which has required estate work prior to handing over to operational management to provide assurance that any new works meets best IPC standards.

8. **Risk Management / Surveillance**

The IP&C team will continue to provide clinical risk management advice to reduce the risk of health care acquired infections.

Mandatory reporting will continue for the following organisms:

- MRSA, MSSA & E coli bacteraemia (48 hours after admission)
- *Clostridium difficile* or MRSA deaths
- *Clostridium difficile* positive results (72hrs after admission).
- New MRSA positive results post 48hrs of admission in inpatient settings
- Glycopeptide Resistant Enterococci (GRE) bacteraemia
- Ward closures due to infection / Outbreaks of infection
- In addition the IP&C team will be alert to the emergence of new health threats eg carbapenemase-producing Enterobacteriaceae and implement strategies where required to minimise risk within the organisation and wider health economy.

**Root Cause Analysis (RCA)**

**Serious Incidents:** MRSA bacteraemia’s, *Clostridium difficile* deaths (part 1 on the death certificate) and ward closures due to infection will be reported as Serious Incidents (SI’s) and fully investigated with a root cause analysis (RCA). The Divisional Director is responsible for overseeing the SI investigation and will appoint a Senior Manager from within their Division to be the Commissioning Manager. The Division will also appoint an Investigating Officer to lead on this investigation. The IP&CN will provide support to the Investigating Officer as part of the SI investigation to ensure the investigation and report is completed as per SI policy timelines. Commissioners and any external providers (if applicable) will be invited to attend the Review Panel meeting.

**Other IPC incidents:** which require investigation but are not graded as Serious Incidents will undergo a joint investigation led by the IPCT with support from the clinical team. Incidents graded as ‘moderate’ or above will be discussed at the next 48hr Divisional Panel and investigated within agreed time lines. Incidents graded as ‘low’
harm will be investigated and if necessary a panel arranged locally to discuss any learning or actions required. The team manager is responsible for ensuring any actions identified are completed.

Learning identified from RCA investigations will be shared with clinical teams through the IPC link network, through formal quarterly reporting and also through a quarterly newsletter called IPC Matters.

**Reporting**

**Monthly: IP&C Summary for Trust Board**
Each month the IP&C Lead will provide a summary of IP&C by infection incidents by exception for the DIPC to take to Trust Board. This includes:
- IPC incidents relating to organisms included under mandatory reporting
- Ward or bay closures due to infection incidents
- Any other significant IPC incidents

**Quarterly: Infection Prevention and Control and Decontamination Group meetings**
The IPC lead will produce a summary report on all IPC activity each quarter, including information on surveillance, training compliance, audit results and any learning identified through investigation of infection incidents. This report will be presented to members of the IPC and Decontamination Group for discussion and approval. All Divisions are requested to be represented at the IP&C and Decontamination Group and attendees are responsible for disseminating the quarterly report locally to teams within their directorate.

Following approval at the IPC Group meeting, the IPC quarterly report is presented to the Patient Safety Group.

**Annual: IP&C Annual Report**
The IP&C Lead will write an Annual Report to be approved by the IP&C & Decontamination Group. This report will provide a summary of all IP&C activity for the previous year and an outline of the plan of activity for the subsequent year. Following internal approval it will be available for public viewing on the Trust website.

9. **Meets the requirements for IP&C as outlined in Local Quality Indicators**
The IPC team will continue to work with local acute and community providers with the Urinary Catheter Collaborative Project (previously a Quality Indicator).

10. **Support staff to manage service users with significant clinical results**
Infection Prevention and Control Nursing (IPCN) Teams working in neighbouring acute trusts will continue to phone IPCNs with significant clinical results.* In addition the IPC team receive either a daily or weekly report from local acute trusts summarizing significant IPC results. The IPCNs will provide advice on care in relation to infection
incidents, helping with risk assessment in relation to isolation room capacity in in-patient settings.

* except Southampton University Hospital Trust where the IPCN has to make daily contact for results.

11. **Outbreak Management**

Outbreaks will continue to be managed as per the Trust Outbreak Policy. All outbreaks which result in a ward closure will be treated as a Serious Incident (SI) in line with the national requirements (Public Health England) and will be investigated in line with the Trust Serious Incident Policy. A SI panel meeting will be held to discuss any learning identified (see 2.8 above).

Learning identified from serious incidents and root cause analysis will be shared with clinical teams through the IPC Link Network and through quarterly reporting.

12. **Product Selection**

The IPC Team will continue to work with other professionals within the organisation, to assist in the selection of products which minimise the risk of infection and represent good value for money.

13. **Cleanliness monitoring**

Matrons/Managers will continue to be responsible for monitoring and ensuring high standards of environmental cleanliness are maintained in our clinical settings. The IPC team are not routinely part of the PLACE assessments as they are now more ‘patient led’. However the IPC Team remains an integral part of the monitoring process and attends Medirest Performance meetings where results are presented and discussed. The IPC team are an integral part of the monthly monitoring with the Trust cleaning contractor and will support Managers and Matrons with maintaining high standards of cleanliness.

14. **Decontamination**

The IP&C Team will continue to respond to issues around decontamination as required.

15. **Antimicrobial Resistance**

The IPC Lead will support the Chief Pharmacist in the development of an Antimicrobial Policy and supporting Antimicrobial Strategy. Antimicrobial Stewardship will be a standing agenda item for the IPC and Decontamination Group. The Chief Pharmacist or designated pharmacist will provide an Annual Report regarding AMS activity and results of annual AMS prescribing audit to IPC Lead for inclusion in the IPC Annual Report.
16. To ensure information is available to patients to help minimise the risk of infection

The IP&C team will work with other teams including patient focus groups where necessary to ensure patient information including leaflets are available to patients and visitors, to help minimise the risks of infection. This year the Team will focus on empowering patients in their own home with information on how to recognise symptoms of sepsis.

17. To strengthen and promote the IP&C agenda to maintain best practice in IPC

The IP&C team will work with teams to strengthen the IP&C agenda in all areas across the organisation. IPC Link meetings have been reduced this year to enable the IPC nurses to visit and support clinical teams more closely. The IPC team will deliver ‘Back to the Floor visits’ whereby the IPC Team expertise can be used to influence practice.

18. To continue to work the Occupational Health provider

The IP&C team will continue to work closely with the OH team to ensure policies and procedures are in place that reflect national guidance. In addition the team will continue to support Divisions to improve compliance with the immunisation programme.

19. Project work

The IPC team will support any projects relating to infection prevention as they arise

Jacky Hunt, Lead Nurse IP&C
INFECTION PREVENTION AND CONTROL

CLEAN YOUR HANDS

HAND HYGIENE ANNUAL AUDIT REPORT

(April 2017 to March 2018)
AUDIT DETAILS

Introduction
Clean Your Hands hand hygiene audits are carried out on a monthly basis in Physical Health and Older Persons Mental Health inpatient wards, OPD's and ECT departments. Hand hygiene audits in Mental Health, Specialist Services, Learning Disabilities, Physical/Mental Health Community teams and Childrens services are carried out on a quarterly basis unless otherwise agreed with the IP&C Team.

Process
The IP&C team support our clinical teams in the completion of hand hygiene audits. When hand hygiene audits drop below 80% teams are asked to address corrective actions locally and repeat the audit until results demonstrate an improvement in hand hygiene standards. If scores persist below 80%, the IPC nurse will contact and / or visit the team to support with the development of an action plan to improve their scores. This may involve additional training with the ‘light box’ or shadowing the IPC Link during the completion of the audit.

For additional assurance and at the request of IPC Group Members, from January 2016 peer review audits have commenced whereby IPC links will now complete the hand hygiene audit for a nearby team (where possible). Where hand hygiene audits are monthly, peer review audits will be undertaken once a quarter. Where hand hygiene audits are quarterly, peer review audits will be undertaken once every 6 months.

Teams not submitting hand hygiene audits will receive reminders from the IPC team and if necessary this will be escalated to the Manager / Matron for follow up as required. Teams failing to submit audits will be named in Divisional Governance reports.

Each audit is based on a minimum of 10 hand hygiene opportunities per reporting period. Compliance will be shown as:
HH (O) – indicates the number of opportunities for hand hygiene observed by the person undertaking the audit
HH (H) – indicates the number of times hand hygiene was observed/performed following each opportunity

To score 100% the number of H's must be the same as the number of O's.

Reporting
Hand hygiene audit results will be reported quarterly in the IPC report, and in Divisional Governance reports. Results will also be discussed as part of the IPC Group meetings.

Reminders
Please note that IP&C Links and their Managers are reminded to complete their hand hygiene audits on a regular basis.
Physical Health – inpatient wards/departments
Hand hygiene audits are carried out each month as part of the Clean Your Hands campaign. These audits are carried out by our Infection Prevention and Control Links and are based on a minimum of 10 hand hygiene opportunities per month.

East ISD - Business Unit 1

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* Audit not completed due to Link nurse being off sick and low staffing numbers

Breakdown of hand hygiene compliance by staff group

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<th>Opportunities (O)</th>
<th>Qualified Nurses</th>
<th>HCA's</th>
<th>Student Nurses</th>
<th>Doctors</th>
<th>Therapist</th>
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### Lymington New Forest Hospital – hand hygiene audit results

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<th>Jun 17 %</th>
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Weekly audits were undertaken on MAU at Lymington New Forest Hospital from April to September 2017 due to low hand hygiene compliance:

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<th>Ward/Department</th>
<th>w/c 7.8.17</th>
<th>w/c 14.8.17</th>
<th>w/c 21.8.17</th>
<th>w/c 28.8.17</th>
<th>w/c 4.9.17</th>
<th>w/c 11.9.17</th>
<th>w/c 18.9.17</th>
<th>w/c 25.9.17</th>
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</thead>
<tbody>
<tr>
<td>MAU</td>
<td>**80</td>
<td>**80</td>
<td>**23</td>
<td>**80</td>
<td>80</td>
<td>100</td>
<td>Nil return</td>
<td>**80</td>
</tr>
</tbody>
</table>

* audits were undertaken by Michelle from Deb Cutan, the Trust’s hand hygiene provider on the 27.7.17. The Heads of Nursing and ward managers have been informed and Joanne Williams, IPCN for West ISD will be visiting the wards to carry out repeat audits w/c 31.7.17

**repeat audits undertaken by Joanna Williams – further weekly audits will continue until compliance is met.

Breakdown of hand hygiene compliance by staff group

<table>
<thead>
<tr>
<th></th>
<th>Qualified Nurse</th>
<th>HCA</th>
<th>Student Nurse</th>
<th>Doctor</th>
<th>Radiographer / Radiologist</th>
<th>RDA</th>
<th>Therapist</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities (O)</td>
<td>1038</td>
<td>815</td>
<td>181</td>
<td>455</td>
<td>267</td>
<td>66</td>
<td>133</td>
<td>110</td>
</tr>
<tr>
<td>Hand Hygiene (H)</td>
<td>999</td>
<td>791</td>
<td>177</td>
<td>397</td>
<td>261</td>
<td>65</td>
<td>129</td>
<td>90</td>
</tr>
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</table>

North/NE – Business Unit 3

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Apr 17</th>
<th>May 17</th>
<th>Jun 17</th>
<th>Jul 17</th>
<th>Aug 17</th>
<th>Sep 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alton CH, Anstey ward</td>
<td>Nil return</td>
<td>100</td>
<td>100</td>
<td>Nil return</td>
<td>89</td>
<td>Nil return</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Oct 17</th>
<th>Nov 17</th>
<th>Dec 17</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alton CH, Anstey ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Nil return</td>
<td>83</td>
<td>Nil return</td>
</tr>
</tbody>
</table>
### Breakdown of hand hygiene compliance by staff group

<table>
<thead>
<tr>
<th></th>
<th>Qualified Nurses/MHP</th>
<th>HCA’s</th>
<th>Student Nurses</th>
<th>Doctors</th>
<th>Therapist</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities (O)</td>
<td>330</td>
<td>384</td>
<td>119</td>
<td>60</td>
<td>12</td>
<td>63</td>
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<tr>
<td>Hand Hygiene (H)</td>
<td>329</td>
<td>377</td>
<td>119</td>
<td>60</td>
<td>12</td>
<td>55</td>
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</table>

### Older Persons Mental Health – inpatient wards

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Apr 17 %</th>
<th>May 17 %</th>
<th>Jun 17 %</th>
<th>Jul 17 %</th>
<th>Aug 17 %</th>
<th>Sep 17 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>GWMH, Daedalus Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>GWMH, Dryad Ward</td>
<td>92</td>
<td>92</td>
<td>93</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>ML, Stefano Olivieri Unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Parklands, Beechwood</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Nil return</td>
</tr>
<tr>
<td>Parklands, ECT</td>
<td>100</td>
<td>100</td>
<td>Nil return</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Parklands, Elmwood Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>WCH, Beaulieu Ward</td>
<td>83</td>
<td>80</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>WCH, Berrywood Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Oct 17 %</th>
<th>Nov 17 %</th>
<th>Dec 17 %</th>
<th>Jan 18 %</th>
<th>Feb 18 %</th>
<th>Mar 18 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>GWMH, Daedalus Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<tr>
<td>GWMH, Dryad Ward</td>
<td>90</td>
<td>90</td>
<td>89</td>
<td>87</td>
<td>87</td>
<td>92</td>
</tr>
<tr>
<td>ML, Stefano Olivieri Unit</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Parklands, Beechwood</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Parklands, ECT</td>
<td>Nil return</td>
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<tr>
<td>WCH, Beaulieu Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Nil return</td>
<td>100</td>
</tr>
<tr>
<td>WCH, Berrywood Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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</tbody>
</table>
Mental Health

Hand hygiene audits in Mental Health and Specialist services are carried out on a quarterly basis, apart from ECT which will remain on a monthly basis. These audits are carried out by our Infection Prevention and Control Links and are based on a minimum of 10 hand hygiene opportunities per month.

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr-Jun %</td>
<td>Jul-Sep %</td>
<td>Oct-Dec %</td>
<td>Jan-Mar %</td>
</tr>
<tr>
<td>Antelope House: Saxon Ward</td>
<td>Peer audit 100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Antelope House: Trinity Ward</td>
<td>Peer audit 100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Antelope House: Hamtun Ward</td>
<td>80</td>
<td>91</td>
<td>89</td>
<td>100</td>
</tr>
<tr>
<td>Crowlin House</td>
<td>93</td>
<td>93</td>
<td>Nil return</td>
<td>100</td>
</tr>
<tr>
<td>Elmleigh – Blue</td>
<td>80</td>
<td>Nil return</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>Elmleigh – Green</td>
<td>86</td>
<td>Closed</td>
<td>Closed</td>
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<tr>
<td>Elmleigh – Red</td>
<td>89</td>
<td>Nil return</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td>Forest Lodge</td>
<td>90</td>
<td>85</td>
<td>92</td>
<td>84</td>
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<tr>
<td>Hollybank</td>
<td>91</td>
<td>95</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Melbury Lodge – Kingsley Unit</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Melbury Lodge – Mother &amp; Baby</td>
<td>*see scores below</td>
<td>*see scores below</td>
<td>*see scores below</td>
<td>*see scores below</td>
</tr>
<tr>
<td>Parklands Hospital – Hawthorns 1</td>
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<td>91</td>
<td>83</td>
</tr>
<tr>
<td>Parklands Hospital – Hawthorns 2</td>
<td>99</td>
<td>88</td>
<td>Nil return</td>
<td>100</td>
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</table>

*the MBU are undertaking monthly audits due to the increased incidence of D&V on the ward during 2016/2017

<table>
<thead>
<tr>
<th>Ward/ Department</th>
<th>Apr 17 %</th>
<th>May 17 %</th>
<th>Jun 17 %</th>
<th>Jul 17 %</th>
<th>Aug 17 %</th>
<th>Sep 17 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Melbury Lodge – Mother &amp; Baby</td>
<td>100</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Ward/ Department</th>
<th>Oct 17 %</th>
<th>Nov 17 %</th>
<th>Dec 17 %</th>
<th>Jan 18 %</th>
<th>Feb 18 %</th>
<th>Mar 18 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Melbury Lodge – Mother &amp; Baby</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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</table>

The ECT Departments at Antelope House and Elmleigh complete audits on a monthly basis

<table>
<thead>
<tr>
<th></th>
<th>Apr %</th>
<th>May %</th>
<th>Jun %</th>
<th>Jul %</th>
<th>Aug %</th>
<th>Sept %</th>
<th>Oct %</th>
<th>Nov %</th>
<th>Dec %</th>
<th>Jan %</th>
<th>Feb %</th>
<th>Mar %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope House ECT</td>
<td>97</td>
<td>96</td>
<td>96</td>
<td>96</td>
<td>94</td>
<td>97</td>
<td>97</td>
<td>98</td>
<td>97</td>
<td>96</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Elmleigh ECT</td>
<td>100</td>
<td>89</td>
<td>90</td>
<td>90</td>
<td>86</td>
<td>88</td>
<td>90</td>
<td>87</td>
<td>87</td>
<td>88</td>
<td>91</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breakdown of hand hygiene compliance by staff group</th>
<th>Opportunities (O)</th>
<th>Hand Hygiene (H)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities (O)</td>
<td>704</td>
<td>646</td>
</tr>
<tr>
<td>Hand Hygiene (H)</td>
<td>636</td>
<td>603</td>
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</table>

180605 TB 12.1 Infection & Prevention Control Annual Report
185
### Specialised Services - Inpatient

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Quarter 1 Apr-Jun %</th>
<th>Quarter 2 Jul-Sep %</th>
<th>Quarter 3 Oct-Dec %</th>
<th>Quarter 4 Jan-Mar %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bluebird House: Moss Ward</td>
<td>Nil return</td>
<td>Nil return</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Bluebird House: Stewart Ward</td>
<td>94</td>
<td>Nil return</td>
<td>Nil return</td>
<td>82</td>
</tr>
<tr>
<td>Leigh House</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Ravenswood – Ashurst Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Ravenswood – Lyndhurst</td>
<td>100</td>
<td>90</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Ravenswood – Malcolm Faulk</td>
<td>90</td>
<td>100</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Ravenswood – Mary Graham</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Ravenswood – Meon Valley</td>
<td>100</td>
<td>100</td>
<td>Ward closed</td>
<td>Ward closed</td>
</tr>
<tr>
<td>Southfields: Beech Ward</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Southfields: Cedar Ward</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Southfields: Oak Ward</td>
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<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Woodhaven – Ashford Unit</td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

### Breakdown of hand hygiene compliance by staff group

<table>
<thead>
<tr>
<th></th>
<th>Qualified Nurses/MHP</th>
<th>HCA’s</th>
<th>Student Nurses</th>
<th>Doctors</th>
<th>Therapist</th>
<th>Patient search</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities (O)</td>
<td>221</td>
<td>182</td>
<td>63</td>
<td>24</td>
<td>13</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Hand Hygiene (H)</td>
<td>218</td>
<td>176</td>
<td>62</td>
<td>23</td>
<td>11</td>
<td>33</td>
<td>17</td>
</tr>
</tbody>
</table>

### Learning Disabilities

Hand hygiene audits in Learning Disabilities are carried out on a quarterly basis.

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Quarter 1 Apr-Jun %</th>
<th>Quarter 2 Jul-Sep %</th>
<th>Quarter 3 Oct-Dec %</th>
<th>Quarter 4 Jan-Mar %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willow Ward</td>
<td>82</td>
<td>Nil return</td>
<td>79</td>
<td>Repeat</td>
</tr>
<tr>
<td>Evenlode Tfr to Oxford Health 1.7.17</td>
<td>Nil return</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Stepdown Tfr to Oxford Health 1.7.17</td>
<td>Nil return</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

### Breakdown of hand hygiene compliance by staff group

<table>
<thead>
<tr>
<th></th>
<th>Qualified Nurses/MHP</th>
<th>HCA’s</th>
<th>Student Nurses</th>
<th>Doctors</th>
<th>Therapist</th>
<th>Other</th>
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</thead>
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<tr>
<td>Opportunities (O)</td>
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<td>82</td>
<td>1</td>
<td>16</td>
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<td></td>
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<tr>
<td>Hand Hygiene (H)</td>
<td>41</td>
<td>73</td>
<td>0</td>
<td>11</td>
<td></td>
<td></td>
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</tbody>
</table>
Integrated Community Teams – Physical Health & OPMH

Hand hygiene audits are carried out on a quarterly basis for clinic based community staff. The IP&C Link is required to complete one audit per quarter.

<table>
<thead>
<tr>
<th>Integrated Community Care Teams (ICT)</th>
<th>Quarter 1 Apr-Jun %</th>
<th>Quarter 2 July-Sept %</th>
<th>Quarter 3 Oct-Dec %</th>
<th>Quarter 4 Jan-Mar %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East ISD - Business Unit 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fareham 1 ICT</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>92</td>
</tr>
<tr>
<td>Fareham 2 ICT</td>
<td>97</td>
<td>Nil return</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>F&amp;G OPMH</td>
<td>N/A</td>
<td>N/A</td>
<td>80</td>
<td>Nil return</td>
</tr>
<tr>
<td>Gosport 1 ICT</td>
<td>100</td>
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<td>Nil return</td>
<td>96</td>
</tr>
<tr>
<td>Gosport 2 ICT</td>
<td>86</td>
<td>Nil return</td>
<td>Nil return</td>
<td>86</td>
</tr>
<tr>
<td>Havant OPMH ICT &amp; OPMH ICT</td>
<td>OPMH 100</td>
<td>OPMH 94</td>
<td>OPMH 89</td>
<td>100</td>
</tr>
<tr>
<td>Hayling Island ICT</td>
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<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Petersfield &amp; Bordon ICT</td>
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<td>80</td>
<td>89</td>
<td>90</td>
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<tr>
<td>Waterlooville ICT</td>
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<td>97</td>
<td>97</td>
<td>100</td>
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<tr>
<td><strong>West ISD - Business Unit 2</strong></td>
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<td></td>
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</tr>
<tr>
<td>Avon Valley ICT</td>
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<td>98</td>
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<td>Chandlers Ford ICT</td>
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<td>97</td>
<td>96</td>
<td>93</td>
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<td>Lymington ICT</td>
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<td>94</td>
<td>94</td>
<td>90</td>
</tr>
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<td>New Milton ICT</td>
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<td>100</td>
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<td>Romsey ICT</td>
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<td>100</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Southampton East OPMH ICT</td>
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<td>Nil return</td>
<td>N/A no opportunities</td>
<td>N/A no opportunities</td>
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<td>Southampton West OPMH ICT</td>
<td>Nil return</td>
<td>Nil return</td>
<td>N/A no opportunities</td>
<td>N/A no opportunities</td>
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<td>Southern Parishes ICT</td>
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Breakdown of hand hygiene compliance by staff group Teams

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<tr>
<th></th>
<th>Qualified Nurses</th>
<th>HCA’s</th>
<th>Student Nurses</th>
<th>Doctors</th>
<th>Therapist</th>
<th>Other</th>
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Hand hygiene audits are carried out on a quarterly basis for clinic based community staff. The IP&C Link is required to complete one audit per quarter.

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<th>Physical Health Community Therapy Teams</th>
<th>Quarter 1 Apr-Jun %</th>
<th>Quarter 2 July-Sept %</th>
<th>Quarter 3 Oct-Dec %</th>
<th>Quarter 4 Jan-Mar %</th>
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### Outpatients

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### Breakdown of hand hygiene compliance by staff group Teams

<table>
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<tr>
<th>Opportunities / MHP</th>
<th>Qualified Nurses</th>
<th>HCA</th>
<th>Student Nurses</th>
<th>Doctors</th>
<th>GP</th>
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### Mental Health Community Therapy Teams

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### Breakdown of hand hygiene compliance by staff group Teams

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<th>Opportunities / MHP</th>
<th>Qualified Nurses / MHP</th>
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Children’s Services

Hand hygiene audits are carried out on a quarterly basis for clinic based children’s staff.

The IP&C Link is required to complete one audit per quarter, however some Links complete more than one audit and these are detailed in the graph below. If known, the name of the clinic is written in brackets next to the % scored. The table below includes all Children’s teams in SHFT.

### Children’s Teams (Health Visitors, School Nursing)

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<th>Quarter 3 Oct-Dec</th>
<th>Quarter 4 Jan-Mar</th>
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<td>Farnborough</td>
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<td>100</td>
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<tr>
<td>Fleet &amp; Yateley</td>
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<td>Yateley MC 100</td>
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<td><strong>South East HV Teams</strong></td>
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<td>Lee on Solent 100</td>
<td>Lee on Solent 100</td>
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<td>Genesis Centre 100</td>
<td>Genesis Centre 100</td>
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<td>Abbey Hall 100</td>
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<td>WW 100</td>
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<td>100</td>
<td>Blackfield 100</td>
<td>Totton 100</td>
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180605 TB 12.1 Infection & Prevention Control Annual Report  191
## Children's Teams (Health Visitors, School Nursing)

<table>
<thead>
<tr>
<th>Quarter 1 Apr-June %</th>
<th>Quarter 2 July-Sept %</th>
<th>Quarter 3 Oct-Dec %</th>
<th>Quarter 4 Jan-Mar %</th>
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<tr>
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<td>Totton 100</td>
<td>Blackfield 100</td>
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<td>R&amp;F 100</td>
<td>New Milton 100</td>
<td>Lymington 100</td>
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<td>Lyminston 100</td>
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<td>Winchester 100</td>
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<td>100</td>
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</tbody>
</table>

### West School Nursing teams

| Andover              | 100                     | Harrow Way 100      | Gratley 100         | Team has merged with Winchester School nursing team |
|                      |                         | Test Valley 100     | Kimpton 100         |
|                      |                         | John Hanson 100     | Clatford 100        |
|                      |                         | Farleigh 100        |                    |
| Eastleigh            | Wildern School 100      | 100                 | Wellstead 100       | Crestwood 100                                      |
| New Forest & Romsey  | Mountbatten School 100  | Applemore 100       | Hazelwood 100       | Testwood 100                                       |
| Winchester           | 100                     | N/A                 | 100                 | 100                                                |

## Hand Hygiene (H)

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<tr>
<th>Community Nurse</th>
<th>School Nurse</th>
<th>Health Visitor</th>
<th>HCSW</th>
<th>Nursery Nurse</th>
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<td>352</td>
<td>973</td>
<td>16</td>
<td>456</td>
</tr>
<tr>
<td>Hand Hygiene (H)</td>
<td>319</td>
<td>352</td>
<td>958</td>
<td>16</td>
<td>453</td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD

Date 05.06.2018

Agenda Item 13

Title Learning from Deaths: Mortality Data and Learning for Quarter 4 2018.

Author(s) Helen Ludford, Associate Director of Quality Governance
Sarah Pearson, Head of Legal Services, Risk & Patient Safety

Sponsoring Director Julie Dawes, Director of Nursing and AHP’s

Purpose & Action Required
This report is provided for Board assurance that Southern Health NHS Foundation Trust has a structured process for reporting and reviewing deaths, is learning from the review of deaths and is compliant with the requirements of the National Quality Board.

Executive Director Overview
This report provides assurance that Southern Health NHS Foundation Trust has a robust process in place for reporting, reviewing and learning from deaths.

Quarter Four reporting has established:
• 213 deaths were reported and reviewed through a 48 hour mortality process.
• 12 deaths were externally reported as Serious Incidents and a comprehensive investigation commissioned.

Quarter Three investigations have been completed and it has been established that:
• 3 / 1.4% of deaths that were reviewed and considered more likely than not to be due to problems in care.

Themes for learning and improvement have been established:
• The need to improve communication with GP’s especially about prescribed medication and risk.
• The need to continue to improvement the documentation of risk and crisis planning with the involvement of families.
• The practice of assessing for the risk of venous thromboembolism in OPMH and ECT services needs to be improved and clearly documented.
### Previously considered by:

<table>
<thead>
<tr>
<th>Serious Incident and Mortality Forum – 10 May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Safety Committee – 8 May 2018</td>
</tr>
</tbody>
</table>

### Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Quality</th>
<th>People</th>
<th>Transformation</th>
<th>Money</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Quality**

- Reporting on our Learning from Deaths to Trust Board is a specific requirement of the National Quality Board for all NHS Trusts.

**People**

- 

**Transformation**

- 

**Money**

- 

**Does this impact any Board Assurance Framework / Corporate Risks**

- This is assurance against SR1: There is a risk that we provide poor quality or ineffective care resulting in serious harm.
Learning from Deaths: Meeting the Requirements of the National Quality Board

1. Purpose

1.1. It is important to the Trust that Southern Health NHS Foundation Trust prioritises the review, investigation and learning from deaths to ensure that learning opportunities are not missed. The paper provides assurance that this is being undertaken.

1.2. The purpose of this report is to provide assurance that Southern Health NHS Foundation Trust is meeting the requirements of the National Quality Board for all NHS Trusts.

2. Context/Background

2.1. The national document National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care was published by the National Quality Board in March 2017.

2.2. The document introduces key elements which NHS Trusts must adhere to:
   - Governance Arrangements
   - Skills and Training
   - Engagement with Bereaved Families and Carers
   - Improved Data Collection and Reporting.

2.3. There were two stipulated key milestones which Southern Health NHS Foundation Trust met:
   - All NHS Trusts must develop and publish a policy related to reporting, investigating and learning from deaths to their website by the end of quarter two: 30 September 2017.
   - Publication of mortality data and related learning to be published in a Board paper by the end of quarter three: 31 December 2017.

2.4. The report below provides assurance of our compliance to the stipulated milestones and the commitment to learning from deaths. As of 31 December 2017 there is a requirement that all Foundation Trust publish this data on a quarterly basis.

2.5. There is a requirement for each Trust to have a named Executive and Non-Executive for Patient Safety and Mortality. Julie Dawes, Director of Nursing and Allied Health Professionals is the responsible Executive and David Hicks, Non-Executive Director for Quality.

2.6. The Trust records all mortality data on the Ulysses Safeguard risk management system which is extracted into the automated business intelligence system Tableau and the data is available for all teams on a real-time basis.

2.7. Southern Health NHS Foundation Trust has adopted the required practice of publishing the quarterly data and the Policy for Reporting and Investigating Deaths is published to the website.
3. Reporting requirement

3.1. The National Quality Board requirement¹ is specific in some areas where deaths require a case record review:

- all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
- all in-patient, out-patient and community patient deaths of those with learning disabilities;
- all deaths in a service speciality, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means;
- all deaths in areas where people are not expected to die;
- deaths where learning will inform the provider’s existing or planned improvement work;
- a further sample of deaths which do not fit the identified categories;
- those deaths linked to an inquest and issue of a ‘Regulation 28’.

3.2. Case record review within Southern Health NHS Trust is undertaken as part of the creation of the Initial Management Assessment (IMA) and report which is discussed at the 48 hour panel. A version of the Structured Judgement Review (SJR) developed by the Royal College of Physicians is used for physical health in-patient deaths and the Learning Disabilities Mortality Review LeDeR is used within the learning disabilities with onward referral made to the Hampshire-wide programme. These two approaches meet the national requirements.

3.3. The National Quality Board recognises that methods such as SJR were not developed for mental health and community trusts; therefore in the absence of a national tool the use of the IMA process is appropriate.

3.4. Within the Southern Health NHS Foundation policy all in-patient deaths are subjected to review therefore meeting the criteria for those with a Severe Mental Illness (SMI) diagnosis to be reviewed.

3.5. Southern Health NHS Foundation Trust Reporting Flow;

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180605 TB 13 Learning from Deaths Mortality Data and Learning Q4
4. **Quarter Four - Mortality Data**

4.1. This report provides data for quarter four, following on from the previous report which detailed quarter three data and was heard at public Board in January 2018. This report incorporates those deaths reported onto the Ulysses system: 1 January 2018 to the 31 March 2018. It should be noted that the death may have occurred earlier than the period as there are occasions where there is a delay in SHFT being made aware of the death, for example:

- in cases where a patient may have left the area without updating their address or GP status
- in cases where the patient who has been discharged from the Trust patient list dies within 12 months but the Trust is not notified by the GP

In both of these examples the Trust may only discover the death has occurred when the national spine updates the electronic record. This can be up to three months after the person is marked as deceased on the primary care database. Although these delays may occur, all deaths will be captured.

4.2. The Tableau (Business Intelligence System) is the source of the data publication related to mortality which is extracted from the Safeguard Ulysses Risk Management System.

4.3. NHS Improvement stipulated a comprehensive dataset to assist Foundation Trusts in reporting their data this consists of the following requirements and results;

<table>
<thead>
<tr>
<th>Comprehensive NHS Improvement Reporting Criteria</th>
<th>Quarter Four Number and where applicable percentage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths in the care of Trust as reported under the Policy and Procedure(^2)</td>
<td>213</td>
</tr>
<tr>
<td>Number of those deaths subject to case record review</td>
<td>213 / 100%</td>
</tr>
<tr>
<td>Number of deaths investigated under the serious incident framework and declared as serious incidents</td>
<td>12 / 5.6%</td>
</tr>
<tr>
<td>Number of deaths of people with learning disabilities</td>
<td>13</td>
</tr>
<tr>
<td>Number of deaths of people with learning disabilities that have been reviewed</td>
<td>13 / 100% initial Trust review&lt;br&gt;11 / 84% LeDeR(^3) review, as two cases did not meet the criteria</td>
</tr>
</tbody>
</table>

4.4. All 213 deaths have been reported and have been reviewed using the IMA and 48 hour panel methodology.

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\(^2\) Policy and Procedure for Reporting and Investigating Deaths

\(^3\) **Learning Disabilities** Mortality Review (**LeDeR**) Programme.
4.5. Although the overall conversion rate to SI is 5.6% the percentage of conversion to SI in the Mental Health division is consistently higher than the Integrated Service Division (ISD) or Learning Disabilities (LD) at 16.9% average due to the nature of the categories of death reported from this service. All deaths of those with an ICD10 (International Classification of Diseases, tenth revision) coding of Severe Mental Illness (SMI) are investigated as an SI.

4.6. The ISD did not declare any SI’s related to patient deaths but did commission four internal root cause analysis investigations; these are known as Red Incidents.

4.7. The outcome of the investigations into the deaths in quarter four will be reported in quarter one of 2018/19 to allow for the 60 working day investigation period.

5. Final Impact Grading of Deaths Investigated as Serious Incidents in Q3.

5.1. Of the 209 deaths reported in quarter three 12 deaths were investigated as Serious Incidents following the Initial Management Assessment.

5.2. Upon completion of the Root Cause Analysis investigation, the reports are heard and considered at Corporate Panel, led by an Executive Team member. Consideration is given to the final impact grading that should be applied to the incident.

5.3. The impact grading relates to the impact the Trust had upon acts or omissions which could have prevented the eventual outcome of the incident, i.e. was there a Root Cause directly attributable to an act or omission in the care provided, and/or there were significant care and service delivery issues.

5.4. This impact grading is more easily defined in the below table:

<table>
<thead>
<tr>
<th>Actual Impact Grading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Impact</strong></td>
</tr>
<tr>
<td>No Harm</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Low Harm</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Moderate Harm</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Major Harm</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Catastrophic Harm</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
5.5. Analysis of the 12 deaths provides the following information:

- **Service Provided**
  - Community Mental Health Team, 7
  - Older Persons Mental Health
  - Community, 1
  - Older Persons Mental Health Inpatients, 2
  - Probation / Pathfinder, 1

- **Cause of Death**
  - Acute Myocarditis, 1
  - Suicide - Hanging, 4
  - Suicide - Overdose, 3
  - Pulmonary embolism, 1
  - Bronchopneumonia, 2
  - Alcohol toxicity, 1
5.6. Of the 12 deaths investigated the final impact grading is as follows:

<table>
<thead>
<tr>
<th>Final Impact Grading</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>2</td>
</tr>
<tr>
<td>Low Harm</td>
<td>3</td>
</tr>
<tr>
<td>Moderate Harm</td>
<td>2</td>
</tr>
<tr>
<td>Major Harm</td>
<td>2</td>
</tr>
<tr>
<td>Catastrophic Harm</td>
<td>3</td>
</tr>
</tbody>
</table>

5.7. The impact can be demonstrated as:

<table>
<thead>
<tr>
<th>Comprehensive NHS Improvement Reporting Criteria</th>
<th>Quarter Three Number and Percentage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths that were reviewed and considered more likely than not to be due to problems in care</td>
<td>3 / 1.4%</td>
</tr>
<tr>
<td>Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care</td>
<td>0 / 0%</td>
</tr>
</tbody>
</table>

5.8. All incidents with a final impact grading of Major or Catastrophic harm are brought back to an Evidence of Improvement Panel approximately 6 months after the initial Corporate Panel. This is in order to ensure that the related action plan is completed; learning is evidenced and embedded in practice.

6. Opportunities for Learning

6.1. Every death is an opportunity for learning regardless of whether it is externally reported as a Serious Incident.

6.2. The Trust utilises a variety of different methodologies for learning which include;

- Patient stories at Quality and Safety Meetings
- Patient stories at Mortality Meetings
- Incident review at Team Meetings
- Hotspots and Learning Counts publications
- ‘Could it happen here?’ presentations
- Learning Network meetings in each of the four Adult Mental Health localities
- Immediate Learning Alerts from Serious Incident Corporate Assurance Panels automatically issued through the Ulysses system.
- Learning from Incidents meetings (Specialised Services)
- Individual clinical supervision
- Evidence of Improvement Panels – attended by both the Trust and Commissioners as third tier assurance.
6.3. A review of the investigations into the twelve deaths in quarter three highlights the following themes for improvement;

- Communication between Southern Health and General Practitioners in relation to prescribed medications especially opiates. This is necessary if it is presumed that an individual is also obtaining medications over the internet.
- Ensuring that individuals have been offered a referral to substance misuse services.
- There is a continued need for improvement in the documentation of risk assessments and crisis planning which includes family involvement.
- The practice of assessing for the risk of venous thromboembolism in OPMH and ECT services needs to be improved and clearly documented. This was a priority action for which the improvement has already been made. The review of the initial admission assessment of VTE risk is now undertaken and documented as part of the weekly multi-disciplinary meeting for all OPMH patients.
- Emphasis should not be put on the family to maintain the safety of their loved one and request Mental Health Act assessments, Southern Health should also be a partner in this.

6.4. Risk assessment and crisis contingency planning was evident as a top contributory factor during 2016 and it became a quality account priority for improvement for 2017/18. Improvement work continues with over 90% of patients having plans in place however this is being rolled over as a quality improvement priority into 2018/19 so the work on the quality of the plans and the family involvement.

7. **Next Steps**

7.1. The Structured Judgement Review Tool for Mental Health services is awaited from the Royal College of Psychiatrists. Once this is published the Trust will utilise the tool and integrate it into the Ulysses electronic system.

7.2. Through the Hampshire-wide STP Mortality Group there is now sharing of the review processes and the tools used in each provider organisation. There is an emphasis on streamlining the approach of reviewing and investigation of deaths of individuals who have touched a multitude of providers. The aim is to create a system where a death is reviewed once by the correct team to do so which creates the least distress for family members. SHFT is represented on this group comprising of membership from all providers, primary care, local authorities and safeguarding Boards.

8. **Recommendation**

8.1. This report is provided for Board assurance that Southern Health NHS Foundation Trust has a structured process for reporting and reviewing deaths, is learning from the review of deaths and is compliant with the requirements of the National Quality Board.
# REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>14</td>
</tr>
<tr>
<td>Title</td>
<td>Complaints, Concerns and Compliments Annual Report 2017/18 (01/04/2017 – 31/03/2018)</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Kate Oliver, Complaints and Patient Experience Team Manager</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Julie Dawes, Director of Nursing and Allied Health Professionals</td>
</tr>
</tbody>
</table>

## Purpose & Action Required
- To evidence adherence to the Trusts Complaints, Concerns and Compliments Policy and Procedure.
- To highlight progress against key performance metrics.
- To analyse trends and demonstrate learning in practice.
- To illustrate how complaints have driven actions that will lead to improved quality of care and enhance patient experience.

The Committee is asked to take assurance from this report.

## Executive Director Overview
Data is accurate as of 12 April 2018; this may change due to complaints being withdrawn, amended complaint type or being closed.

- 363 complaints and 688 concerns were raised during 2017/18.
- Of the 363 complaints received in 2017/18, 19 complaints were withdrawn by the complainant.
- 95.04% of formal complaints met the standard of acknowledgement within three working days, a small increase from 94.8% in 2016/17.
- 371 complaints were closed from 01/04/2017 – 31/03/2018. These complaints may have been received before 01/04/2017.
- 71% of all closed complaints in 2017/18 were either upheld or partially upheld. This is a 3% decrease from 2016/17.
- 5,305 compliments were received during 2017/18.

A thematic peer review undertaken by Calderdale, made recommendations for improving the complaints process and a further review in preparation for the CQC inspection. This was translated into an action plan. As of 12 April 2018, 99% (94 actions) from the action plan had been completed with one remaining action due to be closed by 31 July 18. This one outstanding action relates to sharing actions with complainants once they have been completed and implemented, this will ensure complainants feel reassured that the Trust have acted on feedback as a result of their complaint.

| Previously considered by: | Patient Experience, Engagement and Caring Group. 15\textsuperscript{th} June 2017 |

<p>| Strategic Priorities this paper supports: | |
| Quality | X | Ensuring patient receive the best experience possible. |
| People | X | Ensuring patient receive the best experience possible. |
| Transformation | | |
| Money | | |
| Does this impact any Board Assurance Framework / Corporate Risks | Risk 1432 &amp; Risk 601 – details can be found under point 21. |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>4</td>
</tr>
<tr>
<td>Complainants and Patient Experience Data</td>
<td>4</td>
</tr>
<tr>
<td>Divisional Analysis</td>
<td>5</td>
</tr>
<tr>
<td>Timeliness of acknowledgement and final responses</td>
<td>5</td>
</tr>
<tr>
<td>Outcomes</td>
<td>8</td>
</tr>
<tr>
<td>Complaints by division as a percentage of activity</td>
<td>9</td>
</tr>
<tr>
<td>Parliamentary and Health Service Ombudsman/Local Government Ombudsman (PHSO)</td>
<td>10</td>
</tr>
<tr>
<td>Complaints by division as a percentage of contacts 2017/18</td>
<td>11</td>
</tr>
<tr>
<td>Themes</td>
<td>12</td>
</tr>
<tr>
<td>Complaints about Clinical Care and Nursing Care</td>
<td>13</td>
</tr>
<tr>
<td>Complaints about Communication</td>
<td>15</td>
</tr>
<tr>
<td>Complaints about Attitude</td>
<td>17</td>
</tr>
<tr>
<td>Emerging themes over the last 12 months</td>
<td>19</td>
</tr>
<tr>
<td>Access to Services</td>
<td>19</td>
</tr>
<tr>
<td>Medication and prescribing</td>
<td>20</td>
</tr>
<tr>
<td>Discharge</td>
<td>20</td>
</tr>
<tr>
<td>Themes and learning across the Trust</td>
<td>20</td>
</tr>
<tr>
<td>Complainant Satisfaction Survey</td>
<td>20</td>
</tr>
<tr>
<td>Compliments</td>
<td>21</td>
</tr>
<tr>
<td>Initiatives in 2017/18</td>
<td>23</td>
</tr>
<tr>
<td>Risk Narrative</td>
<td>24</td>
</tr>
<tr>
<td>Next Steps</td>
<td>25</td>
</tr>
<tr>
<td>Recommendation</td>
<td>25</td>
</tr>
</tbody>
</table>
1. Purpose

1.1 This report sets out to;

- To evidence adherence to the Trusts Complaints, Concerns and Compliments Policy and Procedure.
- To highlight progress against key performance metrics.
- To analyse trends and demonstrate learning in practice.
- To illustrate how complaints have driven actions that will lead to improved quality of care and enhance patient experience.

2 Complainants and Patient Experience Data

Graph: Feedback received and requests for advice and assistance comparing last the three years.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints</td>
<td>429</td>
<td>386</td>
<td>363</td>
</tr>
<tr>
<td>Concerns</td>
<td>561</td>
<td>672</td>
<td>688</td>
</tr>
<tr>
<td>Compliments</td>
<td>1317</td>
<td>3190</td>
<td>5305</td>
</tr>
<tr>
<td>Signposting</td>
<td>207</td>
<td>145</td>
<td>66</td>
</tr>
<tr>
<td>Information</td>
<td>134</td>
<td>134</td>
<td>126</td>
</tr>
<tr>
<td>SH Listens</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Comments</td>
<td>48</td>
<td>24</td>
<td>30</td>
</tr>
</tbody>
</table>

2.1 In 2017/18 there has been a 6% reduction in complaints raised and a 2% increase in concerns compared to the previous year. The reduction in complaints is attributed to early resolution within divisions and addressing concerns at the point they are raised. The benefits of early resolution within the divisions and addressing concerns as they arise, has contributed to reducing the numbers of formal complaints. The Complaints and Patient Experience Team have been working closely with the divisions to promote the benefits of local resolution whilst sharing best practises and learnings from complaints.

2.2 There has been a significant increase in the number of compliments received within 2017/18 with 5,305 compliments received; this equals a 66% increase when compared to 3,190 compliments received in 2016/17 and 1,317 in 2015/16. This positive increase can be attributed to staff members being encouraged to record all compliments they receive on our internal risk management system Safeguard Ulysses; there has been a continued focus on ensuring staff members are recording all compliments received throughout 2017/18. The Complaints and Patient Experience Team have also started working closely with The People Development Team by providing them with compliments to be shared...
2.3 The Complaints and Patient Experience Team share a sample of compliments received every week via our internal team bulletin which is sent to all staff members within Southern Health Foundation Trust and highlights the great care and service we provide every day. Compliments are also shared by the Complaints and Patient Experience Team within the local governance meetings to ensure we are celebrating the great work our staff is doing and also to share best practises across The Trust.

2.4 The Complaints and Patient Experience Team have signposted or provided information to 192 enquiries.

3 Divisional Analysis
Numbers of complaints and concerns by division
Graph: Complaints and concerns received by division. Excludes withdrawn complaints.

### Complaints and Concerns Received by Division 2016/17

<table>
<thead>
<tr>
<th>Division</th>
<th>Complaints</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health</td>
<td>184</td>
<td>338</td>
</tr>
<tr>
<td>OPMH</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>East ISD/BU1</td>
<td>55</td>
<td>86</td>
</tr>
<tr>
<td>New Forest, Lower Hants &amp; Southampton ISD / BU2</td>
<td>28</td>
<td>94</td>
</tr>
<tr>
<td>North ISD / BU3</td>
<td>22</td>
<td>81</td>
</tr>
<tr>
<td>Children’s ISD / BU4</td>
<td>13</td>
<td>37</td>
</tr>
<tr>
<td>Corporate</td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>

4 Timeliness of acknowledgement and final responses
4.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require complaints to be acknowledged within there working days of receipt.

4.2 95.04% of complaints were acknowledged within three days in 2017/18 showing a 0.2% improvement when compared to 2016/17 (94.8%). From 1 March 2018 the Complaints and Patient Experience Team have two fulltime administrators who now aim to speak with a complainant on the same day the team are contacted to log and acknowledge a complaint on the day it is received. Where possible the Commissioning Manager will also be notified the same day a complaint is received allowing them the opportunity to review the complaint and where possible try and resolve the complainants concerns through local resolution.
By focusing on speaking with the complainant the same day their concern/complaint is received, the team hope to be able to resolve more concerns/complaints locally by involving the service at the beginning of the process. The team aim to improve the complainants experience in a positive way, as feedback received on our questionnaires has shown that a patient/family member usually complains because they would like a quick answer/resolution, an apology for how their feeling and to ensure the same thing doesn’t happen to someone else in the future.

4.3 Throughout 2017/18 there are 18 recorded complaints which did not meet the three day acknowledgement metric. In these cases the timescales for acknowledgement range between five to 15 days. The delays occurred due to the following reasons:

- Change in Team Administrator who required training within the role.
- Complaints not reaching the Complaints and Patient Experience Team within the three day acknowledgement period as they have been initially raised within the service.
- Complaints originally logged as a “concern” however upon receipt of further information from the complainant, the concern has been re-categorised to a formal complaint. To prevent this happening in future, all complaints and concerns will now have a formal acknowledgement sent by the Complaints and Patient Experience Administrators.

4.4 There is no longer a stated national timeframe for a final complaint response to be completed. Current regulations state that the organisation and complainant should agree how the complaint will be handled along with a timescale for a final response to be issued. The Trust aims to have all final response letters sent within a 30 working day timescale for a standard complaint, and 60 working days for a complex complaint, however this is not a regulatory requirement.

4.5 Of the 371 cases closed between 1 April 2017 – 31 March 2018, 35 were withdrawn by the complainant and 2 were signposted to a different Trust. Of the remaining 334 cases, 125 (37%) were sent within their agreed timeframe with the complainant. This is a decrease of 40% when compared to 77% overall performance in 2016/17. This decrease is as a result of implementing internal timescales (see 4.6) however the average response time for a complaint resolution has improved when compared to the same period in 2016/17. (See graph below under 4.7).

4.6 In an effort to improve our overall response times, internal timeframes were agreed for complaints that come into the Complaints and Patient Experience Team. From 1st May 2017 complaints were logged as either “standard” or “complex”. All standard complaints were given a 30 working day timescale and all complex complaints were given a 40 day timescale. From 1 March 2018, it was agreed that all complex cases would have an increased timescale of 60 working days, making us in line with our serious incident framework.

4.7 Whilst the percentage for complaints sent within their agreed timescale has decreased, we have seen the average handling time of a standard complaint (which represents the majority of the complaints we receive within the Trust) reduce on a continuous basis over the last year. The Trust has invested a lot time focusing on the improvement of complaint timescales over the 12 months, the Complaints and Patient Experience Team Manager spends time with the Chief Executive and the Chief Nurse every month to escalate any concerns they may have. Complaints are a key part of the agenda during division governance meetings and the Trust also holds two Investigating Officer training sessions per year to allow staff to learn how to be a successful Investigating officer, ensuring they feel confident when dealing with complaints.

180605 TB 14 Complaints, Concerns and Compliments Annual Report 201718
4.8 The Complaints and Patient Experience Team have continued to focus on building strong relationships within the divisions and will always be available to go to team meetings to discuss complaints to help staff within the services.

4.9 The Complaints and Patient Experience have recently re written the complaints e learning module which is available to all staff via the people development website.

4.10 Over the last 12 months The Complaints and Patient Experience have invested a lot of time on their own self development by attending courses to help them improve the overall patient experience, these include “Manage Conflict on the Telephone”, “Sage & Thyme Communication Skills @ Oakhaven Hospice” and a team away day. During the team away day they were able to focus on creating an action plan to help them continue to improve the process and overall experience for patients and their families. The team also receive monthly clinical supervision which allows them the opportunity to discuss their complaints and seek advice if required. The team have also been encouraged to attend at least one peer review this year to allow them the chance to see our services and speak to patients about their overall experience.

4.11 The Complaints and Patient Experience Team Manager also attends the Wessex complaints managers’ forum once a quarter, which allows them the opportunity to speak with other complaints managers across the area and ensure that we are all working consistency and sharing best practises.

4.12 For 2018 the Complaints and Patient Experience Team has set themselves a trajectory of improvement to help the Trust achieve 90% of complaints closed within their agreed timescale by December 2018. This can only be achieved with full support from the divisions as well as the Complaints and Patient Experience Team.
4.13 A weekly flash report continues to be sent to divisions and Executive team, showing progress of all overdue complaints enabling them to identify delays and where action is required. This also highlights complaints due to breach within the next week. The new modules on Safeguard Ulysses also enable the clinical services to monitor the progress of all complaints.

5 Outcomes

5.1 Number of complaints upheld/partially upheld based on complaints closed from 01/04/2017 – 31/03/2018.

5.2 Within the Trust the investigating officer makes a recommendation at the end of the investigation as to whether a complaint is upheld, partially upheld or not upheld.

5.3 Data is accurate as of 12 April 2018; this may change due to complaints being withdrawn, amended complaint type or being closed.

5.4 Figures for upheld/partially upheld complaints in 2017/18 are 71% in the Trust compared to 74% in the Trust in 2016/17. Nationally the average position is 64% of all NHS written complaints based on data from NHS Digital for 2017/18.
Complaint Outcomes 2017/18

NB. Excludes complaints that are withdrawn or signposted to another organisation

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Closed Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld</td>
<td>71 – 21%</td>
</tr>
<tr>
<td>Partially Upheld</td>
<td>167 – 50%</td>
</tr>
<tr>
<td>Not Upheld</td>
<td>96 – 29%</td>
</tr>
</tbody>
</table>

6 Complaints by division as a percentage of activity

Table: Complaints by Division and numbers upheld, partially upheld, not upheld 2017/18
NB: Percentages of upheld complaints are calculated based on numbers of closed complaints and excludes complaints that are withdrawn or signposted to another organisation.

<table>
<thead>
<tr>
<th>Division</th>
<th>Number of complaints received</th>
<th>Numbers/percentages of complaints upheld or partially upheld</th>
<th>Number of complaints not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health (AMH)</td>
<td>185</td>
<td>124 (67%)</td>
<td>61 (33%)</td>
</tr>
<tr>
<td>Older Persons Mental Health (OPMH)</td>
<td>5</td>
<td>5 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>14</td>
<td>5 (36%)</td>
<td>9 (64%)</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>4</td>
<td>1 (25%)</td>
<td>3 (75%)</td>
</tr>
<tr>
<td>Integrated Service Division (ISD) East / Business Unit 1 (BU1)</td>
<td>47</td>
<td>39 (83%)</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>Integrated Service Division (ISD) New Forest, Lower Hants &amp; Southampton / Business Unit 2 (BU2)</td>
<td>26</td>
<td>20 (77%)</td>
<td>6 (23%)</td>
</tr>
<tr>
<td>Integrated Service Division (ISD) North / Business Unit 3 (BU3)</td>
<td>29</td>
<td>24 (83%)</td>
<td>5 (17%)</td>
</tr>
</tbody>
</table>

180605 TB 14 Complaints, Concerns and Compliments Annual Report 201718
7 Parliamentary and Health Service Ombudsman/Local Government Ombudsman (PHSO)

7.1 The Trust has been made aware of nine complaints that have been referred to the Parliamentary and Health Service Ombudsman (PHSO) in 2017/18. This number has remained the same as 2016/17.

7.2 The length of time for the PHSO to investigate a complaint varies depending on complexity. Some cases are closed with no recommendations, others identify that although there were failings, the Trust has already taken action to address these and some conclude that more could have been done to address the issues raised by the complainant. In these cases recommendations are made and the Trust is expected to take further action.

7.3 Seven cases have been closed between 01/04/2017 – 31/03/2018 with five having no recommendations for the Trust, one was partially upheld, and one upheld. The Trust has carried out all recommendations made by the PHSO. These recommendations are monitored by the Complaints and Patient Experience Team who are required to provide evidence to the PHSO demonstrating that these actions have been implemented.

<table>
<thead>
<tr>
<th>Clinical area</th>
<th>Current position at end of year</th>
<th>If closed, upheld/not upheld? Detail of any recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Corporate</td>
<td>Closed</td>
<td>Discontinued by the PHSO</td>
</tr>
<tr>
<td>2 LD Oxford Community Team</td>
<td>Under investigation</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>3 ISD - MSK</td>
<td>Closed</td>
<td>Not Upheld</td>
</tr>
<tr>
<td>4 South West - CMHT AMH</td>
<td>Closed</td>
<td>Upheld. Recommended financial redress and an apology acknowledging that we did not hold their care plan in an accessible place. We also included our learnings and plans to improve this moving forward with the complainant.</td>
</tr>
<tr>
<td>5 ISD- South East</td>
<td>Under investigation</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>6 MH North Hants Community Team</td>
<td>Under investigation</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>7 ISD Fareham &amp; Gosport</td>
<td>Under Investigation</td>
<td>To be confirmed</td>
</tr>
</tbody>
</table>
7.4 During 2017/18 the Trust has worked alongside the PHSO to review nine complaints. The current position of these nine complaints is below.

Table: Ombudsman cases received 2017/18 detailing position at end of year

<table>
<thead>
<tr>
<th>#</th>
<th>Division</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>ISD Health Visiting Fleet &amp; Yateley</td>
<td>Under Investigation</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>9</td>
<td>ISD Lymington Hospital - New Forest</td>
<td>Under investigation</td>
<td>To be confirmed</td>
</tr>
</tbody>
</table>

7.5 On 4 July 2017 the Complaints and Patient Experience Team invited the Liaison Manager from the Parliamentary Health Ombudsman to join their team meeting. They shared their best practices with the team as well as guidance for them to use when dealing with complaints moving forward. They also reviewed the updated policy and procedure for the Trust in relation to Complaints, Concerns and Compliments. It is pleasing to report that the Liaison Manager complimented the team on how well they are managing complaints and commented that Southern Health NHS Foundation Trust are definitely moving in the right direction when it comes to the handling of our complaints.

8 Complaints by division as a percentage of contacts 2017/18

8.1 Calculating numbers of complaints per patient contact enables comparison between divisions as detailed below. As in previous years Mental Health services has the highest percentage of complaints per activity, and is of a similar order to 2016/17.

8.2 Specialised Services figures would have formed part of the Mental Health data for 2016/17.

8.3 Older Persons Mental Health figures would have formed part as of the Integrated Service Division data for 2016/17. OPMH has now become its own business unit reporting under Mental Health.

Graph: Complaints by division as a percentage of contacts 2017/18

<table>
<thead>
<tr>
<th>Division</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISD</td>
<td>0.014</td>
<td>0.011</td>
</tr>
<tr>
<td>Children</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>AMH</td>
<td>0.09</td>
<td>0.07</td>
</tr>
<tr>
<td>LD</td>
<td>0.03</td>
<td>0.02</td>
</tr>
<tr>
<td>OPMH</td>
<td>0</td>
<td>0.01</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>0</td>
<td>1.01</td>
</tr>
</tbody>
</table>
9 Themes

9.1 The three top categories for complaints align with the national data collected by NHS Digital and have been consistent over recent years. The three top categories make up 70% (60% in 2016/17) of all complaints and 67% (47% in 2016/17) of all concerns.

Table: Categories of complaints and concerns excludes complaints that have been withdrawn.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Complaints</th>
<th>Number of Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care / Nursing care</td>
<td>172</td>
<td>362</td>
</tr>
<tr>
<td>Communication</td>
<td>35</td>
<td>65</td>
</tr>
<tr>
<td>Attitude</td>
<td>33</td>
<td>36</td>
</tr>
</tbody>
</table>

Graph: complaints and concerns received by top three category type across the divisions 2017/18
10 Complaints about Clinical Care and Nursing Care

10.1 There were 172 complaints and 362 concerns that related to Clinical Care and Nursing Care. This category spans across all the divisions proportionally to the numbers of complaints for that division, so no particular division raises specific cause for concern.

10.2 Clinical Care and Nursing Care covers a varying range of subjects around a person’s clinical treatment. These include, but are not exclusive to:

- Change in doctor/care coordinator
- Alleged negligence.
- Lack of support.
- Patient request for change in clinical team.
- Patient’s feelings not being taken into account.

A small selection of complaints and the applied learning are shown below:

Complaints and actions – Clinical Care and Nursing Care

**Clinical Area:** Alton Community Hospital

**Detail of complaint:** Lack of physio therapy in a community hospital, lack of mental stimulation for patients and lack of time for staff to talk to carers.

**Action taken:** The Head of Nursing took on the role of the investigating officer for this complaint and met with the complainant at their home to discuss their concerns and agree the terms of reference for their complaint; this also gave the complainant the opportunity to be involved in the investigation process. The investigation officer also interviewed staff involved in their care and staff who were named in the complaint. A carers assessment was also looked into as part of this complaint.
Improvements made/learning:
- Ward Manager and Sister to run a weekly session for relatives to drop in and discuss their family member and any questions or concerns the family may have.
- Quality Improvement Plan to be updated with Privacy, Dignity and Respect Policy compliance.
- Area Matron and Ward Manager to set up a timetable of activities working with the league of Friends and local volunteer groups.
- Day physiotherapy on the ward.

Clinical Area: Fareham & Gosport Community Mental Health Team (CMHT)

Detail of complaint: CMHT failed service user and didn't listen to the people closest to him. He then self-harmed and required extensive surgery.

Action taken: The complaint advisor met with the complainant to listen to their concerns and agree the terms of reference for the complaint. The complainant also met with the investigating officer which allowed the complainant the opportunity to be involved in the investigation process. The investigation officer also interviewed staff involved in the care of the patient and staff who were named in the complaint.

Improvements made/learning:
- Service user to have a care plan agreed by a Care Plan Approach meeting.
- Carer’s care plan to be completed with the patient’s mother and carer’s assessment to be offered to his mother.
- Risk assessment and care plan to highlight risk of clinical disengagement and actions to reduce this risk. Assertive approach to be used by the team as patient has a history of clinical disengagement.
- Fareham and Gosport to follow the clinical disengagement policy when a service user disengages.

Clinical Area: Mental Health South Area Community Mental Health Trust (CMHT)

Detail of complaint: Patient is a diabetic with a history of physical and mental health problems. The patient’s health has deteriorated significantly. Upon being admitted to hospital it was observed that the patient’s foot was gangrenous.

Action taken: A meeting was offered to the complainant however their preferred method of contact was via email and the telephone. The investigating officer stayed in regular contact with the complainant and also engaged with another Trust as this was a multi-agency complaint. The investigation officer also interviewed staff involved in their care and staff who were named in the complaint.

Improvements made/learning:
- Team aware of medication compliance issues – more assertive management of diabetes; liaise with GP/MDT meetings / physical health nurse.
- Care coordinator (COO) to review cancelled appointments and risk assess if the cancellations could impact on patient care or if there are existing known risks -
rationale to be recorded on the electronic medical records called RiO to
demonstrate risks have been considered.

- All agreed and communicated actions should be carried out. Remind staff about
effectively using the planner to forward plan the next day’s visits.
- If consent is given to the family, ensure they have been made aware of the
principles of capacity assessments.
- Clear RIO evidence that medications have been reviewed and compliance / side
effects noted after visit.
- To consider future service users with medication / compliance issues/ diabetics to
clearly document compliance and how any issues are shared / discussed

Clinical Area: Adult Mental Health – Antelope House

Detail of complaint: Referrer states that she sustained a head injury, whilst an inpatient,
and that she did not receive adequate follow up care.

Action taken: A meeting was offered to the complainant however their preferred method
of contact was via the telephone. The investigating officer stayed in regular contact with
the complainant and interviewed staff involved in their care and staff who were named in
the complaint.

Improvements made/learning:
- All paper charts should be completed in full with patient details. If a patient
information sticker is available, this should be added to the form.
- Where a clinician has completed a paper form in the secondary file, this must be
signed and dated.
- The frequency of observations should be completed on the track and trigger tool.
- Whenever a patient reports a fall, a post falls checklist must be completed.
- All falls incidents should be reported through the Safeguard Ulysses system.
- Where there is information relating to self-harm, this should be followed up and
recorded.

11 Complaints about Communication

11.1 There were 35 complaints and 65 concerns that related to Communication. These
complaints/concerns can be categorised into 5 main themes, these are:
- The style that a message is delivered which may lack empathy with a patient;
- Lack of family/carers involvement in a patient’s treatment plan;
- Failing to ensure understanding of a patient’s treatment plan;
- Agreed levels of contact with a patient not adhered to;
- A patient’s expectation isn’t met with their treatment plan or the services which the
Trust can offer.

11.2 A small selection of complaints and the applied learning are shown below;
Complaints and actions – Communication

Clinical Area: Children’s Health Records

Detail of complaint: Very disheartened and disappointed. As a first time parent to a 6 month old little boy I received a letter to get my son booked in for vaccines when he had already had these vaccines.

Action taken: A meeting was offered to the complainant however their preferred method of contact was via email and the telephone. The investigating officer stayed in regular contact with the complainant and also interviewed staff involved in the child’s care and staff who was named in the complaint. The health visiting team also reviewed the letters as part of this complaint.

Improvements made/learning:
- Tracking report to be created immediately to ensure all lists are returned.
- Contact with the Practice Manager to inform them of the complaint and discuss the timely return of clinic lists.

Clinical Area: Adult Mental Health – Elmleigh

Detail of complaint: Patient’s father went back to Elmleigh to speak to someone but was told it wasn’t a convenient time and was asked to call back. 2nd and 3rd time phoned, not convenient however spoke to a lady, and she said she would pass it on but no one called. Information was not passed on. His son phoned him to say that he had been discharged and they let him go home alone, family not aware of the discharge or involved. Father was concerned that his son is not getting much support since discharged.

Action taken: The complainant received a phone call from the team manager to see if their concerns could be resolved locally. A formal complaint was agreed as the best route. A meeting was offered to the complainant however their preferred method of contact was via email and the telephone. The investigating officer stayed in regular contact with the complainant and also interviewed staff involved in their sons care and staff who were named in the complaint.

Improvements made/learning:
- Patient and his father to receive an apology from the Trust for their experience of not being involved in Care Planning or Discharge.
- All staff should be reminded of the importance of involving family members as well as service users in care planning, where this is wanted by the service user and carers.
- Staff to be reminded of the need to take age and any communication needs (sight or hearing loss for example) into consideration when engaging carers and other family members in the care of service users.
- Parents to be offered a carer assessment.
**Clinical Area:** Gosport Integrated Care Team (ICT)

**Detail of complaint:** Standard letter sent to patient which caused upset following a fall. The patient felt as the doctor was telling her off within the consent on the letter.

**Action taken:** The Community matron visited the complainant on the ward to discuss their concerns. A personal apology was also offered from the Dr who wrote the letter to the patient and as a result of their complaint the letter was reviewed for future patients.

**Improvements made/learning:**
- Patient offered an apology & an explanation of the process re the letters.

12 Complaints about Attitude

12.1 There were 33 complaints and 36 concerns that related to Attitude.

12.2 Attitude covers a broad range of categories; these include but are not limited to:
- Rudeness from staff when speaking to patients and their families;
- Patients and families feeling like staff members are not engaging with them;
- Patients and families feeling like staff members do not have time to see them or are rushed through.

12.3 A small selection of complaints and the applied learning are shown below:

**Complaints and actions – Attitude**

**Clinical Area:** Older Persons Mental Health (OPMH), Community Mental Health (CMHT) East Hants.

**Detail of complaint:** Attitude of Doctor in OPMH assessment process. Complainant felt that doctor showed little empathy when dealing with her diagnosis and their letter contained mistakes.

**Action taken:** The complainant was offered a meeting with the investigating officer to discuss their concerns in person. The doctor involved has since reflected on the concerns raised and discussed this during their annual appraisal. The investigating officer interviewed staff involved in the complainants care and those named in the complaint.

**Improvements made/learning:**
- To ensure all clinic rooms have an adequate supply of patient information leaflets.
- Letter to be corrected both electronically and paper.
- Reflections to be discussed in annual appraisal.

**Clinical Area:** Health Visiting (HV) Team Fareham

**Detail of complaint:** Complainant visited the HV clinic and was told that her baby was heading towards obesity and that the baby would be referred at her 1 year check; however, no advice was given. Felt the HV was rude and unprofessional.
**Action taken:** The complainant was offered a meeting with the investigating officer and the manager of the service gave the complainant a call to offer them an apology. The investigating officer interviewed staff involved in the patient's care and those names in the complaint. The Complaints and Patient Experience Manager met with the member of staff named in the complaint along with their line manager to discuss their concerns. As a result of this meeting the Complaints and Patient Experience Manager has created a support guide which will be sent to staff who have been named in a complaint, this will help them have an understanding of the complaints process and appropriate support if required.

**Improvements made/learning:**
- For role play to be included in the Healthy Weights training in order for staff to practice how to discuss Healthy Weights in a supportive way.
- Clinical staff in the Health Visiting Team to attend Care Planning and Communication Skills training.
- Clinical staff in the Health Visiting Team to be compliant in UNICEF Baby Friendly training.
- For all informal complaints or concerns received by the team to be managed by Clinical Team Lead in the first instance.
- All staff within the Health Visiting Team to complete Southern Health Customer Care and Complaints e-learning module.

**Clinical Area:** Adult Mental Health - Avalon House

**Detail of complaint:** Patient unhappy with attitude of receptionist - including remarks made and actions/gestures towards him

**Action taken:** A meeting was offered to the complainant however their preferred method of contact was via email and the telephone. The investigating officer stayed in regular contact with the complainant and also interviewed staff involved in the patient's care and staff who were named in the complaint. The receptionist also discussed this situation in their supervision with their line manager to reflect on learnings for the future.

**Improvements made/learning:**
- For Adult Mental Health team to provide a clinic list for reception.
- Non-clinical staff to have more awareness of Mental Health cliental.
- All non-clinical staff to be in date with conflict resolution training.

**Clinical Area:** Specialist Nursing Respiratory

**Detail of complaint:** Patient unhappy with the attitude of a member of staff.

**Improvements made/learning:**
- Administration team informed that this patient does wish to see this staff member in clinic so that alternative arrangements can be made when booking clinic appointments.
- Reflections to be discussed in clinical supervision.
13 Emerging themes over the last 12 months

13.1 The next three categories of complaints and concerns have also been reviewed:
- Access to services (17 complaints and 44 concerns)
- Medication/Prescribing (13 complaints and 29 concerns)
- Discharge (11 complaints and 16 concerns)

Graph: complaints and concerns received by next 3 highest category types across the divisions 2017/18

14 Access to Services

14.1 Access to services includes but is not limited to the following:
- Access to services after discharge has taken place

Graph: concerns received, by the next 3 highest category type, by Service division in 2017/18
• Availability of blood tests
• Difficultly getting support out of hours
• Long waiting times for therapy for example, DBT, CBT, Italk services.

15 Medication and prescribing

15.1 Medication & prescribing includes but is not limited to the following:
• Incorrect medication or dosage prescribed to a patient;
• A change in a patient’s medication with little or no explanation provided;
• The side effects of new medication not fully explained to a patient;
• Delay’s in a patient receiving medication when a dosage is due.

16 Discharge

16.1 Discharge includes but is not limited to the following:
• No discharge plan agreed with a patient;
• No involvement for family or carers in a patients discharge plan;
• A patient or their family feel that they have been prematurely discharged;
• No effective transition plan between the Trust and other agencies involved in a patient’s treatment plan.

17 Themes and learning across the Trust
17.1 The main themes identified by the Trust are that complainants would like faster resolutions and more empathy of their need to complain. The Trust has improved the policy and procedures for complaint handling as well as updating our online training for employees. This training encourages employees to be more open about resolving complaints at the first point of contact to support with patient with their concerns. Investigating officers are now encouraged to make direct contact with complainants as early as possible to prevent any unnecessary delays to a complaint resolution.

17.2 A thematic peer review undertaken by Calderdale, made recommendations for improving the complaints process and a further review in preparation for the CQC inspection. This was translated into an action plan. As of 12 April 2018, 99% (94 actions) from the action plan had been completed with one remaining action due to be closed by 31 July 18. This one outstanding action relates to sharing actions with complainants once they have been completed and implemented, this will ensure complainants feel reassured that the Trust have acted on feedback as a result of their complaint.

18 Complainant Satisfaction Survey

18.1 During the latter part of 2017, it proved difficult to compare the survey results due to a variety of different versions of the survey being issued as a consequence of changes made by the interim complaints manager and by participating in a pilot national survey. There was a break in sending out satisfaction surveys whilst it was redesigned to meet the requirements of the Complaints Working Group.

18.2 Satisfaction surveys are sent out monthly (at least two weeks after the response letter has been issued). They are either sent out electronically with a link to the on-line survey or via the post as a paper copy, depending on the previously established correspondence preferences of the complainants. All paper surveys are sent with a pre-paid envelope.

18.3 Survey responses have been received from 23% of those approached. It has been noted that survey respondents tend to submit a reply within a couple of days of receiving the request or not at all, and chasing replies does not yield a response. A benchmarking exercise is planned to look at similar trusts and their response rates in May 2018.

18.4 Responses showed that the majority of complainants found that staff were helpful or very helpful when they first raised a complaint and it was not difficult for them to raise a complaint. However, it was found that the majority of respondents were worried that raising a complaint would negatively affect their care. The vast majority of respondents were dissatisfied or very dissatisfied with the response they received and were not confident or convinced that the Trust had learnt from their complaint. Overall, respondents did not feel that the Trust had been open and honest in the responses given. The team continue to work with the divisions to share this feedback and focus on ensuring staff are confident when dealing with concerns/complaints. The Complaints and Patient Experience Team are working with divisions to ensure actions are being recorded on our internal systems and from 1st July 2018, complainants will be offered the opportunity to see evidence of the recommendations put into place as a result of their complaint. This will be included in their final response letter.

18.5 Over half of the people surveyed stated that they had not seen any posters and / or leaflets distributed around the Trust sites explaining the complaints process.

As a consequence of receiving this feedback from the satisfaction survey a staff bulletin was sent out to all staff to remind them to prominently display the Complaints and Patient Experience Team and Patient Experience Team are working with divisions to ensure actions are being recorded on our internal systems and from 1st July 2018, complainants will be offered the opportunity to see evidence of the recommendations put into place as a result of their complaint.
Experience Team leaflets and posters. The C&PE experience team will also carry out a mystery shopper exercise over the next 12 months ensure services are providing patients and families with up to date information.

19 Compliments

19.1 The number of compliments reported in 2017 has increased quite considerably. This is as a result of the new process which allowed clinical staff to record compliments directly onto the system in a similar way to reporting incidents rather than forwarding them to the central Complaints and Patient Experience Team. A selection of compliments are shared with staff through the weekly bulletin and staff members are continuing to be encouraged to record all compliments they receive on our internal system Ulysses; there has been a continued focus on ensuring staff members are recording all compliments received through 2017/18.

19.2 The Complaints and Patient Experience Team have also started working closely with The People Development Team by providing them with compliments to be shared during team away days. These examples exhibit the great service staff within the Trust is providing to our patients and their families and encourages them to continue investing time in recording compliments they receive onto our internal systems.

Chart: Compliments received by Service Division

<table>
<thead>
<tr>
<th>Service Division</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health</td>
<td>398</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>59</td>
</tr>
<tr>
<td>East ISD/BU1</td>
<td>874</td>
</tr>
<tr>
<td>New Forest, Lower Hants &amp; Southampt ISD/BU2</td>
<td>620</td>
</tr>
<tr>
<td>North ISD/BU3</td>
<td>336</td>
</tr>
<tr>
<td>Children's ISD/BU4</td>
<td>2873</td>
</tr>
<tr>
<td>Corporate</td>
<td>9</td>
</tr>
<tr>
<td>Contracted Services</td>
<td>5</td>
</tr>
<tr>
<td>OPMH</td>
<td>71</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>60</td>
</tr>
</tbody>
</table>
19.3 Examples of compliments received in 2017/18:

- I was very thankful and stated that the LD Team had been "fantastic", that she "didn't have a bad word" and "couldn't have asked for a better team". – Learning Disabilities

- Patient has been admitted to hospital, J called to say that the District Nurses have been amazing, the bed that we sourced for her has made the world of difference to the quality of her life, and it has enabled the patient to stay at home for as long as she has. Her daughter was very complimentary to the nursing team. – ISD

- Thank you so much for helping me through this tough time! You are genuinely kind and understanding! I could not have done it without you! Good luck in your career, not that you will need it as you are awesome!! – Mental Health

- Just to say thank you to all the Community nurses that came every week to look after xxxxx. Over the years they became like family and he always thought they did a good job. They were kind and caring. Thanks again. – ISD

- The care that my mum received at Melbury Lodge was exceptional; all the staff was absolutely brilliant, demonstrating compassion and competence. Their communication skills with our family were exceptional. At all times we felt fully informed and involved in Mums care. Please can you ensure that the staffs are aware of how excellent they are? – Mental Health

- I was taken seriously, my views taken into account. I was given time to talk and made to feel valued. I felt so much better after leaving, with new strategies and a positive approach. Thank you S1 & S2. – ISD

- Just wanted to express my thank you for all the hard work E has done with me and offenders within the court, more specifically with AB who was in court today. E was very empathetic towards A who has had a very hard life and E handled the situation so professionally. I feel very comfortable to go to E with my concerns knowing she will have the right answers for me and most times will have a conversation with the offender. E always comes back to me and we have a discussion on how we will proceed. E is always a person the whole team within the court feels we can rely on and, if we are aware that she is the representative within the court today we feel at else. The whole court probation team feel very highly about E and enjoy the prospects of continually working with her – Mental Heath.

20. Initiatives in 2017/18

20.1 A Working Group, including complainants, patients, relatives, members and staff was set up to implement recommendations to improve the experience for complainants in the future. The Group reviewed and advised on the format and style of letters to complainants, looked at and made improvements to information on our website about raising a concern or complaint; reviewed the Trust Policy and Procedure, revised the satisfaction survey for complainants and helped reword the Complaints and Patient Experience leaflet. All of these recommendations were accepted and the changes have been implemented.
20.2 The Trust invited the Quality Governance Team from Calderdale and Huddersfield NHS Foundation Trust to conduct a peer review of the Complaints and Patient Experience Team.

20.3 A single action plan following these reviews and CQC inspection was developed. As of 12 April 2018, 99% (94 actions) from the action plan had been completed with one remaining action due to be closed by 31 July 18. This relates to sharing actions which complainants once they have been completed and implemented.

20.4 From the 1 August 2017 any complaints received in the Complaints and Patient Experience Team required the Investigation Officer (IO) to write the investigation report; the Complaints and Patient Experience advisor’s now draft the final response letter. There has been positive feedback from the IO’s regarding this change as it allows them more time to focus on conducting a thorough investigation. Consistency within letters has been an additional benefit and fewer letters are being returned with amendments from the Chief Executive Office.

20.5 All complaints received from a complainants Member of Parliament (MP) are now being overseen by our Director of Operations for Mental Health and the Integrated Service Division once consent has been obtained to ensure a tight turnaround in timescale and a high level focus given to these complaints.

20.6 The Complaints and Patient Experience Team now formally acknowledge all concerns and complaints within 3 working days to ensure any change of classification will still comply with the timescales.

20.7 A 48 hour panel within the Integrated Service Division has been introduced to ensure an Investigating Officer is appointed in a timely manner. During the panel, the complaint is reviewed and a suitable investigating officer is allocated based on the complaint points and experience required in order to resolve the complaint. This panel is always chaired by a Head of Nursing from the Integrated Service Division to ensure a high level of focus when dealing with complaints.

20.8 An introduction of a new complaint classification for complex complaints. a complex complaint will meet one or more of the following conditions:
- Or more complaint points
- issues spanning over more than one service or Trust
- issues which are older than one year old
- issues which will require interviewing more than 3 staff members
- issues which will require seeking an expert opinion from outside the service involved/the Trust
- a complaint which sights a member of the Executive team
- complaints linked to a Serious Incident

If the complaint handler/division feel a complaint should be classified as complex however it does not meet one or more of the above criteria’s, this will need to be approved by the complaints manager.
20.9 Restructure of the Complaint and Patient Experience Team to now include two patient experience advisors whose focus is on ensuring all complaints and concerns are acknowledged within three working days of receipt. As well as managing the day to day running of the mailbox, post and telephone lines.

20.10 The Complaints and Patient Experience Team now have two administrators to support the team which enables a quicker response to complaints & concerns.

20.11 The inclusion of the Willow Group into the Trust, sharing best practices has reduced the complaint volumes within their service. The complaints advisor from the Willow Group continues to be mentored by a member of the Complaints and Patient Experience Team.

20.12 The Complaints & Patient Experience Team has had new telephones installed within their Tatchbury Mount office. The new system shows the number calling and allows for calls to be transferred to other team members when the mainline is busy. This enhancement will reduce the need for patients to leave a voicemail and await a call back from the team.

21 Risk Narrative

21.1 The Complaints and Patient Experience Team currently have two open risks on the Trusts Risk Register; these highlight areas of concern for the Complaints and Patient Experience Team that may hinder their ability to meet their internal timeframes. These risks are reviewed on a monthly basis by the Complaints and Patient Experience Manager and have been shared with the Trusts Executive Team for their awareness.

<table>
<thead>
<tr>
<th>Risk Register / BAF No.</th>
<th>Risk Score</th>
<th>Narrative regarding changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1432 Moderate</td>
<td>9</td>
<td>There is a risk that the Complaints and Patient Experience Team will not be able to resolve some complaints satisfactorily and manage calls effectively due to lack of automated recording facilities. A capital bid has been approved to install 6 recording telephones into the Complaints and Patient Experience Team; this should be completed by Q2 2018.</td>
</tr>
<tr>
<td>601 High</td>
<td>16</td>
<td>Failure to meet internal timescales to complaint response times. A trajectory of improvement has been put into place within the Complaints and Patient Experience Team. This can only be achieved with support from the divisions as well as the Complaints team.</td>
</tr>
</tbody>
</table>
22 Next Steps

22.1 To reduce time taken to resolve complaints, working with service divisions to implement the trajectory of improvement plan.

22.2 To publish this Annual Report on the Trust website.

To introduce a recording telephone system to ensure the Complaints and Patient Experience Team are responding to complaints in a timely manner as well resolving complaints and concerns in a satisfactory way. Some of the benefits of call recording are:

- Staff performance monitoring
- Training support can be offered to staff
- Improved Customer Support
- Regulation compliance
- Call monitoring allowing the Executive team to see how often the team are contacted.
- Transcripts available for our patients who use our services

23 Recommendation

23.1 The Committee are asked to gain assurance that National Regulations are met and that the Trusts Complaints policy is followed.
<table>
<thead>
<tr>
<th>REPORT TO THE TRUST BOARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td><strong>Agenda Item</strong></td>
</tr>
<tr>
<td><strong>Title</strong></td>
</tr>
<tr>
<td><strong>Author(s)</strong></td>
</tr>
<tr>
<td><strong>Sponsoring Director</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Purpose &amp; Action Required</strong></th>
<th>The Board is asked to note the update given in this report.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Director Overview</strong></td>
<td>An interpretation of the report from the Directors’ point of view;</td>
</tr>
<tr>
<td></td>
<td>- Key Points of the paper;</td>
</tr>
<tr>
<td></td>
<td>• An update on the Transformation Programme Board and activities</td>
</tr>
<tr>
<td></td>
<td>• A decision on the resourcing route to support QI Facilitator development</td>
</tr>
<tr>
<td></td>
<td>- Key risks that the Board should be aware of;</td>
</tr>
<tr>
<td></td>
<td>• The programme is proceeding rapidly and requires appropriate resourcing</td>
</tr>
<tr>
<td></td>
<td>• An outline of actions to be taken;</td>
</tr>
<tr>
<td></td>
<td>• A decision is requested as above</td>
</tr>
</tbody>
</table>

| **Previously considered by:** | N/A |

<table>
<thead>
<tr>
<th><strong>Strategic Priorities this paper supports:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td><strong>People</strong></td>
</tr>
<tr>
<td><strong>Transformation</strong></td>
</tr>
<tr>
<td><strong>Money</strong></td>
</tr>
<tr>
<td><strong>Does this impact any Board Assurance Framework / Corporate Risks</strong></td>
</tr>
</tbody>
</table>
Transformation Programme Update

1. **Purpose**
   1.1. This report provides an update to members of the work being undertaken within the Transformation Programme Board (TPB) and progress on the transformation agenda.

2. **Context**
   2.1. The TPB has been reporting directly to the Trust Board. In this context an update on activities is provided. An Executive Transformation Programme Board is now proposed that would fulfil this role and change the function of the existing TPB.

3. **Report**
   3.1 *Update on the functioning of the Transformation Board*

The Transformation Programme Board has made good progress on the transformation and QI agenda in its early stages. The TPB contains active and broad representation from service users, governors, clinical and non-clinical staff and executive directors. It has overseen the formation of the transformation team and appointed two clinical leads to develop and champion the programme. It has been entrusted with the decision making powers to determine the operational pathway of transformation.

The TPB is currently active in forming the critical stakeholder mapping, asset mapping and communications strategy whilst learning from the fast initiator work in PSEH (item 3).

An Executive Transformation Steering Board (ETSB) is being formed (terms of reference are coming to the Trust Board) to enable the TPB to focus more on the management and operation of the transformation programmes, by providing steer and strategic direction to it on behalf of the Trust Board.

The governance structure is set out below (Diagram 1);

**Diagram 1:**

![Diagram](image-url)
3.2 Quality Improvement & Transformation training

The initial plan is to have 4 cohorts trained (3 during the NTW supported timeframe). Cohort 1 training took place between 21-25 May. The cohort of 15 was comprised of staff including executive directors, clinicians and administrators from across the organisations services (physical health, mental health and corporate services) and a representative with lived experience. Following the training there is a viva voce, planning for a transformation event and then developing the level of intelligence required to understand the ‘current state’, which will lead into a transformation event over 5 days with a team or service and their ‘customers’ (up to 15 people) who will be facilitated to design their own solutions to improve their service. Support is then given to the implementation phase. It is estimated that this will require a minimum commitment of 35 days for this one cycle.

The intention by the end of this year is to have 60 people who have completed this process and are supporting quality improvement as part of the transformation. They will become the Trust’s quality improvement facilitators.

The application process for the further cohorts (2 and 3) is now open and requires that applicants complete a short form asking them to identify their suitability and qualities for joining the QI facilitator team. From this process, applicants will be selected by the executive team to join a cohort. The identification of the programmes being transformed will be based on the content of the Board Assurance Framework and Trust risk register, the quality priorities and the Trust objectives.

The application process is open until 1 July.

To note: NTW are delivering the first 3 cohorts and will coach and support us to deliver cohort 4 and beyond. We therefore need to identify a resource for supporting the ongoing provision of QI facilitator development and its position in the organisation. This could be LEaD, People Development or a central QI / Transformation function. It would be helpful to know the thoughts and preferences of the Board on this. This also leads to the question of ongoing resourcing and funding for this programme and its consequences. This is a matter that will be considered by the executive team in June.

The Transformation programme is in the process of submitting a further bid to NHSI for 18/19 funds of £200k, of which £110k is accounted for through the NTW work.

3.3 Update on programmes already running (PSEH)

The Portsmouth & South East Hants (PSEH) Transformation work is covering CMHTs in the South East area. Having undertaken a series of week-long observations of the teams by peers, there have now been the first two week-long, design workshops – the first looked at advice and information, the second at managing urgent referrals.

Concurrently, Team Leads for each of the observed teams have also received 1 day training introducing them to QI concepts to assist them in the implementation of any small scale change. When the final two workshops (focussing on non-urgent referrals and Promotion & Communication) are complete (mid-June) a 3 day review of the design will bring in a wider participation and proposals for transformational changes to pathway or process.

The 3 day review workshop is for senior managers from the providers and commissioners and will look at the gap between current state analysis and the future design and agree the implementation plan for moving forward. This will include prioritising the steps, as some development may require investment (call centre for example) or restructuring (crisis care) or adaptation (wellbeing house).
Initial invitations have been sent but require review to ensure people present have the right authority to agree decisions. The workshop will take place between 20-22 June.

The workshop process has been very intensive for service users and staff alike and it is hoped this process, allied to the explicit support enjoyed from the organisation, will produce tangible changes.

4. **Next Steps**

4.1. As described in the report, Cohort 1 will proceed through the steps outlined and Cohorts 2 and 3 will be populated and proceed on the same journey.

4.2. A decision will be required on the preferred resourcing option to support the QI Facilitator development.

5. **Recommendation**

5.1. The Board is asked to receive this report and consider the resourcing question.
# REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>17</td>
</tr>
<tr>
<td>Title</td>
<td>Compelling case for change</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Tom Westbury, Associate Director of Communications</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Nick Broughton, Chief Executive</td>
</tr>
</tbody>
</table>

## Purpose & Action Required
The Board is asked to note the compelling case for change document and approve its content for use in communications with staff and stakeholders.

## Executive Director Overview
The trust is undertaking significant and large scale transformational change. Evidence suggests that this is more likely to be successful if there is a compelling case for change which establishes a sense of urgency which can mobilise and motivate the workforce and stakeholders. This document reflects the opinions, insights and reflections of many of our key stakeholders including a group of families with whom we continue to work. It sets out why the organisation must continue to change. This will form the basis upon which the trust strategy will be created. The document is a frank assessment of where we need to improve, however in the interests of honesty and transparency we believe it is important to openly communicate this internally and externally.

## Previously considered by:
The Trust Executive team.

## Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Support Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Highlights quality challenges that require continuous vigilance and improvement</td>
</tr>
<tr>
<td>People</td>
<td>Describes how we need to improve the way we engage and support our workforce, and create a truly just culture</td>
</tr>
<tr>
<td>Transformation</td>
<td>Articulates why transformation is required in this</td>
</tr>
<tr>
<td>Organisation.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Money</td>
<td>N/A</td>
</tr>
<tr>
<td>Does this impact any Board Assurance Framework / Corporate Risks</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The case for change at Southern Health

As a new board we are planning for the future and thinking about the organisation we aspire to become. What does outstanding care look like and how do we get there?

Before we can answer this question we need to clearly understand where we are now, and be honest with ourselves about the scale and breadth of change required. This can sometimes make for difficult reading but only with a frank and accurate assessment of our current state can we set realistic and achievable goals for the future.

In making this assessment we have:

- Reflected on past failings, most recently highlighted by the prosecution of the Trust but also our wider work with families.
- Looked at changes already made over recent years to improve, in many cases in response to failings or serious incidents, but also as part of other change programmes
- Examined the findings of the staff survey and other feedback from our workforce.
- Examined feedback we have had from patients, carers, and families
- Taken findings and guidance from key sources such as inspection reports and national reports aimed at improving care in the NHS*
- Considered how we compare with the best NHS Trusts in the country

There is evidence that changes have happened and are making an impact: it's important to recognise this. We thank colleagues who have worked hard to deliver these changes so far, and the patients, carers, families and others who have shared their time, expertise, and experiences to help us improve. We have also seen real examples of excellent practice happening across Southern Health. Furthermore, we are very confident that the vast majority of our 6,000 staff are compassionate and dedicated people who have chosen to work in the NHS because they want to make a difference.

This is a strong foundation upon which to build.

Whilst progress has been made, we have identified that significant further change is needed in a number of key areas:

**Improving quality, safety, and consistency of care**

- Past health and safety failings have resulted in avoidable deaths in our care. We must keep striving to ensure our services are as safe as possible.
- There is too much variation in quality and approach between different parts of the trust – this leads to a variation in outcomes and experience for patients.
- We don’t have a consistent, evidence-based approach to quality improvement embedded across the whole organisation.
Involving people

- We do not consistently involve and work in partnership with people who use our services, their families and carers, and other people affected by what we do.
- Many staff do not feel actively involved in decisions about the trust and their services.
- We must challenge ourselves to be as open and transparent, yet accessible, as possible.

Joining up care

- Although we provide both mental and physical health services, we are only scratching the surface of what integrated care can bring to patients.
- We are not working as effectively as we could with other organisations that support the same population.

Supporting our workforce

- We don’t do enough to support the health and wellbeing of our colleagues, and to create the environment where employees feel comfortable speaking out if they have concerns. Not all our staff feel that we operate a just culture.
- More needs to be done to retain our staff and make Southern Health an attractive place for prospective employees to come and build their careers.

Transforming care pathways

- We have opportunities to improve every part of our patients’ journey – from prevention to crisis care. By making this better we can tackle long-standing issues such as the placement of some patients in hospitals far from home and supporting health and social aspects of recovery.

Meeting these challenges will require more than discrete, incremental changes. We must go beyond this and seek to fundamentally transform the way we do things. This won’t be easy. It will take time. But we are convinced it is the best way to truly deliver the outstanding care our patients deserve.

Next steps

We are developing a new vision and strategy for Southern Health which will describe how we will address the challenges set out above. In the meantime we are keen to hear any feedback you may have on our case for change.

The Board of Southern Health NHS Foundation Trust

April 2018
*Key references:*

- Review into the quality of care and treatment provided by 14 hospital trusts in England, Professor Sir Bruce Keogh, 2013.
- A promise to learn – a commitment to act: Improving the safety of patients in England, 2013
- Learning from Deaths in the NHS, NHS Improvement, 2017
- Valued care in mental health: Improving for excellence, NHS Improvement, 2018
- Driving Improvement: Case Studies from seven mental health NHS trusts, Care Quality Commission, 2018
**REPORT TO THE TRUST BOARD**

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</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>18</td>
</tr>
<tr>
<td>Title</td>
<td>Board Assurance Framework</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Jake Pursaill, Risk Manager</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Julie Dawes, Director of Nursing &amp; Allied Health Professionals</td>
</tr>
</tbody>
</table>

**Purpose & Action Required**
The Board is asked to discuss this report, reflecting the key strategic risks, controls and lines of assurance against our strategic objectives. Further, the Board is asked to review the proposed assurance framework for future reporting to the Board.

**Executive Director Overview**
This report presents the revised Board Assurance Framework for 2018/19, following the Board Seminar on the 8th May.

The three areas showing greatest risk at this time are staffing, patient and service user engagement, and financial performance and there is significant action underway in these areas to bring them down to an acceptable level of risk in the shortest timescales possible.

**Previously considered by:**
Executive Risk & Assurance Group, 16/05/2018

**Strategic Priorities this paper supports:**

<table>
<thead>
<tr>
<th>Quality</th>
<th>☒</th>
<th>The board assurance framework provides assurance against risks to all four priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Transformation</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td>☒</td>
<td></td>
</tr>
</tbody>
</table>

**Does this impact any Board Assurance Framework / Corporate Risks**
SR5: There is a risk that we have ineffective governance which prevents effective decision making.
BOARD ASSURANCE FRAMEWORK

1. **Purpose**

1.1. This report sets out the Board Assurance Framework (BAF) reflecting the key strategic risks, controls and lines of assurance against our strategic objectives.

1.2. The Board Assurance Framework has been refreshed for 2018/19, and the Board is asked to consider this framework for future reporting.

1.3. This report seeks to provide assurance to the Board that the Trust is appropriately sighted on, and managing, key strategic risks through an appropriate governance structure.

2. **Background**

2.1. The role of the BAF is to provide evidence and structure to support effective management of Risk within the organisation. The BAF provides assurance to identify which of our strategic objectives are at risk of not being delivered, and provides evidence to support the Annual Governance Statement.

2.2. The BAF presented reflects work carried out at the Board Seminar held on the 8th May. A number of strategic risks are still being developed with the responsible executives. These are:

   - There is a risk that we do not support organisational change in an appropriate and sustainable fashion.
   - There is a risk that we fail to deliver truly integrated services.
   - There is a risk that we do not implement our agreed strategy to expand specialised services in a way that benefits patients.

2.3. We expect to report on these risks fully at the next meeting of the Board, and ask for formal approval of the new Board Assurance Framework.

3. **Board Assurance Framework**

3.1. At an overall level we are managing our strategic risks well and have mitigations and action plans in place to bring down current risk scores over the next 12 to 24 months, with some areas expecting more rapid progress.

3.2. The full Board Assurance Framework is provided as appendix 1.
3.3. The Committees which review each BAF risk are set out in the table below.

<table>
<thead>
<tr>
<th>Board Committee</th>
<th>Strategic Risk</th>
</tr>
</thead>
</table>
| Quality & Safety Committee                     | SR1 - There is a risk that we provide poor quality or ineffective care resulting in serious harm.  
SR2 - There is a risk that we fail to continually improve the services provided by the Trust to deliver better outcomes.  
SR4 - There is a risk that patients have a poor experience with our services due to lack of meaningful engagement  
SR9 - There is a risk that we fail to maintain and develop confidence in SHFT as a care provider. |
| Workforce and Organisational Development Sub-Committee | SR3 - There is a risk that we cannot attract and retain sufficiently skilled staff.  
SR6 - There is a risk that we fail to develop and maintain a culture in line with Trust values and supports the delivery of outstanding services. |
| Audit, Risk, & Assurance Committee              | SR5 - We lack a governance structure that enables effective decision making. |
| Strategic Performance & Transformation Committee | SR7 - There is a risk that we fail to deliver medium & long-term financial sustainability. |

3.4. Further, BAF risks are directly linked to identified strategic priorities for 18/19.

- Quality
  - SR1: There is a risk that we provide poor quality or ineffective care resulting in serious harm.
  - SR2: There is a risk that we fail to continually improve the services provided by the Trust to deliver better outcomes.
  - SR4: There is a risk that patients have a poor experience with our services due to lack of meaningful engagement.
  - SR9: There is a risk that we fail to maintain and develop confidence in SHFT as a care provider.

- Transformation
  - SR5: There is a risk that we have ineffective governance which prevents effective decision making.

- Money
  - SR7: There is a risk that we fail to deliver medium & long-term financial sustainability.

- People
  - SR3: There is a risk that we cannot attract and retain sufficiently skilled staff.
  - SR6: There is a risk that we fail to develop and maintain a culture in line with Trust values and supports the delivery of outstanding services.

4. Recommendation

4.1. The Board is asked to discuss this report, reflecting the key strategic risks, controls and lines of assurance against our strategic objectives. Further, the Board is asked to review the proposed assurance framework for future reporting to the Board.

5. Appendices

Appendix 1: Board Assurance Framework MAR 18
Appendix 2: Glossary of Terms v4
SR1: There is a risk that we provide poor quality or ineffective care resulting in serious harm.

### Impact, Likelihood, Score, Rating

<table>
<thead>
<tr>
<th>Description</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent risk score, in the absence of controls</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>High</td>
</tr>
<tr>
<td>Current risk score, with identified controls applied</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Moderate</td>
</tr>
<tr>
<td>Target risk score, following actions implemented</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

| Reported to: | Quality & Safety Committee |
| Executive Lead: | Chief Nurse / Medical Director |

### Potential Causes:
- We do not maintain a competent and capable workforce;
- Our practices are not evidence based;
- We have no effective process for learning from mistakes;
- Our care environment places patients and service users at risk.

### Controls:
- Revalidation processes for clinical staff, clinical & managerial supervision
- Policy and process documentation and standard operating procedures for clinical work.
- Training, clinical competencies, appraisal and performance management processes and associated frameworks.
- Care delivered in line with patient pathways
- Led by NICE guidance and best clinical practice
- Our SIRI process is supported by root cause analysis and organisational learning
- We invest appropriately in our care environment and comply with NHS estates standards.

### Assurances:
- Processes are supported by appropriate strategy documentation, approved by the Board or appropriate sub-committees
- Committee and meeting governance structures in place to identify and share good practice and learning.
- Subject matter expert groups with good clinical attendance
- Training compliance and revalidation and appraisal, supervision job planning metrics reviewed and reported to appropriate oversight groups.
- Clinical audit programme
- NICE group
- Patient and service user feedback reported to
- CQC review under the safe and effective frameworks
- Safeguarding Boards review of serious cases
- MHA committee
- Thematic complaints, incident, concerns analysis

### Gaps and actions to address:
- To complete an audit of NICE compliance and effectiveness, and implement recommendations – Medical Director, Jul-18
- Develop clinical pathways in line with strategy – Medical Director, Aug-18
- Review of mandatory training package and give recommendations to SMC – Medical Director, Jan-19
- Clinical risk training to be reviewed – Medical Director, Jan-19
- Review NICHE SI review and implement recommendations – Chief Nurse, Jun-19
- Develop 12 month plan to review assurance process for driving improvement – Chief Nurse, Sep-19
- Work to address appraisal weaknesses as part of the staff survey recommendations – Workforce Director, Apr-19
**SR2:** There is a risk that we fail to continually improve the services provided by the Trust to deliver better outcomes.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent risk score, in the absence of controls</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Current risk score, with identified controls applied</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Target risk score, following actions implemented</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

**Potential Causes:**
- We may not have a clear strategic direction for services;
- Service improvements are not co-developed with our stakeholders;
- We do not have the methodology or the information to implement changes.

**Controls:**
- Clinical services strategy, embedded by divisional leads.
- Patient engagement & experience strategy
- Annual planning processes
- Organisational strategy developed in line with wider area health agenda
- Research & Development
- LEAD support development and training for staff.
- QI transformation programme supported by local improvement methodologies (Local QI plans)
- Business Intelligence System

**Assurances:**
- NHS England review progress of NCP model
- Annual plans submitted to NHSI for approval, as well as Trust Board
- Transition Board, attended by SHFT directors, reports to STP.
- Strategy implementation monitored by appropriate Board sub-committee and operational divisional sub-committees.
- Clinical Audit

**Gaps and actions to address:**
- System agreement with MOU to bring new model of community services, signed off by system Boards. – Chief Executive, ongoing
- Develop systems for service redesign engagement in years 2 & 3 of the strategy: The first six months have focussed on embedding milestones, and the co-development of the strategy with NTW is planned – Chief Nurse, Sep-18
- A programme to be established to implement a data assurance standard for key information reported to Board – Finance Director, Oct-18
- Deliver the quality improvement programme, working to engage staff in delivery – Medical Director, Jan-19.
SR4: There is a risk that patients have a poor experience with our services due to lack of meaningful engagement.

<table>
<thead>
<tr>
<th>Potential Causes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- We do not engage patients or families in their care;</td>
</tr>
<tr>
<td>- We do not provide timely or appropriate access to our services;</td>
</tr>
<tr>
<td>- There is limited public involvement or co-production in the design of our services;</td>
</tr>
<tr>
<td>- We do not involve patients or their families following incidents;</td>
</tr>
<tr>
<td>- We do not understand our obligations of equality &amp; diversity.</td>
</tr>
</tbody>
</table>

**Controls:**
- Responsive and appropriate access to services
- Demand management for waiting times
- Implementation of patient engagement & experience strategy
- Risk assessment & care planning process
- Equality and diversity impact assessments
- Clinical service strategies co-designed with service users
- Implementation of the involvement of families in investigations report recommendations
- Investigations and complaints process
- Putting patients and public first is a key value for the Trust, reflected in key documentation (appraisals, strategies, etc.)

**Assurances:**
- Thematic complaints analysis reported to Quality & Safety Committee
- Waiting time group chaired by director of operations
- Friends and family survey results reviewed by Strategic Performance & Transformation Committee
- Narrative report produced by the family liaison officer on the experience of families of the SIRI process
- Ombudsman feedback
- Service user meetings and community group involvement in impact assessments and team self-assessments
- Community and inpatient surveys of user experience

**Gaps and actions to address:**
- Standardise waiting time management methodology – South East development supported by Northumberland, Tyne and Weir is in place – Director of Operations (MH), Jul-18
- Co-development of the Engagement and Experience 2 year strategy with NTW – Chief Nurse, Jul-18
- Northumberland Tyne & Wear buddy programme to continue stats analysis and design workshops with service users & carers. - Medical Director, Jul-18
- Evaluation of our patient engagement & experience strategy – Chief Nurse, Oct-18
- Review of incident reporting, complaints, and concerns against protected characteristics, Workforce Director, Oct-18
- Establish Trust wide service user and Trust wide partnership groups – Chief Nurse, Jul-18
- Roll out of safer wards agenda, Medical Director, Jul-18
SR9: There is a risk that we fail to maintain and develop confidence in SHFT as a care provider.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent risk score, in the absence of controls</td>
<td>3 4</td>
<td>12</td>
<td>Moderate</td>
</tr>
<tr>
<td>Current risk score, with identified controls applied</td>
<td>3 3</td>
<td>9</td>
<td>Moderate</td>
</tr>
<tr>
<td>Target risk score, following actions implemented</td>
<td>3 2</td>
<td>6</td>
<td>Low</td>
</tr>
</tbody>
</table>

To be achieved by Dec 2018

### Potential Causes:
- We fail to demonstrate learning following incidents;
- We fail to advertise service improvements;
- We do not celebrate success externally;
- We do not effectively engage or manage our relationships with our key stakeholders (Commissioners, regulators, NHSI, partnerships, and patients and service users) etc.;
- We do not play a leadership role as part of the STP.

### Controls:
- Communications strategy
- Development of the Council of governors
- Executive involvement in the STP programme (LDS)
- Development work with NHSI consultants
- Performance framework under which the Trust operated
- Board development programme
- Delivery of high quality, safe, and effective care (SR1, SR2, and SR4)
- Trust wide and locally held emergency planning processes

### Assurances:
- Relationship meetings with NHSI and CQC
- Oversight meeting
- External reporting of national audit figures
- National benchmarking
- Positive and negative story analysis through the Communications team report to SMC
- CQC
- Monitoring of work to address NHSI undertakings
- Council of Governors

### Gaps and actions to address:
- Refresh of the Communications Strategy for the year – Workforce Director, Jul-18
- We are not currently involved in all LDSs as much as we would like, and are restructuring the medical governance structure and appointing to gaps to address—Chief Executive, Aug-18
- To recruit a new non-executive director following the appointment of a Chief Operating Officer – Chief Executive, Aug-18
SR3: There is a risk that we cannot attract and retain sufficiently skilled staff.

<table>
<thead>
<tr>
<th>People</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent risk score, in the absence of controls</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>High</td>
</tr>
<tr>
<td>Current risk score, with identified controls applied</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>High</td>
</tr>
<tr>
<td>Target risk score, following actions implemented</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Moderate</td>
</tr>
<tr>
<td>To be achieved by</td>
<td>Mar 2019</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Potential Causes:
- We cannot recruit appropriate candidates in a timely manner.
- We do not recognise, reward, or engage staff appropriately.
- We do not develop our staff or support them in their own development

### Controls:
- 3-year workforce plans in place for each business unit
- Efficient recruitment process that supports the needs of the Trust
- People and OD strategy addressing 18/19.
- Processes and controls to minimise agency / locum staff, and incentivise permanent employment
- Staff engagement plan, led by the Director of Workforce
- Workforce, health & safety, wellbeing, and training policies in place.
- Attraction and recruitment plan in place.
- Common framework for capturing and sharing reward and recognition schemes
- Effective staff wellbeing plan to improve morale, and mitigate sickness and turnover
- Organisational development programme

### Assurances:
- Annual baseline established for staff in post requirements, monitored by SPTC and NHSI
- Vacancy, recruitment, and back / agency metrics monitored by SPTC as part of workforce reporting.
- Quarterly friends & family test scores, and annual staff survey and engagement reported to SPTC
- Staff engagement group oversee and support engagement plans
- Workforce committee review key metrics and KPIs.

### Gaps and actions to address:
- Development of medical workforce plan, supported by the workforce Director – Medical Director, Oct-18
- Introduce Career advisory service – Chief Nurse, Oct-18
- Supporting staff in continuing their professional development / CPD – Workforce Director, Sep-18
- Bank and Agency reduction plan to be implemented – Workforce Director, ongoing
- QI improvement of workforce process – Workforce Director, Nov-18
- Review feedback from first six months of engagement plan implementation and set objectives for next six months. Full evaluation of year and objectives in Mar-18 – Workforce Director, ongoing
- Implement findings of review of exit interview process – Workforce Director, Mar-19
- Introduce go engage as quarterly cultural surveys – Workforce Director, Sep-18
SR6: There is a risk that we fail to develop and maintain a culture in line with Trust values and supports the delivery of outstanding services.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>16</td>
<td>High</td>
</tr>
</tbody>
</table>

**Impact**

**Likelihood**

**Score**

**Rating**

<table>
<thead>
<tr>
<th>Reported to:</th>
<th>Workforce &amp; OD sub-committee</th>
</tr>
</thead>
</table>

**Executive Lead:** Director of Workforce

**To be achieved by:** May 2020

**Potential Causes:**
- We do not articulate clear values
- Leadership role models do not behave in line with values

**Controls:**
- Clearly communicated organisational values, reflected in core documentation (strategies, appraisals, etc.)
- Values-based recruitment process
- Exec completing back to the floor sessions
- Mechanisms for staff to raise concerns: Freedom to speak up, guardian of safe work, etc.
- People & OD strategy and associated policies
- Equality and Diversity policy guidance and impact assessments

**Assurances:**
- Values agreed and reviewed annual by the Trust Board, developed in partnership with staff.
- Staff feedback through annual survey and friends & family scores reported to SPTC
- CQC assessment under the caring and well led domains
- F2SU reporting to the Chief Executive
- Your voice reported to the exec team
- Exception reporting on safe working reported to the medical director.
- Appraisal frameworks measure staff compliance against Trust values.
- Exit interviews
- Patient and partner feedback.

**Gaps and actions to address:**
- Continued promotion of the F2SU guardian across all teams and sites – Chief Executive, Ongoing
- Personal development plan (CPD).
- Board development – Chief Executive, Nov-18
- Development of the coaching network – Workforce Director, Nov-18
- QI improvement methodology – Workforce Director, Nov-18
SR7: There is a risk that we fail to deliver medium & long-term financial sustainability.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent risk score, in the absence of controls</td>
<td>5</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Current risk score, with identified controls applied</td>
<td>5</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Target risk score, following actions implemented</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

To be achieved by: Apr 2020

### Potential Causes
- We fail to attract and sustain investment
- We do not forecast or plan appropriately
- We do not control expenditure, income, and cash

### Controls:
- We demonstrate cost effective services which meet quality and access standards in line with commissioner specification
- Standard financial policies and procedures.
- Transformation programme to deliver value for money.
- Cash reserves to cover expenditure
- Recovery plans in place for areas missing forecasts
- Financial approval and tender limits imposed through scheme of delegation and SFIs
- Recruitment panel process for reviewing and approving roles.
- Support and financial awareness training provided to budget holders
- Appropriately resourced and qualified finance team.

### Assurances:
- Established and monitored KPIs reported to SPTC
- Monthly contract meetings with commissioning managers & Trust operational managers
- Value for Money opinion annually audited and provided in the annual report
- Annual plan approved by the Trust Board
- In year budget changes signed off by finance director
- Forecasting reported to Board
- Monitoring non-essential spend that is not cost effective (out of area beds, agency spend, etc.)
- Internal and external audit of financial management
- NHSI scrutiny of financial plans.
- Plan for every medical vacancy.

### Gaps and actions to address:
- Workplan to strengthen commissioner specifications and ensure holistic approach to money, staff, outcomes, activity, and capacity pressure – Finance Director / Directors of Operations, Mar-19
- Programme of work to address enforcement notice from NHSI – Chief Executive / Finance Director, Aug-18
- Delivery of recovery plan – Finance Director, Oct-18
- Delivery of long term financial strategy, aligned with STP, Finance Director – Apr 20
- Project plan for purchase ordering to be implemented, aiming to achieve 100% compliance with eligible spend – Finance Director, Ongoing
- Clinical engagement in budget management – Medical Director, Apr-19
SR5: There is a risk that we have ineffective governance which prevents effective decision making.

<table>
<thead>
<tr>
<th>Transformation</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Score</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent risk score, in the absence of controls</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>High</td>
</tr>
<tr>
<td>Current risk score, with identified controls applied</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Moderate</td>
</tr>
<tr>
<td>Target risk score, following actions implemented</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

To be achieved by Dec 2018

Potential Causes:
- Our governance structures are inappropriate or ineffective
- The governance structure is not adhered to
- We do not receive timely or accurate information from which to make decisions

Controls:
- Board governance structure meets the requirements of the FT code of governance
- Data and reporting systems accurately link finance, performance, workforce, and quality information.
- Policies and procedures to guide decision-making and approval, (learning policy & strategy, SI framework, etc.)
- Board members demonstrate
- Senior management responses to escalated concerns.
- Communication and clarity of structures, ownership, and escalation processes.
- Consistent devolved accountability frameworks are in place across the Trust.

Assurances:
- Our annual compliance statement is signed off by the Board
- Regular assessment of the Trust’s governance framework under the CQC’s well led framework
- Integrated performance reports are reviewed by SPTC and the Trust Board
- Internal audit programme targets key areas of compliance risk
- Performance management processes are overseen by the executive management team
- Support from NSHI consultants
- Visible leadership programme – board walkabouts.
- Senior management committee in place to review matters escalated from divisions.

Gaps and actions to address:
- Board development plans and governance framework to be documented – Board Chair / Chief Executive, Jul-18
- Formal self-assessment of Well led in advance of CQC inspection – Chief Nurse, Jul-18
- Programme of continuous improvement to IPR process – Finance Director, Jun-18
- Activity analysis by service line – Finance Director, Dec-18
- Resilient management structure and addressing senior vacancies, Workforce director, Aug-18.
## Glossary of Terms

<table>
<thead>
<tr>
<th>Wordlist</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance</td>
<td>Also referred to as assurance measures. These are methods of measuring the level of risk and effectiveness of controls in place, for example; monitoring incidents related to the risk, formal audit reports (clinical, internal, external, etc.) or compliance with external standards (NHSI, NICE, etc.).</td>
</tr>
<tr>
<td>Assurance Gap</td>
<td>Where there are inadequate assurances; or where assurance measures are limited and cannot provide full assurance that controls are effectively mitigating the risk. Gaps should be identified and listed with actions to close.</td>
</tr>
<tr>
<td>Assurance strength</td>
<td><strong>Robust Assurance:</strong> Taking account of the issues identified, the Board can take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.</td>
</tr>
<tr>
<td></td>
<td><strong>Substantial Assurance:</strong> Taking account of the issues identified, the Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.</td>
</tr>
<tr>
<td></td>
<td><strong>Partial Assurance:</strong> Taking account of the issues identified, the Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.</td>
</tr>
<tr>
<td></td>
<td><strong>Limited Assurance:</strong> Taking account of the issues identified, the Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.</td>
</tr>
<tr>
<td>Board Assurance Framework (BAF)</td>
<td>The BAF enables the Board to: identify and understand the principal risks to achieving its strategic objectives, and understand the control and assurance framework in place to manage these risks. Further, identified areas of improvement and action plans are provided.</td>
</tr>
<tr>
<td>Control Gap</td>
<td>Where there are inadequate controls or where the controls measures are limited or incomplete. Thus where gaps are identified, there should be a list of actions to close them.</td>
</tr>
<tr>
<td>Current Risk Score</td>
<td>(This is also known, interchangeably, as the residual risk score). It is the score assigned to any risk after the control measures in place are taken into account. It involves the use of the 5x5 risk matrix with impact and likelihood being adjusted following the inherent risk score. The scoring matrix and definitions are provided following the glossary.</td>
</tr>
<tr>
<td>First line of assurance</td>
<td>See ‘lines of Assurance’</td>
</tr>
<tr>
<td>Inherent Risk Score</td>
<td>This is the score assigned to any risk, which articulated how severe and likely a risk is to occur if the controls in place are found to be ineffective, or absent. It involves the use of the 5x5 risk matrix with impact and</td>
</tr>
</tbody>
</table>
### Appendix 2. Glossary of Terms

<table>
<thead>
<tr>
<th>Wordlist</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>likelihood.</td>
<td>The scoring matrix and definitions are provided following the glossary.</td>
</tr>
<tr>
<td>Key Control</td>
<td>These are the management systems and processes the Trust have in place to manage its principal risks. Examples include professional, clinically trained staff, appropriate skill mixes and staff numbers, etc.</td>
</tr>
<tr>
<td><strong>Lines of Assurance</strong></td>
<td><strong>First line of assurance</strong>: This relates to Operational management and day-to-day assurance measures. Examples include the implementation of local policies, training compliance, and local management oversight. A key source of first line assurance for the Trust is the business intelligence and analytics system; Tableau.</td>
</tr>
<tr>
<td></td>
<td><strong>Second line of assurance</strong>: This relates to management or committee oversight (and scrutiny) of the control framework. It ensures compliance with regulations and risk management frameworks. The management or committee also ensures that the first line of defence is properly designed, in place and operating in line with objectives. Examples include formal assurance reports to executive led Groups or the Board and Board sub-committees.</td>
</tr>
<tr>
<td></td>
<td><strong>Third line of assurance</strong>: This relates to external assurance. This includes professional internal audit carried out by external agencies, external auditors, regulatory bodies such as CQC, NHSI, NHSE, NHSLA, Commissioners, Safeguarding agencies, and other groups outside the Trust.</td>
</tr>
<tr>
<td>Negative assurance</td>
<td>Negative assurance is where evidence shows that controls are not operating effectively to mitigate the risk to the achievement of objectives. An example would be a critical audit report that identifies failings.</td>
</tr>
<tr>
<td>Neutral assurance</td>
<td>A neutral assurance indicates either a new control, for which it is hard to provide sound assurance, or a mixed assurance that provides some criticism of the control framework, but also identified positives. An example would be a Friends and Family survey that contains criticism of a service, but still reflects a high percentage</td>
</tr>
<tr>
<td>Positive Assurance</td>
<td>Positive assurance indicates that controls are operating effectively to mitigate the risk to the achievement of objectives. An example would be a positive peer review, or a CQC monitoring visit that identifies no issues to be addressed in an action statement.</td>
</tr>
<tr>
<td>Limited Assurance</td>
<td>See ‘assurance strength’</td>
</tr>
<tr>
<td>Partial Assurance</td>
<td>See ‘assurance strength’</td>
</tr>
<tr>
<td>Residual Risk Score</td>
<td>See ‘current risk score’</td>
</tr>
<tr>
<td>Risk score</td>
<td>Risk score involves the use of the 5x5 risk matrix with impact and likelihood being multiplied to reach the risk score. The scoring system allows individual risks to be prioritised. Risk scores are not intended to be precise mathematical measures of risk, but are a useful tool to help in the prioritisation of action plans for the treatment of risk.</td>
</tr>
<tr>
<td>Robust Assurance</td>
<td>See ‘assurance strength’</td>
</tr>
<tr>
<td>Second line of assurance</td>
<td>See ‘lines of Assurance’</td>
</tr>
<tr>
<td>Source/categories of Assurance</td>
<td>Assurance sources can further be categorised into Positive, Neutral, and Negative, reflecting the nature of the assurance provided (for example, an</td>
</tr>
</tbody>
</table>
### Appendix 2. Glossary of Terms

<table>
<thead>
<tr>
<th>Wordlist</th>
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</tr>
</thead>
<tbody>
<tr>
<td>internal audit report</td>
<td>identifying major failings within a set of controls).</td>
</tr>
<tr>
<td>Substantial</td>
<td>See ‘assurance strength’</td>
</tr>
<tr>
<td>Target Risk Score</td>
<td>The keyword here is “target”. This is the future (or prospective) risk score assigned to any risk after gaps in control measures have been addressed, and outstanding actions implemented. It is the level of risk which the Department of Division feel they can tolerate.</td>
</tr>
<tr>
<td>Third line of assurance</td>
<td>See ‘lines of Assurance’</td>
</tr>
</tbody>
</table>

#### Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Impact</th>
<th>Catastrophic</th>
<th>Major</th>
<th>Moderate</th>
<th>Minor</th>
<th>Negligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Unlikely</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Possible</td>
<td>10</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Likely</td>
<td>15</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Almost Certain</td>
<td>20</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Escalated to the Executive</td>
<td>25</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
</tr>
<tr>
<td>Unlikely</td>
</tr>
<tr>
<td>Possible</td>
</tr>
<tr>
<td>Likely</td>
</tr>
<tr>
<td>Almost Certain</td>
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</table>
### Impact Guidance:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on the safety of the patient, staff or public (physical/psychological harm)</strong></td>
<td>Minimal injury requiring no/minimal treatment</td>
<td>Minor injury or illness, requiring minor intervention</td>
<td>Moderate injury requiring professional intervention</td>
<td>Incidents resulting serious injury or permanent disability/incapacity. Increase in length of hospital stay by &gt;15 days</td>
</tr>
<tr>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Catastrophic</td>
<td></td>
</tr>
<tr>
<td>No time off work</td>
<td>Increase in length of hospital stay by 1–3 days</td>
<td>Increase in length of hospital stay by 4–15 days</td>
<td>Mismanagement of patient care with long-term effects</td>
<td></td>
</tr>
<tr>
<td><strong>Quality/Complaints/audit</strong></td>
<td>Overall treatment or service suboptimal</td>
<td>Treatment or service has significantly reduced effectiveness</td>
<td>Non-compliance with national standards with significant risk to patients if unresolved</td>
<td>Totally unacceptable level or quality of treatment/service</td>
</tr>
<tr>
<td>Peripheral element of treatment or service suboptimal</td>
<td>Formal complaint (stage 1)</td>
<td>Formal complaint (stage 2)</td>
<td>Multiple complaints / independent review</td>
<td>Gross failure of patient safety if findings not acted on</td>
</tr>
<tr>
<td>Informal complaint/inquiry</td>
<td>Local resolution</td>
<td>Local resolution (with potential to go to independent review)</td>
<td>Low performance rating</td>
<td>Inquest/ombudsman inquiry</td>
</tr>
<tr>
<td></td>
<td>Single failure to meet internal standards</td>
<td>Repeated failure to meet internal standards</td>
<td>Critical report</td>
<td>Gross failure to meet national standards</td>
</tr>
<tr>
<td></td>
<td>Minor implications for patient safety if unresolved</td>
<td>Major patient safety implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced performance rating if unresolved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human resources/organisational development/staffing/competence</strong></td>
<td>Short-term low staffing level that temporarily reduces service quality (&lt; 1 day)</td>
<td>Low staffing level that reduces the service quality</td>
<td>Late delivery of key objective/service due to lack of staff</td>
<td>Uncertain delivery of key objective/service due to lack of staff</td>
</tr>
<tr>
<td>No or minimal impact or breach of guidance/statutory duty</td>
<td>Breach of statutory legislation</td>
<td>Unsafe staffing level or competence (&gt;1 day)</td>
<td>Unsafe staffing level or competence (&gt;5 days)</td>
<td>Non-delivery of key objective/service due to lack of staff</td>
</tr>
<tr>
<td>No or minimal impact or breach of guidance/statutory duty</td>
<td>Reduced performance rating if unresolved</td>
<td>Low staff morale</td>
<td>Loss of key staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low staff morale</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Very low staff morale</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No staff attending mandatory/key training</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statutory duty/inspections</strong></td>
<td>Breach of statutory legislation</td>
<td>Single breach in statutory duty</td>
<td>Enforcement action</td>
<td>Multiple breaches in statutory duty</td>
</tr>
<tr>
<td>No or minimal impact or breach of guidance/statutory duty</td>
<td>Reduced performance rating if unresolved</td>
<td>Challenging external recommendations/improvement notice</td>
<td>Multiple breaches in statutory duty</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Improvement notices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low performance rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Critical report</td>
<td></td>
</tr>
<tr>
<td><strong>Adverse publicity/reputation</strong></td>
<td>Rumours</td>
<td>Local media coverage—short-term reduction in public confidence</td>
<td>National media coverage with &lt;3 days service well below reasonable public expectation</td>
<td>National media coverage with &gt;3 days service well below reasonable public expectation</td>
</tr>
<tr>
<td>Potential for public concern</td>
<td>Elements of public expectation not being met</td>
<td>Local media coverage—long-term reduction in public confidence</td>
<td>MP concerned (questions in the House)</td>
<td>Total loss of public confidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Key objectives not met</td>
<td></td>
</tr>
<tr>
<td><strong>Business objectives/projects</strong></td>
<td>&lt;5 per cent over project budget</td>
<td>5–10 per cent over project budget</td>
<td>10–25 per cent over project budget</td>
<td>&gt;25 per cent over project budget</td>
</tr>
<tr>
<td>Insignificant cost increase/schedule slippage</td>
<td>Schedule slippage</td>
<td>Schedule slippage</td>
<td>Schedule slippage</td>
<td>Schedule slippage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Key objectives not met</td>
<td></td>
</tr>
</tbody>
</table>

180605 TB 18.2 App 2
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance including claims</strong></td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
</tr>
<tr>
<td>Negligible loss</td>
<td>Loss of less than £10,000</td>
<td>Loss of between £10,000 and £100,000</td>
<td>Loss of between £100,000 and £1 million</td>
<td>Loss of major contract / payment by results</td>
<td></td>
</tr>
<tr>
<td>Failure to meet CIPs or CQUINs targets of between £10,000 and £50,000</td>
<td>Purchasers fail to pay promptly</td>
<td>Failure to meet CIPs or CQUINs targets of between £50,000 and £0.5 million</td>
<td>Loss of more than £1 million</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to meet CIPs or CQUINs targets of between £50,000 and £0.5 million</td>
<td>Loss of major contract / payment by results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of between £100,000 and £1 million</td>
<td>Loss of more than £1 million</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of more than £1 million</td>
<td>Failure to meet CIPs or CQUINs targets of more than £0.5 million</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service/business interruption</td>
<td>Loss/interruption of &gt;1 hour</td>
<td>Loss / interruption of &gt;8 hours</td>
<td>Loss / interruption of &gt;1 day</td>
<td>Loss / interruption of &gt;1 week</td>
<td>Permanent loss of service or facility</td>
</tr>
<tr>
<td>Environmental impact</td>
<td>Minimal or no impact on the environment</td>
<td>Minor impact on environment</td>
<td>Moderate impact on environment</td>
<td>Major impact on environment</td>
<td>Catastrophic impact on environment</td>
</tr>
<tr>
<td>Information Governance</td>
<td>Minor breach of confidentiality.</td>
<td>Breach with potential for theft, loss or communicating/sharing inappropriate information with between 20 – 50 people affected</td>
<td>Breach with potential for theft, loss or communicating/sharing inappropriate information with over 50 – 100 people affected</td>
<td>Serious breach with potential for theft, loss or communicating/sharing completely inappropriate information with over 100 - 500 people affected</td>
<td>Major breach with potential for theft, loss or communicating/sharing completely inappropriate information with over 500 people affected</td>
</tr>
<tr>
<td>Single individual affected</td>
<td>Theft, loss or clinical information of up to 20 people affected (unencrypted media)</td>
<td>Loss or misuse of very sensitive / confidential information relating to 2-5 persons</td>
<td>Loss or misuse of very sensitive / confidential information relating to 5-20 persons</td>
<td>Damage to an organisation’s reputation/ Local media coverage due to IG breach</td>
<td>Loss or misuse of extremely sensitive / confidential information relating to over 20 people (e.g. sexual health information, along with names and addresses)</td>
</tr>
<tr>
<td>Damage to NHS reputation/ National media coverage due to IG breach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Likelihood Guidance**

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>Descriptor</th>
<th>Frequency</th>
<th>Probability Chance of occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>• This will probably never happen/recur&lt;br&gt;• Not expected to occur for years</td>
<td>&lt; 20%</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>• Do not expect it to happen/recur but it is possible it may do so&lt;br&gt;• Expected to occur at least annually</td>
<td>20%-40%</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>• Might happen or recur occasionally&lt;br&gt;• Expected to occur at least monthly / bi-monthly</td>
<td>40%-60%</td>
</tr>
<tr>
<td>4</td>
<td>Likely</td>
<td>• Will probably happen/recur, but it is not a persisting issue/circumstances&lt;br&gt;• Expected to occur at least weekly / monthly</td>
<td>60%-80%</td>
</tr>
<tr>
<td>5</td>
<td>Almost certain</td>
<td>• Will undoubtedly happen/recur, possibly frequently&lt;br&gt;• Expected to occur at least daily</td>
<td>&gt; 80%</td>
</tr>
<tr>
<td>REPORT TO THE TRUST BOARD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>05.06.2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agenda Item</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Risk Report to the Trust Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Jake Pursaill, Risk Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Julie Dawes, Director of Nursing &amp; Allied Health Professionals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Purpose & Action Required

The Committee is asked to discuss the key operational risks highlighted in this report. Further, the committee is asked to take assurance that the Trust is appropriately sighted on, and working to mitigate, the identified risks.

### Executive Director Overview

The structure of operational risk management is set out for the Board to take assurance that key risks are being controlled and overseen by the divisional, executive and Board Sub-Committee structure. The highest rated risks on the risk register and current progress is summarised in the report. An appendix illustrating the trajectory of these risks is provided for the Board’s reference.

### Previously considered by:

Executive Risk & Assurance Group

### Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Strategic Priorities this paper supports:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>✗</td>
</tr>
<tr>
<td>People</td>
<td>✗</td>
</tr>
<tr>
<td>Transformation</td>
<td>✗</td>
</tr>
<tr>
<td>Money</td>
<td>✗</td>
</tr>
</tbody>
</table>

### Does this impact any Board Assurance Framework / Corporate Risks

This report provides assurance against SR5: There is a risk that we have ineffective governance which prevents effective decision making.
RISK REPORT TO THE TRUST BOARD

1. **Purpose**

1.1. This report seeks to assure the Board that the risk management framework employed by the Trust to identify, manage, and escalate operational risks is appropriate and effective.

1.2. Further, the report highlights key operational risks that are outside the Trust’s tolerance and details actions underway to mitigate these risks.

2. **Background**

2.1. While individual employees within the Trust are responsible for identifying and managing risk, the Trust Board is responsible for governing the management of risk within the Trust. The Audit, Assurance, and Risk Committee has delegated responsibility to seek assurance that risks outside the Trust’s tolerance are appropriately identified and managed.

2.2. The Trust Risk Management Strategy and Policy document details the framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, Foundation Trust Terms of Authorisation and its strategic objectives. The policy also identifies individuals with specific responsibility, accountability and authority, as part of their existing roles.

2.3. This report is based on risk reports and supporting data from the month of February 2018. The trajectories of risk scores for the Trust’s key operational risks are provided as **appendix 1**.

2.4. A glossary of terms and phrases used in this report has been included in this report. See **appendix 2**.

3. **Risk Management Framework**

3.1. The risk management framework is part of the annual internal audit process. The most recent audit was completed in April 2017 and provided an amber / green assurance rating. All outstanding actions have been implemented in December 2017. The 2018/19 risk management audit occurred in January 2018, and was reported to the Audit, Assurance, and Risk Committee in May 2018. The identified recommendations are to be implemented by July 2018.

3.2. The Risk Manager benchmarks quality metrics against similarly sized Trusts in the local area. The total number of identified risks, and the number of closed and new risks per month compare favourably.

4. **Key Operational Risks**

4.1. All risks identified across the Trust scoring ‘fifteen’ and above are escalated to the Executive Risk & Assurance Group monthly. These risks are considered for the Trust risk register; risks that impact significantly across the Trust, sitting outside the Trust’s tolerance. These risks are summarised below:
<table>
<thead>
<tr>
<th>Title</th>
<th>Current Risk Score</th>
<th>Progress Summary</th>
<th>Target Risk Score</th>
</tr>
</thead>
</table>
| **576:** There is a risk that the Trust will not be able to provide safe and high quality services due to the inability to maintain safe staffing levels. **Hotspots:** AMH Vacancies (749) Hollybank consultant cover (1661) Eating Disorder Services (920) Lymington – The Practice (1538) Specialised Services – Bluebird Specialised Services – Leigh House (1336) Specialised Services – Southfield Specialised Services – Ravenswood LD – Hampshire OPMH Community South | (I x L) 4 x 5 20 | A number of work streams with respect to recruitment of nursing workforce are underway. A Task and Finish Group has been established to support these workstreams. New ways of rostering are being reviewed. The work to gain greater detailed understanding of the reasons people are leaving the Trust has been finalised and there are three major reasons why staff appear to be leaving:  
- Lack of flexibility in their current working arrangements  
- Lack of career progression  
- Attitude/approach by manager | (I x L) 4 x 3 12  Dec-18 |
<p>| <strong>872:</strong> There is a risk that Trust staff have to manage patients in inpatient mental health and learning disability units who present violently using everyday items fashioned to harm themselves and others, but do not have any training in de-escalating patients, as the Trust’s restraint training programme does not currently include such training. The police increasingly decline to assist in such incident in mental health units | (I x L) 5 x 3 15 | Liaison with Hampshire Constabulary is on-going, both via Safer Forum and the Trust Executive. However, police continue to decline to attend to assist in inpatient mental health units when patients present with weapons and high risk of harm to others, hence risk rating cannot be downgraded. Safer forum has developed a proposal for training a cohort of staff to assist in such situations; this will go to the Trust executive committee for review. | (I x L) 5 x 2 10  Aug-18 |
| <strong>241:</strong> RAVENSWOOD DEROGATION- Ravenswood is not compliant with Medium Secure Standards and is in derogation due to poor lines of sight and lack of perimeter fence. | (I x L) 5 x 3 15 | Perimeter Fence approved, subject to confirmation of final costings. Approval at the Quarterly Capital Prioritisation Panel (QPP) constitutes endorsement of scheme as a strategic or operational requirement, contingent on completion of any actions determined at QPP. Following this approval, final costs and project timescales must now be confirmed and any outstanding documentation requirements completed. Final approval to proceed will be provided by the Capital Governance Group upon confirmation of costs, scope and timescales, Delivery of the scheme will be supported through the Estates Capital Management Group | (I x L) 2 x 2 4  Oct-19 |</p>
<table>
<thead>
<tr>
<th>Title</th>
<th>Current Risk Score</th>
<th>Progress Summary</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1556: There is a risk that patients will not be able to access primary care services from the Willow Group in Gosport due to the telephone systems not being fit for purpose.</td>
<td>(I x L) 3 x 5 15</td>
<td>The new connection has been procured, which has the biggest lead time. We have started to gather the information about telephony in use at the practices in readiness for commencing the detailed planning stage. Until we have a firm date for the connection, everything else is preparatory work.</td>
<td>(I x L) 3 x 2 6 Jul-18</td>
</tr>
<tr>
<td>1621: There has been an increase in self-harming behavior through swallowing items, such as batteries, toothbrushes, pens etc. at Bluebird Adolescent Secure Hospital. This has resulted in increased visits to University Hospital of Southampton and reduced staffing on the unit to facilitate such trips. Subsequently, patients are placing themselves at increased risk of long term harm.</td>
<td>(I x L) 5 x 3 15</td>
<td>While incidents are reducing month by month, the majority of the remaining swallowing incidents relate to Hill Low Secure Ward. A review of security procedures has taken place and Hill Ward is now subject to the same security measures as the other wards. A management of devices containing batteries protocol has been developed and is due for sign off in their next local governance meeting.</td>
<td>(I x L) 5 x 2 10 Jun-18</td>
</tr>
<tr>
<td>1577: There is a risk that we do not achieve the high level of CIPs required (5%) for 18/19 as a result of the high percentage of non-recurrent CIPS identified in 17/18 (60%).</td>
<td>(I x L) 5 x 4 20</td>
<td>Teams have identified £10.9m (83%) of the required CIP schemes but further work is being done to assess the risks on these CIP and ensure that the QIA is robust. Schemes will be signed off by the Chief Nurse and Medical Director. Further work will continue to identify the remaining schemes which are mainly focused in the Adult Mental Health Division and Estates Services. The quarter 1 financial position will be impacted by the delay in implementing cost reductions.</td>
<td>(I x L) 5 x 2 10 Apr-19</td>
</tr>
<tr>
<td>1187: Financial exposure / cost pressure - due to persistent use of Mental Health beds over and above available beds within SHFT</td>
<td>(I x L) 4 x 5 20</td>
<td>The spend on out of area beds in April was in excess of £1m. Since 26/4 the beds have been steadily reducing from 55 to 37 as at 16/5. The Medical Director is now supporting the division in reducing bed numbers and a comprehensive plan is being finalised. This plan and the long term KPIs will be monitored and reported within the IPR with detailed updates in SP&amp;TC.</td>
<td>(I x L) 2 x 3 6 Sep-18</td>
</tr>
</tbody>
</table>
5. **New Key Risks**

5.1. One new risk has been escalated from the Trust Executive Risk & Assurance Group for the Board’s attention:

<table>
<thead>
<tr>
<th>Title</th>
<th>Current Risk Score</th>
<th>Progress Summary</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1569: SECURE PATIENT TRANSPORT- There is a risk that the service users requiring secure transport to access medical treatment are currently experiencing a delay accessing this treatment.</td>
<td>(I x L) 3 x 5 15</td>
<td>Mental Health went into an arrangement two years ago to cover this activity. However the CCG has taken this responsibility for MH, but excludes Specialised Services, which is now outside contract. This is leading to a delay in procuring transport. Evaluation and clarification interviews of tenders have been completed, as well as the scoring. The tender will shortly be awarded. It is expected that the mobilisation of the service will be quick, but timescale not formally confirmed.</td>
<td>(I x L) 4 x 2 8 Aug-18</td>
</tr>
</tbody>
</table>

6. **Reducing Key Operational Risks**

6.1. The following risk was reviewed at the executive risk and assurance group in April and has been closed.

<table>
<thead>
<tr>
<th>Title</th>
<th>Progress Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1323: Financial Penalty and Fine arising from legal prosecution by the CQC and Health &amp; Safety Executive</td>
<td>The Trust is now aware of the outcome of the prosecution, and as such this is no longer a risk.</td>
</tr>
</tbody>
</table>
7. **Mitigating Actions**

7.1. A summary of actions proposed to further mitigate key operational risks are outlined below.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>576:</td>
<td>There is a risk that the Trust will not be able to provide safe and high quality services due to the inability to maintain safe staffing levels.</td>
<td><strong>Director of Workforce</strong>&lt;br&gt;- Implementation of HR strategy. 01/12/18&lt;br&gt;- Implementation of Safe Care and development of process to validate community team establishments. Pilot sites will go live in two weeks. 18/11/18&lt;br&gt;- Development of process to validate community team establishments as we currently do for inpatient areas. 08/06/18</td>
</tr>
<tr>
<td>872:</td>
<td>There is a risk that Trust staff have to manage patients in inpatient mental health and learning disability units who present violently but do not have any training in disarming patients, as the Trust's restraint training programme does not currently include such training. The police increasingly decline to assist in such incident in mental health units.</td>
<td><strong>Director of Operations, MH &amp; LD</strong>&lt;br&gt;- To continue strategic liaison with police through Crisis Concordat, and develop an overarching Trust Memorandum of Understanding with Hampshire Constabulary. 31/08/18&lt;br&gt;- Training in the management of situations where patients use everyday items with which to harm themselves and others opportunistically, in specific inpatient forensic units will be introduced. Training is being sourced. 31/08/18</td>
</tr>
<tr>
<td>241:</td>
<td>Ravenswood derogation - Ravenswood is not compliant with Medium Secure Standards and is in derogation due to poor lines of sight and lack of perimeter fence.</td>
<td><strong>Director of Operations, MH &amp; LD</strong>&lt;br&gt;- Option 8 to be presented to Trust board and agreed. 30/09/18</td>
</tr>
<tr>
<td>1566:</td>
<td>There is a risk that patients will not be able to access primary care services from the Willow Group in Gosport due to the telephone systems not being fit for purpose.</td>
<td><strong>None</strong> – all actions have been completed.</td>
</tr>
<tr>
<td>1577:</td>
<td>There is a risk that we do not achieve the high level of CIPs required (5%) for 18/19 as a result of the high percentage of non-recurrent CIPS identified in 17/18 (60%).</td>
<td><strong>Finance Director / Director of Operations, MH &amp; LD / Director of Operations, ISD</strong>&lt;br&gt;- Schemes to be supported by full documentation and Quality Impact Assessments 10/06/18</td>
</tr>
<tr>
<td>1621:</td>
<td>There has been an increase in self-harming behavior through swallowing items, such as batteries, toothbrushes, pens etc. at Bluebird Adolescent Secure Hospital. This has resulted in increased visits to University Hospital of Southampton and reduced staffing on the unit to facilitate such trips. Subsequently, patients are placing themselves at increased risk of long term harm.</td>
<td><strong>Director of Operations, MH &amp; LD</strong>&lt;br&gt;- Review staff training and local processes to minimize access to swallowing items for at-risk patients. 10/06/18</td>
</tr>
<tr>
<td>1187:</td>
<td>Financial exposure / cost pressure - due to persistent use of Mental Health beds over and above available beds within SHFT</td>
<td><strong>Finance Director / Director of Operations, MH &amp; LD</strong>&lt;br&gt;- Implementation of HR strategy to fill vacant posts, increasing number of available local beds. 01/12/18</td>
</tr>
<tr>
<td>1569:</td>
<td>SECURE PATIENT TRANSPORT- There is a risk that the service users requiring secure transport to access medical treatment are currently experiencing a delay accessing this treatment.</td>
<td><strong>Director of Operations, MH &amp; LD</strong>&lt;br&gt;- Procure new contract for specialised services patient transport. 01/08/18</td>
</tr>
</tbody>
</table>
8. **Recommendations**

8.1. The Board is asked to:
   - Take assurance from the structures and overview provided that the Trust is appropriately sighted on, and managing, key operational risks.

9. **Appendices**
   Appendix 1: 15+ Risk Report Trajectory JUN 2018
   Appendix 2: Glossary of Terms v4
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Title</th>
<th>Date Identified</th>
<th>Inherent Risk Score (IxL)</th>
<th>Jun 17</th>
<th>Jul 17</th>
<th>Aug 17</th>
<th>Sep 17</th>
<th>Oct 17</th>
<th>Nov 17</th>
<th>Dec 17</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18</th>
<th>Apr 18</th>
<th>May 18</th>
<th>Target Risk Score (IxL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>576</td>
<td>There is a risk that the Trust will not be able to provide safe and high quality services due to the inability to maintain safe staffing levels.</td>
<td>25/09/14</td>
<td>4 x 5 20</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20 4 x 3 12 Dec-18</td>
<td></td>
</tr>
<tr>
<td>241</td>
<td>Ravenswood is not compliant with Medium Secure Standards and is in derogation due to poor lines of sight and lack of perimeter fence.</td>
<td>03/09/12</td>
<td>5 x 4 20</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
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<td>15</td>
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<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15 2 x 2 4 Oct-19</td>
<td></td>
</tr>
<tr>
<td>1566</td>
<td>There is a risk that patients will not be able to access primary care services from the Willow Group in Gosport due to the telephone systems not being fit for purpose.</td>
<td>07/12/17</td>
<td>3 x 5 15</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15 3 x 2 6 Jul-18</td>
<td></td>
</tr>
<tr>
<td>872</td>
<td>There is a risk that Trust staff have to manage patients in inpatient mental health and learning disability units who present violently but do not have any training in disarming patients, as the Trust's restraint training programme does not currently include such training. The police increasingly decline to assist in such incident in mental health units.</td>
<td>24/03/16</td>
<td>5 x 4 20</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15 5 x 2 10 Aug-18</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Risk Title</td>
<td>Date Identified</td>
<td>Inherent Risk Score (IxL)</td>
<td>Jun 17</td>
<td>Jul 17</td>
<td>Aug 17</td>
<td>Sep 17</td>
<td>Oct 17</td>
<td>Nov 17</td>
<td>Dec 17</td>
<td>Jan 18</td>
<td>Feb 18</td>
<td>Mar 18</td>
<td>Apr 18</td>
<td>May 18</td>
<td>Target Risk Score (IxL)</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>--------</td>
<td>--------</td>
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<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>1621</td>
<td>There has been an increase in self-harming behaviour through swallowing items, such as batteries, toothbrushes, pens etc. at Bluebird Adolescent Secure Hospital. This has resulted in increased visits to University Hospital of Southampton and reduced staffing on the unit to facilitate such trips. Subsequently, patients are placing themselves at increased risk of long term harm.</td>
<td>28/02/18</td>
<td>5 x 3 15</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>5 x 2 10 Jun-18</td>
</tr>
<tr>
<td>1187</td>
<td>Financial exposure / cost pressure - due to the number of Mental Health out of area placements.</td>
<td>25/01/17</td>
<td>5 x 4 20</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>2 x 3 6 Sep-18</td>
</tr>
<tr>
<td>1569</td>
<td>SECURE PATIENT TRANSPORT- There is a risk that the service users requiring secure transport to access medical treatment are currently experiencing a delay accessing this treatment.</td>
<td>04/05/18</td>
<td>3 x 5 15</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>#N/A</td>
<td>12</td>
<td>12</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>20</td>
</tr>
<tr>
<td>Title</td>
<td>Corporate Governance Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Anna Williams, Company Secretary</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Dr Nick Broughton, Chief Executive</td>
</tr>
</tbody>
</table>

**Purpose & Action Required**

This report is to summarise items requiring approval by the Board and matters that the Board should note. Specifically, the Board is asked to:

- Ratify the use of emergency powers (as set out in paragraph 2.1);
- Approve the variation to the membership of the Senior Management Committee;
- Approve the Terms of Reference of the:
  - Finance & Performance Committee (as successor to the Service Performance & Transformation Committee) (Appendix 2)
  - Quality & Safety Committee (Appendix 3)
  - Transformation Steering Committee (Appendix 4);
- Comment on and approve the Memorandum of Understanding for the Division of Responsibilities between the Chair and Chief Executive (Appendix 5);
- Endorse the criteria for the discussion of confidential business in private (as set out in paragraph 7).

**Executive Director Overview**

This report provides an update on key corporate governance matters that the Board should note, and requires decision on items as identified in the recommendations set out above.

**Previously considered by:** N/A

**Strategic Priorities this paper supports:**

<table>
<thead>
<tr>
<th>Quality</th>
</tr>
</thead>
</table>

| People | |
|--------| Changes to the Board of Directors and Council of Governors are outlined in this report |
| Transformation |  |
| Money |  |
| Does this impact any Board Assurance Framework / Corporate Risks | SR5: There is a risk that we have ineffective governance which prevents effective decision making. |
CORPORATE GOVERNANCE REPORT

1. Purpose

1.1. This report is to summarise items requiring approval by the Board and matters that the Board should note.

2. Use of emergency powers

2.1. On 8 May 2018, consideration was given to the Trust’s self-assessment of readiness in relation to the 10 Data Security Protection Requirements. NHS Improvement required Trust’s to submit a Board approved self-certification by 11 May 2018. A report was considered and support by members of the Board, with authorisation given to make the required submission (Appendix 1). This was approved via the exercise of emergency powers, as set out in the Trust’s Standing Orders. The Board is asked to ratify this decision.

2.2. There has been no other use of emergency powers in the period 27.03.2018 up to the point of writing the report (21.05.2018).

3. Board of Directors

3.1. The Trust has confirmed the appointment of Barry Day as Chief Operating Officer; he will commence in post in July.

3.2. Julie Dawes will leave the Trust in August 2018; the interview process for her successor is scheduled for Wednesday 20 June.

3.3. Mark Morgan left the Trust on Friday 18 May; Debbie Robinson has been appointed as Interim Director of Operations for Mental Health & Learning Disabilities for a four month period.

3.4. In light of new executive appointments to the Board, a meeting of the Appointment Committee is scheduled for 29.05.2018 to commence the Non-Executive Director appointment process.

4. Council of Governors

4.1. Elections are currently underway in the following constituencies:

4.1.1. Public Southampton (2)
4.1.2. Public South West Hampshire (2)
4.1.3. Public South East Hampshire (1)
4.1.4. Public North Hampshire (1)

4.1.5. Staff constituency (2), comprising:

4.1.5.1. South East Hampshire class (1)
4.1.5.2. North Hampshire class (1)

4.2. Cllr Paul Lewzey resigned as Appointed Governor from the Council of Governors with effect from 03.05.2018. The Trust has invited a further nomination from Southampton City Council.

4.3. The election timetable is set out below:
5. **Board Committees**

5.1. **Variation to Senior Management Committee Terms of Reference**

5.1.1. Further amendments to the membership of the Senior Management Committee are proposed as follows:

5.1.1.1. The addition of the Chief Operating Officer (from July 2018), the Head of Psychological Therapies and the Head of Executive Affairs & Projects

5.1.1.2. The removal of the Director of Corporate Governance.

5.2. **Finance & Performance Committee**

5.2.1. The Board is asked to approve the establishment of a Finance & Performance Committee, and approve the attached Terms of Reference (Appendix 2); this will be a successor committee to the Service Performance & Transformation Committee.

5.3. **Audit, Risk & Assurance Committee**

5.3.1. Work is underway to review the Terms of Reference for the Audit, Risk & Assurance Committee to take account of the specimen Terms of Reference for an NHS Foundation Trust published in the HFMA Audit Committee handbook. Governors will be consulted on these Terms of Reference, in line with the recommendation in the *NHS Foundation Trust Code of Governance*. It is expected that these be presented to the Board in July for approval.

5.4. **Quality & Safety Committee**

5.4.1. The Board is asked to approve the Terms of Reference for the Quality & Safety Committee (Appendix 3); these were considered by the Committee in March 2018.

5.5. **Transformation Steering Committee**

5.5.1. The Board is asked to approve the establishment of a Transformation Steering Committee; the Terms of Reference are attached at Appendix 4.

6. **Statement of Division of Responsibilities between Chair and Chief Executive**

6.1. The NHS Foundation Trust Code of Governance requires that NHS Foundation Trust have in place a statement, agreed by the Board, which sets out the different, but complementary roles of the Chair and Chief Executive.

6.2. Appendix 5 sets out a draft Memorandum of Understanding for the Division of Responsibilities between the Chair and Chief Executive for approval by the Board.

7. **Criteria for discussion of confidential business in private**

7.1. The Board is committed to working in an open and transparent way and to limiting business considered in confidential session of the Board. It is proposed that the Board
formally endorse the principles for business to be discussed in confidential session, noting that these are the principles that have been used in practice to date.

7.2. The following criteria are proposed for business to be discussed in private:

7.2.1. Any matter arising from individual contracts of employment (as opposed to general HR policy issues);
7.2.2. Any matter which involves the consideration of confidential information which the Trust has a duty of confidentiality to a third party;
7.2.3. Commercial matters where public disclosure might reasonably be expected to disadvantage the Trust in commercial relationships;
7.2.4. Legal advice and communications with legal advisers subject to legal privilege;
7.2.5. The conduct of actual or anticipated litigation, including any arbitration or dispute resolution process;
7.2.6. Drafts of documents not in final form where early publication is restricted by external regulatory authorities.

7.3. An indication, where appropriate, will be given on the agenda, as to why the item will be considered by the Board in private.

8. Information provided to Board between meetings

8.1. A log of information that has been sent to Board members between meetings is attached at Appendix 6.

9. Trust Seal

9.1. The following entries have been made to the Register of sealing since last reported:

<table>
<thead>
<tr>
<th>Entry</th>
<th>Description</th>
<th>Date</th>
<th>Signatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>450</td>
<td>Lease relating to Fleet Community Hospital, Church Road, Fleet, GU51 4lz</td>
<td>16.03.2018</td>
<td>• Finance Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Interim Medical Director</td>
</tr>
<tr>
<td>451</td>
<td>Supp Agreement to the land retained at Antelope House, Royal South Hants Hospital, Southampton</td>
<td>16.03.2018</td>
<td>• Finance Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Interim Medical Director</td>
</tr>
<tr>
<td>452</td>
<td>Lease relating to Reside Housing Association Ltd, 36 Station Road, Petersfield, GU32 3ES</td>
<td>02.05.18</td>
<td>• Director of Nursing &amp; AHPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Finance Director</td>
</tr>
</tbody>
</table>

10. Recommendation

10.1. The Board is asked to:

- Note this report;
- Ratify the use of emergency powers (as set out in paragraph 2.1);
- Approve the variation to the membership of the Senior Management Committee
- Approve the Terms of Reference of the:
- Finance & Performance Committee (as successor to the Service Performance & Transformation Committee) (Appendix B)
- Quality & Safety Committee (Appendix C)
- Transformation Steering Committee (Appendix D)
- Comment on and approve the Memorandum of Understanding for the Division of Responsibilities between the Chair and Chief Executive (Appendix E)
- Endorse the criteria for the discussion of confidential business in private

11. Appendices

Appendix 1: Self-assessment of readiness in relation to Data Security Protection Requirements
Appendix 2: Terms of Reference for the Finance & Performance Committee
Appendix 3: Terms of Reference for the Quality & Safety Committee
Appendix 4: Terms of Reference for the Transformation Steering Committee
Appendix 5: Memorandum of Understanding for the Division of Responsibilities between the Chair and Chief Executive
**REPORT TO THE TRUST BOARD: Data Security Protection Requirements (DSPR)**

<table>
<thead>
<tr>
<th>Date</th>
<th>04/05/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>Ad-hoc item for Board consideration/approval</td>
</tr>
<tr>
<td>Title</td>
<td>Submission of DSPR compliance to NHS Improvements (NHSI).</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Ed Purcell – IT Security Specialist</td>
</tr>
</tbody>
</table>
| Purpose           | • To provide assurance regarding the Trust’s compliance with the DSPR.  
                    • To gain authorisation from the board to submit the Trust’s DSPR compliance to NHSI. |
| Previously Considered by | N/A |
| Sponsoring Director | Paula Anderson – Finance Director / SIRO |

**Executive Director Overview**

This report aims to provide a summary of the DSPR requirements and provide the Trust current status against the standard.

The submission, in most cases, requires a status of either 'Fully Implemented', ‘Partially Implemented’, or ‘Not Implemented’. There is no requirement to evidence against each of the statements.

In instances of requirements that are to be submitted as ‘Partially Implemented’ or ‘Not Implemented’ further background is provided to the Board as assurance that appropriate action plans are in place.

**Action Required**

The Board is asked to review the Trust’s current position against DSPR and approve the final submission to NHSI.
1. **Purpose**

1.1. To provide the Board with assurance regarding the Trusts compliance with the 10 Data Security Protection Requirements (DSPR), following a request from NHS Improvement for all Boards to confirm compliance by 11 May 2018.

2. **Background**

2.1. In January 2018 the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards to improve data security and protection for health and care organisations.

2.2. The DSPR are based on the recommendations made by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by government in July 2017.

2.3. All providers of health and care must comply with the standards and this will be assessed on an annual basis through the revised Information Governance Toolkit for 2018/19 which has been renamed Data Security and Protection Toolkit (DSPT) and has been live since April 2018.

2.4. The first performance review submission of the new DSPT does not take place until October 2018 and it will not be until this date that governing bodies can understand the level of cyber assurance nationally across the sector. In light of this NHSI have asked all providers to confirm whether or not they are complying with the DSPR standards. As part of the assurance process, the board must sign off the response before it is submitted.

3. **DSPR Submission to NHSI**

3.1. The 10 standards are grouped into three leadership obligations; People, Process, Technology. Against each standard the Trust must select the simple statement which is applicable.

3.2. The following is the response as compiled by the Head of Information Assurance, the Head of IT Operations and IT Security Specialist. [The response highlighted in blue is the recommended submission to NHSI]

3.3. For those standards that are not ‘Fully Implemented’ brief notes are provided on the current position and plans for development – these are provided for the board’s benefit and are not part of the submission to NHSI.

**Leadership obligation 1: PEOPLE**

3.4. **Senior level responsibility**

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation has a named senior executive who reports to the board who is responsible for data and cyber security and this person is also the SIRO</td>
<td>The organisation has a named senior executive who reports to the board who is responsible for data and cyber security but this person is not the SIRO</td>
<td>The organisation does not have a named senior executive who is responsible for data and cyber security</td>
</tr>
</tbody>
</table>
Appendix 1

3.5. Completing the Information Governance toolkit v14.1

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation has completed the IG toolkit, submitted its results to NHS Digital and obtained either level 2 or 3.</td>
<td>The organisation has completed the IG toolkit and submitted its results to NHS Digital but has not attained level 2.</td>
<td>The organisation has not completed the IG toolkit and submitted the results to NHS Digital</td>
</tr>
</tbody>
</table>

3.6. Preparing for the introduction of the GDPR in May 2018

<table>
<thead>
<tr>
<th>Fully Implemented</th>
<th>Partially Implemented</th>
<th>Not Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>By May 2018, the organisation will have an approved plan to detail how it will achieve compliance with the GDPR. This will have board-level sponsorship and approval.</td>
<td>By May 2018, the organisation will have a plan that has been developed but not yet sponsored and approved at board level on how it will achieve compliance with the GDPR.</td>
<td>A plan has not been yet been developed.</td>
</tr>
</tbody>
</table>

- Planning for GDPR has been ongoing in excess of 12mths and development plans have been in place that have been reported on a regular basis to the Information Governance Group (IGG).
- GDPR planning/progress reports have also been provided to the following committees: Trust Exec Committee (TEC); Senior Management Committee (SMC); Audit, Assurance and Risk Committee (AARC).
- A GDPR readiness assessment was carried out by RSM, the Trust’s internal auditors, the week commencing 23 April. The formal report has not yet been returned as of 4 May.

3.7. Training staff

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 95% of staff have completed either the previous IG training or the new training in the last twelve months.</td>
<td>At least 85% of staff have completed either the previous IG training or the new training in the last twelve months.</td>
<td>Less than 85% of staff have completed either the previous IG training or the new training</td>
</tr>
</tbody>
</table>

Leadership Obligation 2: PROCESSESS

3.8. Acting on CareCERT advisories

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation has registered for CareCERT Collect</td>
<td>The organisation has not registered for CareCERT Collect</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

### Appendix 1

<table>
<thead>
<tr>
<th>The organisation has plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organization (Note: the plan could be that the board accepts the residual risk)</th>
<th>The organisation does not have plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organisation</th>
<th>The organisation has not registered for CareCERT Collect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully implemented</strong></td>
<td><strong>Partially implemented</strong></td>
<td><strong>Not implemented</strong></td>
</tr>
<tr>
<td>The organisation has clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place.</td>
<td>The organisation does not have clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, but is developing these processes.</td>
<td>The organisation does not have clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, and these processes are not under development.</td>
</tr>
<tr>
<td><strong>Fully implemented</strong></td>
<td><strong>Partially implemented</strong></td>
<td><strong>Not implemented</strong></td>
</tr>
<tr>
<td>The organisation has in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories.</td>
<td>The organisation does not have in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories, but is in the process of filling that role.</td>
<td>The organisation does not have in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories, and no plans are in place to fill that role.</td>
</tr>
</tbody>
</table>

### 3.9. Business continuity planning

<table>
<thead>
<tr>
<th>The organisation has an agreed business continuity plan(s) for cyber security incidents in place. The plan(s) take into account the potential impact of any loss of services on external organisations in the health and care system.</th>
<th>The organisation is developing a business continuity plan(s) for data and cyber security incidents. The plan(s) will take into account the potential impact of any loss of services on external organisations in the health and care system.</th>
<th>The organisation does not have a continuity plan for data and cyber security incidents in place.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully implemented</strong></td>
<td><strong>Partially implemented</strong></td>
<td><strong>Not implemented</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The business continuity plan for cyber security incidents in has been tested in 2017/18.</td>
<td>The business continuity plan for data and cyber security incidents has not been tested in 2017/18.</td>
</tr>
</tbody>
</table>
Appendix 1

- The last 12 months have seen testing of many components of the IT infrastructure through standard operational activities. This includes testing elements of the DR plan through planned maintenance activities (for example recovering services or failing to the secondary site) and also includes responding to operational incidents for which the response would be to perform a component or process of the DR plan.

- Ongoing improvements are being made to enhance infrastructure and systems resilience – controls which protect against a requirement to enact a DR scenario. Plans are also in place to ensure that where possible individual aspects of the IT environment are DR tested through planned testing where these may not be tested through standard operational activities.

- A full test of the IT recovery plan would be a major event and one which would invariably cause widespread disruption to services. A test of this nature would require high level organisation buy-in.

3.10. Reporting incidents

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation has a process or working procedure in place for staff to report data security incidents and near misses</td>
<td>The organisation is developing a process or working procedure for staff to report data security incidents and near misses</td>
<td>The organisation does not have a process or working procedure in place for staff to report data security incidents and near misses</td>
</tr>
</tbody>
</table>

Leadership obligation 3: TECHNOLOGY

3.11. Unsupported systems

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation has reviewed all its systems and any unsupported systems have been identified and logged on the organisation’s relevant risk register</td>
<td>The organisation has reviewed all its systems and any unsupported systems have been identified but not logged on the organisation’s relevant risk register</td>
<td>The organisation has not reviewed its systems to identify any that are unsupported</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>By May 2018 the organisation will have developed a plan to remove, replace or actively mitigate or manage the risks associated with unsupported systems</td>
<td>By May 2018 the organisation will not have a plan in place to remove, replace or actively mitigate or manage the risks associated with unsupported systems</td>
</tr>
</tbody>
</table>

3.12. On-site cyber and data security assessments

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
</table>
The organisation has undergone an NHS Digital on-site cyber and data security assessment

Prior to 31 March 2018 the organisation signed up to undergo an NHS Digital on-site cyber and data security assessment but has not yet

Prior to 30 March 2018 the organisation has not signed up to an NHS Digital on-site cyber and data security assessment

Yes

The organisation has used an external vendor to audit the organisation’s data and cyber security risks

The organisation has not used an external vendor to audit the organisation’s data and cyber security risks

No

3.13. Checking Supplier Certification

<table>
<thead>
<tr>
<th>Fully implemented</th>
<th>Partially implemented</th>
<th>Not implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation has checked that the suppliers of all its IT systems have appropriate certification, and can evidence that all suppliers have such certification.</td>
<td>The organisation has checked that the suppliers of IT systems that relate to patient data, involve clinical care or identifiable data have appropriate certification, and can evidence that all suppliers have such certification.</td>
<td>The organisation has not checked whether its suppliers of IT systems have appropriate certification.</td>
</tr>
</tbody>
</table>

- This is currently in place for suppliers of all new systems and is recorded through the Data Privacy Impact Assessment (DPIA) process.
- The tendering process for new systems includes requirements for suppliers to have the appropriate security credentials/certifications.
- An ongoing process is in place to ensure DPIAs are regularly reviewed and this is also identifying existing systems that require a retrospective DPIA.

4. Areas of Development

4.1. For those standards that are not ‘Fully Implemented’ brief notes are provided of the current position and the plans for development; these notes do not form part of the submission to NHSI.

4.2. The actions identified above will be reviewed in detail in the coming months during the completion of the new DSPT, the first performance submission is required in October, followed by final submission in March 2019. The IGG will regularly report on the progress against the new framework and will provide regular updates to the SIRO.

5. Recommendation

5.1 The Board are asked to take assurance from this paper and acknowledge the current position to be reported the NHSI.
Finance & Performance Committee

Terms of Reference

1. Constitution
1.1. The board hereby resolves to establish a committee of the board to be known as the Finance & Performance Committee (the Committee). The Committee is a committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Purpose
2.1. The purpose of the Committee is to provide the Trust Board with independent and objective oversight and assurance that the Trust will continue to meet, or where appropriate seek to improve, the required financial and operational performance of the Foundation Trust to ensure that as far as possible it:

   2.1.1. Meets the requirements of its licence to remain as a going concern, achieves its financial targets and maintains sufficient cash liquidity to meet its ongoing liabilities and investment plans;

   2.1.2. Achieves high standards of operational performance and quality, and delivers the key performance targets assigned to it under the regulator’s compliance framework;

   2.1.3. Provides assurance to the Board of the Trust’s compliance against NHSI governance and financial risk ratings and all other key regulatory requirements, and specifically those outlined in the Single Oversight Framework relating to finance and use of resources and operational performance.

   2.1.4. Provides assurance to the board on the effectiveness of financial and operational performance reporting systems;

   2.1.5. Provides assurance to the board on the effectiveness of governance around efficiency and service transformation programmes.

3. Membership (Including Quorum)
3.1. The Committee will be appointed by the board from amongst the non-executive and executive directors of the Trust. One of the members will be appointed Chair of the Committee by the board. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of the other non-executive directors present to chair the meeting.

3.2. The membership of the Committee will be comprised as follows:

   • Three non-executive directors, one of whom shall chair the Committee;
3.3. A quorum will be four members, including two non-executive directors.

3.4. Members are expected to attend at least 75% of meetings annually.

3.5. Up to a maximum of three Governors are invited to observe and contribute at all meetings of the Committee.

4. **Attendance**

4.1. The Director of Finance will act as lead executive director for the Committee.

4.2. Executive directors and senior managers shall be invited to attend meetings, particularly when the Committee is discussing areas of risk or operation that are within their remit of responsibility.

4.3. The Company Secretary and Head of Corporate Governance shall ensure there is appropriate secretarial and administrative support to the Committee. The duties of the Company Secretary in this regard include, but are not limited to:

- Agreement of the annual agenda framework with the Committee, ensuring that this is regularly reviewed and updated and circulated to all members periodically throughout the year;
- Finalisation of each meeting’s agenda with the Chair of the Committee, in conjunction with the lead executive director;
- Circulating a request for papers no later than 10 working days prior to the submission deadline, and collating papers;
- Ensuring that the agenda and papers are distributed no less than five working days in advance of the meeting;
- Ensuring that minutes of the meeting are taken, including a record of decisions taken, matters arising and that issues to be carried forward are kept in a rolling log;
- Ensuring that draft minutes are circulated within 10 working days of the meeting to all members;
- Advising the Committee as appropriate;
- Supporting the Chair of the Committee to conduct the annual review of the Committee’s effectiveness against the terms of reference.

4.4. The Chair of the Committee may, at their discretion, invite other observers to attend on terms and conditions as deemed fit.

5. **Frequency**

5.1. Meetings shall normally be held bi-monthly, with additional meetings where necessary.
6. **Authority**

6.1. The Committee is authorised by the board to take action in respect of any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. **Duties**

7.1. The Committee is responsible for:

7.1.1. Providing assurance to the board of directors in terms of the performance of the Trust by monitoring the Trust’s Integrated Performance Report (in relation to Quality, performance, finance and workforce indicators), scrutinising and key performance issues and any indicators where there is a deteriorating trend in performance and seeking assurance that actions are being taken to bring performance back to target with specific responsibility for the monitoring of financial and operational metrics;

7.1.2. Reviewing the Trust’s operational performance against the annual plan and monitoring any necessary corrective planning and action;

7.1.3. Developing and annually reviewing the performance indicators relevant to the remit of the Committee;

7.1.4. Providing assurance to the board of directors in respect of the financial performance of the Trust and in respect of the financial strategy of the Trust by:

- Monitoring the performance of all items of income and expenditure against the strategy of the Trust and its annual and long-term plans;
- Ensuring that the Trust meets the information and financial requirements of Monitor and other regulatory bodies;
- Monitoring the annual cost improvement programme and reviewing any components of it that are off track;
- Providing assurance to the board on the financial performance of the Trust identifying issues and conflicts that require board resolution.
- Reviewing and confirming the service and financial management information that is needed at all levels within the Trust and specifically to identify that management information for the board and the Committee is consistent with the strategic action plan and the requirements of regulators and Government;
- Reviewing risks associated with the delivery of the Trust’s financial strategy and ensuring that the Audit, Risk & Assurance Committee is informed of any gaps or recommendations for amendment;
Appendix 2

- Reviewing and analysing the financial basis of potential mergers, acquisitions and other investment projects, ensuring their consistency with the strategic action plan.
- Monitoring compliance with treasury policies and procedures.

7.1.5. Providing assurance to the board of directors on the delivery of the Trust’s People & Organisational Development Strategy, mechanisms in place to support the development of leadership capacity and capability, development and design of the workforce, mechanisms for improving how the Trust engages with its workforce, and approach to ensuring compliance with relevant equality, diversity and human rights legislation.

7.1.6. Oversight of the annual planning process and development of the strategic plan, including:
- Participating in and reviewing the strategic outcomes and strategic action plan, and providing comment back to the executive for their consideration;
- Confirming that the Trust’s commissioner and user (‘customer’) proposition is sufficient to deliver all the strategic outcomes of the Trust;
- Ensuring that annual objectives and major initiatives are consistent with meeting the overall strategic plan;
- Reviewing risks associated with the strategy and the strategic action plan to ensure that appropriate risks have been identified and that actions are in place to manage those risks, and that the Audit, Assurance and Risk Committee are informed of any gaps or recommendations for amendment;
- Monitoring actual performance and implementation of the core strategies, as defined in the Trust’s strategic plan, and any remedial actions;
- Resolving issues and conflicts raised by the executive in connection with the strategic action plan (or to raise these issues with the board, if appropriate);
- Providing assurance to the board that the strategic action plan is complete and appropriate to enable the Trust’s strategy to be delivered; and actual performance is either on track to meet the Trust’s objectives or that remedial actions are necessary to bring the plan back on track.

8. Reporting

8.1. The minutes of the Committee meetings shall be formally recorded and submitted to the board once approved.

8.2. The Chair of the Committee shall draw to the attention of the board any issues that require disclosure or executive action.

8.3. The Committee will report annually to the board of directors in respect of fulfilment of its functions as set out in these terms of reference.

8.4. Minutes from the Workforce & Organisational Development Sub-Committee meetings shall be received by the Committee.
9. **Review**

9.1. The terms of reference of the Committee shall be reviewed by the board of directors at least annually.

9.2. During this review the Committee will be assessed to ensure it has performed in accordance with these terms of reference, specifically that:

- The Committee has carried out the duties required;
- The Committee has reported to the board and other committees as required;
- Membership, frequency of meetings and attendance has been as stated;
- The Committee has been quorate each time it has met.

9.3. The Committee will provide a report to the Board annually on its effectiveness.
### 2018/19 Committee membership

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<td>Jeni Bremner, Non-Executive Director</td>
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<td>Paula Anderson, Director of Finance</td>
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<td>Dr Nick Broughton, Chief Executive</td>
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<td>Barry Day, Chief Operating Officer</td>
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<td>Julie Dawes, Director of Nursing &amp; Allied Health Professionals</td>
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<td>Dr David Hicks, Non-Executive Director</td>
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<td>David Kelham, Non-Executive Director</td>
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<td>Dr Karl Marlowe, Medical Director</td>
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<td>Paul Draycott, Director of Workforce, Organisational Development &amp; Communications</td>
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<td>Sue Damarell-Kewell, Associate Director of Planning &amp; Performance</td>
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<td>Lisa Franklin, Chief Information Officer</td>
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<td>Anna Williams, Company Secretary</td>
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Quality and Safety Committee
Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a committee of the board to be known as the Quality and Safety Committee (the Committee). The Committee is a committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Purpose

The purpose of the Committee is to:

2.1. Monitor and ensure that appropriate arrangements are in place for measuring and monitoring clinical quality;

2.2. Monitor and ensure that appropriate arrangements are in place for measuring and monitoring patient safety;

2.3. Monitor and ensure that appropriate arrangements are in place for the measuring and monitoring the health and safety of our patients, service users, visitors and staff;

2.4. Assure the board that these arrangements are robust and effective, and support the delivery of the strategic objectives;

2.5. Report on and escalate issues which need to be drawn to the board’s attention;

2.6. Review risks to quality and safety and agree management mechanisms to improve these;

2.7. Review and scrutinise sources of assurance relating to clinical safety for patients and service users and reports to board.

3. Membership (Including Quorum)

3.1. The Committee will be appointed by the board from amongst the non-executive and executive directors of the Trust. One of the non-executive members will be appointed Chair of the Committee by the board. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of the other non-executive directors present to chair the meeting.

3.2. The membership of the Committee will be comprised as follows:

- Three non-executive directors, one of whom shall chair the Committee
• Chief Executive
• Medical Director
• Director of Nursing & Allied Health Professionals

3.3. A quorum will be three members and will include at least two non-executive directors.

3.4. Members are expected to attend at least 75% of meetings annually. An annual register of attendance of members will be published by the Committee.

3.5. Governors are invited to observe and contribute at all meetings of this Committee.

4. Attendance

4.1. The Director of Nursing, AHPs and Quality will act as lead executive director for the Committee.

4.2. Executive directors and senior managers shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within their remit of responsibility.

4.3. The Company Secretary and Head of Corporate Governance shall ensure there is appropriate secretarial and administrative support to the Committee. The duties of the Company Secretary in this regard include, but are not limited to:

- Agreement of the annual agenda framework with the Committee, ensuring that this is regularly reviewed and updated and circulated to all members periodically throughout the year;
- Finalisation of each meeting’s agenda with the Chair of the Committee, in conjunction with the lead executive director;
- Circulating a request for papers no later than 10 working days prior to the submission deadline, and collating papers;
- Ensuring that the agenda and papers are distributed no less than five working days in advance of the meeting;
- Ensuring that minutes of the meeting are taken, including a record of decisions taken, matters arising and that issues to be carried forward are kept in a rolling log;
- Ensuring that draft minutes are circulated within 10 working days of the meeting to all members;
- Advising the Committee as appropriate;
- Supporting the Chair of the Committee to conduct the annual review of the Committee’s effectiveness against the terms of reference.

4.4. The Chair of the Committee may, at their discretion, invite other observers to attend on terms and conditions as deemed fit.
5. **Frequency**

5.1. The Committee will meet at least four times per year. Additional meetings may be scheduled where necessary.

6. **Authority**

6.1. The Committee is authorised by the board to take action in respect of any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. **Duties**

The Committee is responsible for providing assurance to the board of directors by:

7.1. Ensuring that the strategic priorities are focused to best support delivery of the Trust’s objectives in relation to:

- Quality, including:
  - The clinical safety of patients and service users
  - Effective outcomes for patients and service users
- Health and safety including:
  - The safety of patients, staff and visitors
  - Environmental safety (clinical and other working environments)

7.2. Scrutinising quality and safety assurance in the following areas (not exclusive):

- Incident reports, including serious incidents
- Clinical complaints and claims
- Mortality
- Key quality and safety risk areas such as suicides, violence and aggression, slips, trips and falls, etc.

7.3. Overseeing the development of the Trust’s quality strategy and the annual quality account, and recommending these for approval to the board.

7.4. Recommending the annual quality priorities for approval to the board and reviewing performance against these priorities throughout the year.

7.5. Reviewing the annual clinical audit programme, as one mechanism of assurance, and ensuring it supports national and Trust priorities.
7.6. Receiving assurance reports relating to risks and compliance with legal, NHS and other regulatory standards (eg CQC, NHSLA, HSE, Monitor Quality Governance Framework, NICE guidance).

7.7. Receiving reports from notable national bodies (Ombudsman, National Enquiries) and reviewing local assurance that actions and learning management arrangements are in place.

7.8. Reviewing relevant strategic and significant operational risks, their controls and assurances via the board assurance framework and providing onward assurance to the Audit, Assurance and Risk Committee and board that these are robust.

8. Reporting

8.1. The minutes of the committee meetings shall be formally submitted to the board. The Chair of the Committee shall draw to the attention of the board any issues that require disclosure, or executive action.

8.2. The Chair, on behalf of the Committee, will report annually to the board of directors in respect of fulfilment of its functions as set out in these terms of reference.

9. Review

9.1. The terms of reference of the Committee shall be reviewed by the board of directors at least annually.

9.2. During this review the Committee will be assessed to ensure it has performed in accordance with these terms of reference, specifically that:

- The Committee has carried out the duties required;
- The Committee has reported to the board and other committees as required;
- Membership, frequency of meetings and attendance has been as stated;
- The Committee has been quorate each time it has met.
Transformation Steering Committee

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Transformation Steering Committee (the Committee). The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

2.1. The purpose of the Committee is to:

   2.1.1. Lead the implementation of the Trust programme approach, ensuring all programmes collectively meet the strategic needs of the organisation and realise expected benefits
   2.1.2. Ensure alignment between individual programmes and with other strategy, policy and operational need
   2.1.3. Manage strategic risk and issues relating to Trust programmes and strategic external dependencies

2.2. The Committee will operate with reference to the Transformation Programme Board which oversees the operational delivery of the transformation programme, engaging a wider group of staff, patient, public and system stakeholders.

3. Membership (including quorum)

3.1. The Committee will be appointed by the Board from amongst the Non-Executive and Executive Directors of the Trust.

3.2. The membership of the Committee will be comprised as follows:

   • Chief Executive (Chair)
   • One Non-Executive Director
   • Medical Director
   • Director of Nursing
   • Chief Operating Officer
   • Director of Workforce, People & Communications

3.3. The Chief Executive shall chair the Committee; in his absence, a nominated deputy from amongst the Executive Directors will chair the meeting.

3.4. A quorum will be 4 members, to include at least 2 Executive Directors.

3.5. Members are expected to attend at least 75% of meetings annually.
Appendix 4

3.6. Up to a maximum of three Governors are invited to observe and contribute at all meetings of the Committee.

4. **Attendance**

4.1. The Clinical Directors of Quality Improvement and the Associate Director of Planning, Performance, Business Development & Contracting shall be invited to attend all meetings. Other Executive Directors and senior managers shall be invited to attend meetings, particularly when the Committee is discussing areas of risk or operation that are within their remit of responsibility.

4.2. Members may, with prior agreement of the Chair, appoint suitable deputies to represent their function at specific meetings; this should only be in exceptional circumstances.

4.3. The Delivery Unit (or equivalent), in providing support to the transformation programme, will provide administrative support to the committee. The duties of the Delivery Unit in this regard include, but are not limited to:

   4.3.1. Finalisation of each meeting’s agenda with the Chair of the Committee;
   4.3.2. Circulating a request for papers no later than 10 working days prior to the submission deadline and collating papers;
   4.3.3. Ensuring that the agenda and papers are distributed no less than five working days in advance of the meeting;
   4.3.4. Ensuring that minutes of the meeting are taken, including a record of decisions taken, matters arising and that issues to be carried forward are kept in a rolling log; and
   4.3.5. Ensuring that draft minutes are circulated within 10 working days of the meeting to all members.

4.4. The Chair of the Committee may, at their discretion, invite other observers to attend on terms and conditions as deemed fit.

5. **Frequency**

5.1. The Committee will meet 10 times per year (monthly excluding August and December).

6. **Authority**

6.1. The Committee is authorised by the Board to take action in respect of any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
Appendix 4

7. **Duties**

7.1. The Committee is responsible for:

7.1.1. Leading the implementation of the Trust programme approach, ensuring all programmes collectively meet the strategic needs of the organisation and realise expected benefits;

7.1.2. Ensuring alignment between individual programmes and with other strategy, policy and operational need;

7.1.3. Managing strategic risk and issues relating to Trust programmes and strategic external dependencies;

7.1.4. Shaping and directing the strategy for working with Northumberland, Tyne and Wear NHS Foundation Trust to implement a QI methodology across the trust, overseeing the structure, timing and scope of the training roll out;

7.1.5. Setting the strategy for the approach to organisational and management development to support a culture of QI throughout the trust;

7.1.6. Ensuring effective implementation of major transformation projects, and that QI and transformation capacity is prioritised to best effect, including oversight of the commercial buddying partnership with Northumberland, Tyne and Wear NHS Foundation Trust;

7.1.7. Receiving regular updates on progress against programme plans, including changes to plan and exceptions and considering risks escalated to the Trust Programme Board;

7.1.8. Ensuring that implementation of both training and transformation projects is expedited whilst ensuring that there is full engagement of staff, service users, carers and other stakeholders to achieve the desired outcomes.

8. **Reporting**

8.1. The minutes of the Committee’s meetings shall be formally recorded and submitted to the board once approved. The Chair of the Committee shall draw to the attention of the board any issues that require disclosure or executive action.

8.2. The Committee will report annually to the board of directors in respect of fulfilment of its functions as set out in these terms of reference.

9. **Review**

9.1. The Terms of Reference of the Committee shall be reviewed by the Board of Directors at least annually.

9.2. During this review the Committee will be assessed to ensure that it has performed in accordance with these terms of reference, specifically that:

- The Committee has carried out the duties required;
- The Committee has reported to the Board and other Committees as required;
- Membership, frequency of meetings and attendance has been as stated;
- The Committee has been quorate each time it has met.
Appendix 5

Memorandum of Understanding

Division of Responsibilities between the Chair and Chief Executive

This Memorandum of Understanding between the Chair and Chief Executive of Southern Health NHS Foundation Trust sets out our differing and complementary leadership roles.

This Memorandum reflects the requirements of The NHS Foundation Trust Code of Governance (2014), that ‘The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors’.

We believe that, as Chair and Chief Executive, it is essential that we are clear about our respective roles. We agree that, at the broadest level, the Chair’s role is to lead the Board of Directors; to ensure that the organisation has the vision, strategy and resources in place which will deliver the objectives of the Trust and to create the conditions of good governance. The Chair is also responsible for leading the Council of Governors; ensuring that Governors are both equipped to understand, develop and deliver their role, having the resources, information and knowledge necessary to discharge their duties. The Chief Executive’s role is to lead the executive team and, ultimately, ensure that the Board’s vision and strategy for the provision of high quality services is achieved and that all risks are identified and managed effectively. These duties are expanded on in the NHS Foundation Trust Accounting Officer Memorandum.

We acknowledge that the Chair’s role is not an executive one and therefore does not require her to become involved in the day-to-day running of the organisation. We also respect the authority of the Board as the ultimate decision-making body in the Foundation Trust, whilst at the same time accepting that the Chief Executive, in his capacity as Accounting Officer, has a personal responsibility to Parliament for the overall performance and conduct of the organisation.

We have a shared role in communicating with external audiences, including our Regulators. At the same time, we agree that the Chief Executive will take the lead in communicating with external parties about performance issues at the Foundation Trust.

We recognise that the way in which we conduct ourselves individually and together has a significant impact on the effectiveness of the Board and the culture of the organisation. We will therefore strive to behave in a manner consistent with the contents of this Memorandum and the values of the organisation at all times. At the same time, we understand that, whilst roles can be clarified and allocated, in practice they can be interpreted differently and there may be a blurring of boundaries as particular situations and needs arise. Therefore, as Chair and Chief Executive, we are committed to ongoing discussions about our roles and to seeking feedback from Board colleagues from time to time, including regularly reflecting on the extent to which we are each operating consistently with the role specifications outlined in this Memorandum.

Lynne Hunt       Dr Nick Broughton
Chair                   Chief Executive
Date   2018       Date   2018
Appendix 5

Role of the Chair

The Chair agrees to:

1. Ensure that the Board of Directors and Council of Governors are effective in all aspects of their respective roles. This will be achieved by:
   a. ensuring that the Board has a strategy and Chief Executive capable of delivering the objectives of the Trust
   b. ensuring that the Board and the Council of Governors understand and focus on their respective roles
   c. setting their respective agendas so that adequate time is available for substantive discussion on strategic and material issues
   d. facilitating, encouraging and expecting the informed and critical contribution of the Directors and Governors in particular
   e. ensuring that Directors and Governors receive all information that is relevant in order to discharge their duties in an accurate, timely and clear form
   f. ensuring that constructive relations exist between Executive Directors, Non-Executive Directors and Governors and, ultimately, between the Council of Governors and the Board of Directors
   g. ensuring that the Directors and Governors continually update their skills, knowledge and familiarity with the organisation
   h. ensuring that new Directors and Governors receive a full, formal and tailored induction

2. Support the Chief Executive in the effective communication with stakeholders.

3. Build strong external networks and liaise with stakeholders.

4. Regularly evaluate the performance of the Chief Executive, the Board, committees and individual Non-Executive Directors.

5. Ensure that the Council of Governors regularly evaluates its own effectiveness and the effectiveness of its individual members.

6. Avoid becoming operationally involved or interfering with the day-to-day strategy or delivery of the organisation's core business.

7. Avoid taking significant decisions without the prior consent of the Board or consultation with the Chief Executive.

8. Avoid demanding too much time of the Chief Executive and his executive colleagues.

Appendix 5

Role of the Chief Executive

The Chief Executive agrees to:

1. Ensure that an appropriate management structure is in place and that appropriate Executive portfolios are in place.
2. Allocate reasonable resources to support the Chair in her role as Chair of both Board and Council.
3. In consultation with the Chair, propose a direction for the organisation for the Board to debate and challenge.
4. Once decided, work towards implementing the Board’s direction for the organisation.
5. Provide leadership in all aspects of organisational activities.
6. Identify, mitigate and/or control all aspects of risk.
7. Provide an effective system of risk management.
8. Oversee the day-to-day running of the organisation with other Executive colleagues.
9. Ensure that the Executive team and individual Executive Directors are effective in their role.
10. Lead effective communication with patients, carers, members, staff, partners and other stakeholders, including the regulators.
11. Recognise and respect the role and authority of the Board and the advice/guidance of the Chair.
12. Brief the Chair on a timely basis.
13. Be open and candid with the Chair over the affairs of the organisation.
14. Accept and reflect on constructive challenge by the Chair.
REPORT TO THE TRUST BOARD

Date | 05.06.18

Agenda Item | 21

Title | Monitor Licence Compliance

Author(s) | Anna Williams, Company Secretary & Head of Corporate Governance
Louisa Felice, Head of Executive Affairs & Projects

Sponsoring Director | Nick Broughton, Chief Executive

Purpose & Action Required | This report sets out the Trust’s proposed declaration against licence condition FT4 and the proposed certification on training of Governors. The Board is asked to approve the recommendations set out in this report.

Executive Director Overview | A review of the Trust’s gap analysis of compliance with the licence conditions has been undertaken, as reported to the ARAC in May 2018. In undertaking this assessment, the paper recognises NHS Improvement's view that the Trust is in breach of some provisions within Licence Condition FT4, as well as the additional licence condition imposed. This is reflected in the Trust’s proposed Corporate Governance Statement.
The Trust’s proposed self-certification on training of Governors is also set out in this report for approval by the Board.

Previously considered by: | ARAC 22.05.18

Strategic Priorities this paper supports:

Quality | The Monitor licence contains obligations for providers of NHS services that cover aspects of all four strategic priorities
People | 
Transformation | 
Money | 

Does this impact any Board Assurance Framework / Corporate Risks | SR5: There is a risk that we have ineffective governance which prevents effective decision making.
MONITOR LICENCE COMPLIANCE

1. Purpose

1.1. This report sets out the Trust’s proposed declaration in accordance with condition FT4 (8) of the NHS provider licence, relating to the submission of a Corporate Governance Statement. This declaration is due to be agreed by the Board and published by 30.06.2018.

1.2. The report also sets out the Trust’s proposed self-certification as to whether the Trust has provided the necessary training to its Governors, as required in the Health & Social Care Act 2012, to ensure they are equipped with the skills and knowledge they need to undertake their role. This is also to be agreed by 30.06.2018.

2. Context

2.1. Licence condition FT 4(8) requires that the Trust makes a corporate governance statement by and on behalf of the Board confirming compliance with licence condition FT4 “NHS Foundation Trust governance arrangements” within three months of the end of each financial year.

Corporate Governance Statement

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.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

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.

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.

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.

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.

3. Report

3.1. A self-assessment of compliance against the conditions of the provider licence was undertaken and reported to the Audit, Risk & Assurance Committee in May 2018. This set out those areas where the Trust has been found to be in breach of the conditions of the provider licence, as set out by the regulator. Progress has been made in addressing the identified licence breaches, as evidenced by the issuing of a number of compliance certificates by the regulator. Nonetheless, it is the Trust's view that until compliance certificates are issued in relation to the remaining undertakings, there will not be a material impact on the Trust's licence compliance position.

3.2. As such, it is proposed that the Trust makes a declaration of “Confirmed” for elements 1 and 2 of the Corporate Governance Statement and declares “Not confirmed” in relation to statements 3-6 (see Appendix A for the full declaration); this is consistent with the Trust’s self-assessment of compliance with the provider licence provisions.

3.3. The Trust is also required to make an annual declaration that it has provided the necessary training to Governors, as required in s151(5) of the Health and Social Care Act 2012, to ensure that they are equipped with the skills and knowledge they need to undertake the role. This can be found at Appendix B.

3.4. Views from governors on the declaration were being sought at the time this paper was written and as such an update position will be given orally at the meeting. Last year the Trust declared compliance with this declaration having taken account of the views of governors. It is expected that given the strengthened arrangements, including external development work, that the governors will support a continued declaration of compliance for this element this year.

3.5. During 2017/18, the Trust provided training and development opportunities through induction meetings (both individual and collective), a new programme of Site Visits, Medicine for Members’ events, internal briefings, video training packages on key topics, as well as through the Council of Governors meetings and Governor Development Sessions (including those which have been externally facilitated). Governor development days have included sessions on:

- Workforce
- Patient experience & Engagement
- Maximising and Valuing the Contribution of the Council of Governors
- Appraisal Process for the Chair and Non-Executive Directors
- Quality Improvement
- Quality Report and Account
- Business Planning
Clinical service Strategy
Whistleblowing

3.6. Other opportunities were also provided throughout the year, which included Governor engagement on the interview panels and/or participation in the appointment processes for both Executive and Non-Executive Director appointments, and opportunities for engagement with the Chair, new Chief Executive as well as open forums with Board members.

3.7. External events such as Conferences (arranged by NHS Providers and other companies) were offered to Governors, and information sharing continued to take place through regular external briefings on topical issues. A list of information shared with Governors between meetings is included within the Corporate Governance Report which is presented to each Council of Governors’ meeting.

3.8. On the basis of the above information, and subject to the oral update confirming the views of governors, it is proposed that the Trust makes a declaration of “Confirmed” in relation to the declaration on training of Governors for the year ended 31.03.2018 (see Appendix B).

4. Recommendation
Recommendation
4.1. The Board is asked to:
4.1.1. Authorise the Chair and Chief Executive Officer to sign the declarations at Appendix A and Appendix B, on behalf of the Board of Directors, and having regard to the views of the governors.

5. Appendices
APPENDIX 1: Declaration on licence condition FT4 – Corporate Governance Statement
APPENDIX 2: Declaration on Training of Governors
### Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond “Confirmed” or “Not confirmed” to the following statements, setting out any risks and mitigating actions planned for each one.

<table>
<thead>
<tr>
<th></th>
<th>Corporate Governance Statement</th>
<th>Response</th>
<th>Risks and Mitigating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Board is satisfied that the Constitution and systems of good corporate governance which reasonably would be regarded as appropriate to a supplier of health care services to the NHS.</td>
<td>Not confirmed</td>
<td>Please complete both risks and mitigating actions.</td>
</tr>
<tr>
<td>2</td>
<td>The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.</td>
<td>Not confirmed</td>
<td>Please complete both risks and mitigating actions.</td>
</tr>
<tr>
<td>3</td>
<td>The Board is satisfied that the systems and process referred to in paragraph 4 (above) should include but not be restricted to systems and processes in the Licence holder's organisation.</td>
<td>Not confirmed</td>
<td>Please complete both risks and mitigating actions.</td>
</tr>
<tr>
<td>4</td>
<td>Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors.</td>
<td>Confirmed</td>
<td>Please complete both risks and mitigating actions.</td>
</tr>
</tbody>
</table>

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.
Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors.

Signature

Name: Lynne Hunt
Capacity: Chair
Date: 05/06/18

Name: Nick Broughton
Capacity: Chief Executive Officer
Date: 05/06/18
Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act.
## REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>05.06.2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>22</td>
</tr>
<tr>
<td>Title</td>
<td>Reporting from Board Committees</td>
</tr>
</tbody>
</table>
| Author(s)    | Anna Williams, Company Secretary & Head of Corporate Governance  
Sarah Spooner, Corporate Governance Coordinator  
Amanda Bryant, Corporate Governance Manager |
| Sponsoring Director | Committee Chairs |
| Purpose & Action Required | To provide an update to Board on items agreed for escalation from Board Committees and minutes from previous meetings. |
| Executive Director Overview | To provide an update to Board on items agreed for escalation from Board Committees. |
| Previously considered by: | Board Committees |

### Strategic Priorities this paper supports:

<table>
<thead>
<tr>
<th>Quality</th>
<th>People</th>
<th>Transformation</th>
<th>Money</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒</td>
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</tbody>
</table>

Committees cover a breadth of Trust performance

Does this impact any Board Assurance Framework / Corporate Risks

Relates to all risks across the Board Assurance Framework
1. **Purpose**  
1.1. To provide an update to the Board on items agreed for reporting to Board.

2. **Reports**  
2.1. Reports are provided from the following meetings:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Summary Report</th>
<th>Approved Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit, Risk &amp; Assurance Committee</td>
<td>22.05.2018 (Oral)</td>
<td>20.03.2018</td>
</tr>
<tr>
<td>Charitable Funds Committee</td>
<td></td>
<td>No meetings held</td>
</tr>
<tr>
<td>Mental Health Act Review Managers’ Forum</td>
<td>29.03.2018</td>
<td></td>
</tr>
<tr>
<td>Mental Health Legislation Sub-Committee</td>
<td>10.04.2018</td>
<td>16.01.2018</td>
</tr>
<tr>
<td>Nominations &amp; Remuneration Committee</td>
<td>10.04.2018 &amp; 15.05.2018</td>
<td></td>
</tr>
<tr>
<td>Quality &amp; Safety Committee</td>
<td>08.05.2018</td>
<td>20.03.2018</td>
</tr>
<tr>
<td>Senior Management Committee</td>
<td>Reporting of key matters via Directors’ Reports</td>
<td>25.04.2018</td>
</tr>
<tr>
<td>Service Performance &amp; Transformation Committee</td>
<td>15.05.2018</td>
<td>26.03.2018</td>
</tr>
<tr>
<td>Workforce and Organisational Development Sub-Committee</td>
<td></td>
<td>No meetings held</td>
</tr>
</tbody>
</table>

3. **Recommendation**  
3.1. The Board is asked to note this report.

4. **Appendices**

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Mental Health Act Review Managers’ Forum Summary Report 29.03.2018</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Mental Health Legislation Sub-Committee Summary Report 10.04.2018</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Nominations &amp; Remuneration Committee Summary Report 10.04.2018 &amp; 15.05.2018</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Quality &amp; Safety Committee Summary Report 08.05.2018</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Service Performance &amp; Transformation Committee Summary Report 15.05.2018</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Audit, Risk &amp; Assurance Committee Approved Minutes 20.03.2018</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Mental Health Legislation Sub-Committee Approved Minutes 16.01.2018</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Quality &amp; Safety Committee Approved Minutes 20.03.2018</td>
</tr>
</tbody>
</table>
Appendix 9  Senior Management Committee Approved Minutes 25.04.2018  
(To Follow)  
Appendix 10  Service Performance & Transformation Committee  
Approved Minutes 26.03.2018
Appendix 1 Mental Health Act Review Managers’ Forum Summary Report 29.03.2018

- MHARMs’ decision writing – this focussed specifically on the process MHARMs adopt for writing their decisions e.g. whether by panel discussion and collegiate writing; or whether individual write-ups and an aggregate version. It was agreed that it would be for each Panel to decide on its overall method for writing the report (as Panels work in different ways) so long as the MHARMs’ decision making template was completed accurately and the final write up was based on the legal criteria for the decision;

- Ensuring panel reports are available to the patients in a reasonable time before the hearing. This is a Trust obligation from the MHA Code of Practice. It was agreed that a failure to give the patients reasonable time to receive/read the reports by the Trust constitutes a ground for adjournment;

- Extended section 17 leave – the MHARMs had asked for guidance on the legal criteria for providing extended section 17 leave. They received a paper outlining this.

- Other matters:
  - For non-NED MHARMs, the notion of independence was discussed. This is a requirement under section 23 MHA i.e. that MHARMs appointed on behalf of the Board must be independent. It was agreed that independent in this context meant ‘independent in decision making’. This will remain a topic for further discussion. The following points for demonstrating independence were raised:
    - Holding appraisals/MHARMs’ Forums off Trust sites;
    - MHARMs ensuring that they hold (short) adjournments to deliberate and confirm their (verbal) decisions whether or not a patient is present at a hearing. MHARMs always adjourn when a patient attends, and it was agreed that this should be done even when patients are not present. This would assure such patients that the MHARMs had discussed their decisions independently of Trusts officers;
    - Declarations of interest will be a standard agenda item at future MHARMs’ Forums;
    - Whether there should be automatic cut-off points after X amount of service (to be discussed at future Forums);

  - The MHARMs were given a Trust update re CQC and outcomes from recent coroner’s inquests.
Appendix 2 Mental Health Legislation Sub-Committee Summary Report 10.04.2018

Mental Health Act National Survey
The Committee noted that the Trust was compiling a response to the survey. Committee members would be considering this prior to submission.

Mental Health Act CQC Report
The Committee discussed the findings made by the CQC in its national report called ‘Monitoring the Mental health Act Report in 2016/17’. Within this report, there were a number of areas for improvement for the Trust (Care Plans, Implementing the Code of Practice, Consent to Care and treatment, and patients’ rights under the Mental Health Act). The Committee noted progress towards the implementation of these, and requested that further evidence be shared (specifically on the embeddedness of the code of practice and the policy framework aligned to this).

Section 136
The Committee looked in detail at this, it considered the powers of the act, the use of the places of safety in place within the Trust, and sources of assurance. The Committee discussed the procedure for transferring a service user between police custody and the Trust, and whether this needed to be strengthened. It was agreed that a risk would be added to the Risk Register around this.

The Committee asked for work to be undertaken to review any Groups/Committees in place across the local area looking at Section 136 to try an join up discussions/approaches.

Section 17 Leave
The Committee looked at this in detail, at the sources of assurance and the outcomes of a recent review in procedures. The Committee has asked for further work to be undertaken to look at the reasons why some granted section 17 leave hadn’t been taken by service users.
The Committee considered the outcome of the Chief Operating Officer Interview and assessment process and approved the proposed appointment of Barry Day.

The Committee discussed the resignation of the Director of Nursing and the intention to proceed to recruit.

The Committee agreed to the appointment of Debbie Robinson as Acting Director of Operations (Mental Health & Learning Disabilities); and

The Committee agreed to extend the appointment of Paula Hull as Acting Director of Operations (Integrated Services)

The Committee supported the proposal to recruit a Deputy Chief Executive
Care Pathway and consistency
The Committee discussed the differing care pathways provided by the Trust, and indicated the need to ensure that there was a consistency of care provided to all service users. It noted that the Trust was currently reviewing the pathways for its services, and that best practice guidelines were being used to inform this work.

RIDDOR Reporting
The Committee received the Health and Safety Q3 2017/18 Report which provided assurance on the management of occupational Health & Safety within the Trust, and how the Trust is performing against this. The Committee noted that discussions were underway with the Executive Team, and that there were eight reportable RIDDOR incidents in quarter 3.

Quality of Mortality Data
The Committee received a report on Learning from deaths: Mortality Data & Learning for Quarter 4, and discussed the number of reported deaths which had been subject to a case review. The Committee felt that further detail around the changes that the Trust had made was required to be made to the report, prior to it being presented to the Board.

Clinical Audit work
The Committee received an update on the Clinical Audit Programme. It suggested that further work was required on this by the Senior Clinical leaders within the Trust, and noted that this had been raised at the Clinical Effectiveness Group, as well as being added to the Risk Register.

Legionella
The Committee received an update on the discovery of Legionella at Melbury Lodge and Gosport War Memorial, noting the a strict admission criteria which had been put in place for admissions to the unit. It was highlighted to the Committee that work continued to take place to eradicate Legionella, including the replacement of the boiler as well as pasteurising and chlorinating the system. The Committee received assurance that a process is in place for all old estate buildings to be tested.
Terms of Reference
The Committee received the Terms of Reference for the establishment of a Finance & Performance Committee which took account of the comments received from Committee members at the last meeting, and expert input from NHS Improvement. The Terms of Reference were agreed and will be presented to the Board on 05.06.2018 for approval.

Board Assurance Framework
The Committee received the Board Assurance Framework. It was noted that the intention was for consideration of draft strategic risks via the Executive Risk & Assurance Group and the inclusion of the agreed changes following the Board seminar session on 08.05.2018 in the framework to be presented to Board.

It was agreed that this be considered at an extraordinary Service Performance & Transformation Committee on 29.05.2018 to enable full consideration prior to presentation to the Board on 05.06.2018, which would recognise that this was as a work in progress. A further updated version of the Board Assurance Framework will be presented to the Board in July 2018.

Integrated Performance Report
The Committee gave positive feedback on the development of the Integrated Performance Report and provided further recommendations for improvements as part of ongoing development of the report.

People & Organisational Development Strategy
The Committee discussed the feedback that had been received following public engagement. The Committee supported the themes identified in section 6, to enable a detailed programme of work to be developed. This would be reported to the Board on a quarterly basis. The fully updated People & Organisational Development Strategy will be presented to the Board in July 2018.

CAMHS Business Case
The CAMHS Business Case was deferred for consideration at an extraordinary Service Performance & Transformation meeting on 29.05.2018.

Contracts
The Committee discussed forthcoming tender opportunities, including those where the Trust is the incumbent provider. A further update will be provided to the Service Performance & Transformation Committee. There was a discussion on ensuring that the Board is sighted on forward contracts and how this will be reported going forward.

Finance
The Committee received an update on the financial outturn for 2017/18 and the key financial risks and mitigation for 2018/19. Although the control total was missed by £1.1m this was after absorbing the impact of the fine and legal fees which were incurred in quarter 4. Although the Q4 STF was therefore not achieved, a general distribution STF was received by all Trusts who signed up to achieving a control total for 2017/18 which amounted to £920k.

There is great pressure on the 2018/19 financial position with the month 1 position of a £1.2m deficit against a planned deficit of £636k. Achievement of the Provider Sustainability Fund

180605 TB 22.0 - Reporting from Board Committees
(previously STF) was under significant pressure in quarter 1 this is largely due to CIP pressures and Mental Health Out of Area beds.
Minutes of the Audit, Risk & Assurance Committee meeting
Tuesday 20 March 2018
09:30 – 12:30
Conference Room, Sterne 7, Tatchbury Mount, SO40 2RZ

Members:
David Kelham Non-Executive Director (Committee Chair)
Jeni Bremner Non-Executive Director
Dr David Hicks Non-Executive Director

In Attendance:
Nick Atkinson Head of Internal Audit, RSM
Lesley Barrington Head of Information Assurance & Data Protection Officer (Item 22)
Kim Hampson Local Counter Fraud Specialist, TIAA
Andrew Jackman Public Governor, Southampton
Sasha Lewis External Audit Partner, PricewaterhouseCoopers
Andy Morley Counter Fraud Area Manager, TIAA
Kim Perry Deputy Director of Finance
Becky Southall NHS Improvement
Lorna Squires NHS Improvement
Paul Streat Director of Corporate Governance
Alice Wainwright Manager, PricewaterhouseCoopers
Anna Williams Company Secretary & Head of Corporate Governance
Fiona Maton Head of Procurement

Apologies:
Paula Anderson Director of Finance
Dr Nick Broughton Chief Executive

1. **Chair’s Welcome and Meeting Protocol**

1.1. David Kelham welcomed members to the meeting, which he opened at 09:30.

1.2. He welcomed Lorna Squires and Becky Southall from NHS Improvement to the meeting, and Andrew Jackman, who was observing and he invited contributions from Andrew to the meeting.

1.3. He outlined the intention for the focus of the meeting to be on where Non-Executive Directors could give independent assurance to the Board on the organisation’s governance arrangements, and that the Trust abides by the highest standards of business conduct and service user delivery. In terms of the context of consideration of papers, he asked that Committee members give thought to whether the Trust was on track to be “outstanding”.

1.4. In recognition of the length of the agenda, David Kelham outlined the intention to focus on items 5 through to 12, and to take questions by exception only for items 13 to 23. He confirmed that Committee members had met in private with the External Audit Partner and Head of Internal Audit prior to the meeting.
2. Apologies for Absence
2.1. David Kelham reported the apologies received.

3. Declarations of Interest
3.1. There were no declarations of interest relating to items on the agenda.

4. Minutes of the meeting held on (09.01.2018) and matters arising
4.1. David Kelham asked that actions be attributed to paragraphs 5.2 and 5.3 of the minutes and that these be included on the action log.
4.2. Subject to the addition of these action points, the minutes were agreed as an accurate record of the meeting held on 09.01.2018.
4.3. In consideration of matters arising, it was confirmed that the Charitable Funds Accounts had now been signed; David Kelham reported on a constructive meeting with Lisa Franklin and Helen Reading in relation to the Trust’s IT and digital systems.
4.4. The Committee considered the action log; the actions completed and the target dates for submission of items to the Board and relevant Committees were noted.
4.5. The following updates were noted:
   ARAC 21.03.2017/4.7 This action remained open and would be considered as part of the discussions on Executive portfolios.
   ARAC 20.09.2017/7.5(a) Two policies had been drafted in response to recommendation arising from a Counter Fraud report; these were undergoing consultation and would come forward for approval via the Service Performance & Transformation Committee.
   ARAC 20.09.2017/7.5(b) It was agreed that this action be closed, with testing via the internal audit follow-up.
   ARAC 20.09.2017/9.3 David Kelham reported on a meeting with Julie Dawes and Jake Pursail, Risk Manager. The current risk appetite statement was considered to be adequate, but generic and that a further review was required. A Board seminar was planned for May 2018; in the meantime, it was proposed to recommend to the Board an extension of 3 months.
   ARAC 09.01.2018/5.4 David Kelham advised that he had spoken with Arthur Monks regarding the concerns raised; he had subsequently met with the IT team and had discussed the concerns regarding data encryption. A further meeting with Arthur Monks was proposed, and a commitment to respond in full to the points raised had been made.
ARAC 09.01.2018/6.3 Paul Streat confirmed that a review had been undertaken and a paper circulated to Committee members with the papers for the meeting; he highlighted the main areas of concern, which included lack of a clear access policy and audit process for the Ulysses system, as well as for other information systems. It was proposed that the report be presented to the Senior Management Committee for oversight of the action plan with assurance provided to the Audit, Risk & Assurance Committee on completion.

Nick Atkinson sought assurance that the specific concerns in relation to access to the whistleblowing element of the Ulysses system; this was confirmed.

Committee members sought clarification as to the management responsibility for the local IT systems; Paul Streat proposed that the system administration for the Ulysses system be brought under the management of the IT team.

It was agreed that this action be closed, on the basis of a report to the Committee following consideration by the Senior Management Committee.

ARAC 09.01.2018/7.3 The timetable was included in the papers for the Committee; the first draft of the Annual Report narrative would be submitted to PricewaterhouseCoopers by 27.04.2018; action closed.

ARAC 09.01.2018/10.2 This would be included as part of the discussion on the Board Assurance Framework; action closed.

ARAC 09.01.2018/10.4 This would be included as part of the discussion on the Board Assurance Framework; action closed.

5. Internal Audit Progress Report

5.1. Nick Atkinson presented the report, highlighting key updates since publication of the report:

5.1.1. The report on the management of temporary staffing had since been completed; some gaps in relation to medical locums had been identified. This would be reported to the next meeting;

5.1.2. Four further audits were nearing completion and were undergoing a final review process. In terms of the recommendations arising from the clinical audit review, Committee members asked that consideration be given to ensuring the recommendations made in the report be taken into account in the presentation of the Clinical Audit programme to the Quality & Safety Committee;

5.1.3. A review of the Trust’s readiness for GDPR compliance was planned for April;
5.1.4. There had been general improvement in terms of the Trust’s responsiveness to matters of overpayment, evidenced through the payroll feeder systems report. However, Nick Atkinson highlighted that some comparator Trusts had made relatively greater progress, most notably through the automation of key processes. Jeni Bremner asked whether the Trust was equally responsive to addressing issues of underpayments to staff promptly, in particular as this had a potentially significant impact on staff morale. It was proposed that a management response be provided.

**Action:** Finance Director / Director of Workforce, Organisational Development & Communications to provide assurance on the Trust’s responsiveness to underpayments to staff

**Date:** July 2018

5.2. David Kelham observed the volume of work planned in March, and noted the importance of management adhering to agreed timings. He also commented on the Non-Executive Director engagement on the review of risk management, noting that, whilst he was not able to comment on the Trust’s position prior to July 2017, there was consistent feedback that higher standards were being applied and that there was greater rigour in terms of the application of a target date and oversight of delivery. He commented that a consistent theme was whether the target scores for risks were realistic and achievable, and what action should be taken if the Trust was outside the agreed risk appetite. It was proposed that this be discussed further at the forthcoming Board seminar on risk.

6. **Internal Audit Strategy and Programme**

6.1. The Committee received the draft Internal Audit strategy for 2018/19 and audit plan for 2018-21. It was acknowledged that Committee members may wish to input to the proposed carry forward of the strategy to ensure this adequately reflected current priorities.

6.2. In terms of Executive engagement, Nick Atkinson confirmed that he had to date met with Paula Anderson, Paula Hull, Dr Nick Broughton and Paul Draycott; he had yet to meet with Julie Dawes. It was noted that whilst there had been no final sign off via the Executive, he was keen to take views from the Committee at this point. It was confirmed that the fees and number of days remained the same. The plan contained a blend of standard audit reports, as well as some which were specifically tailored towards the Trust, such as a review of the Serious Incident and mortality action plan, and work on Health & Safety.

6.3. The plan at Appendix A was highlighted; it was noted that the intention was to ensure that there was an even flow of reports through the year. It was proposed to invite feedback from Committee members over the next month, with initial comments invited at this point.

6.4. Jeni Bremner suggested that the timing to undertake the workforce audit in April be deferred, due to the current position in development of the Workforce Strategy. Nick Atkinson suggested that this provided an opportunity to provide a baseline position on the recruitment process.
6.5. In terms of the proposed coverage of items in the Internal Audit Strategy as set out in Appendix B, the following comments were made:

6.5.1. It was suggested that consideration be given to a focus on the increasing number of Serious Incidents reported in relation to pressure ulcers; it was agreed that Nick Atkinson would pick this up in conversation with Julie Dawes.

6.5.2. Dr David Hicks sought further information as to the focus of the complaints work; Nick Atkinson confirmed that the intended focus was on the management information available, including in relation to timeliness, but that the scope of this work would not include a qualitative review;

6.5.3. It was suggested that given the extent of expenditure on out of area placements, a review be undertaken on the Trust’s bed management processes;

6.5.4. On the basis that the proposed work on controls compliance also featured within the counter-fraud plan, it was suggested that this be delayed. It was noted that whilst work had been undertaken in 2017/18 regarding corporate credit cards, the intention of the internal audit work was to test the Trust’s response in relation to the actions arising from this review.

6.5.5. David Kelham noted the importance of a good understanding of the difference between information and data; he emphasised the importance of getting good quality information (data put into context) to inform decision making. Nick Atkinson confirmed that this was the focus of the work around data quality proposed within the plan.

6.5.6. It was proposed that further consideration be given to the work on financial forecasting and cost improvement plans to reflect the specific challenges faced by the Trust in terms of CIP delivery;

6.5.7. Andrew Jackman asked whether it would be possible for the work on the patient experience audit to be completed to feed in to the Annual Members’ meeting; Nick Atkinson indicated that this should be possible as the intention was for the work to have been completed by this point.

6.5.8. Overall, it was considered that the plan reflected good coverage of the key priorities for the Trust. The opportunity to undertake audit work at an early stage prior to changes being implemented allowed for a baseline position to be determined from which to assess progress;

6.5.9. It was noted that our current internal auditors had been in place for many years and the committee should consider a review in the coming year.

**Action:** Committee to review the internal audit contract in 2018/19

**Date:** 31.03.2019

6.6. Committee members queried the level of the fee that was indicated to be attributable to administration; it was noted that this reflected the seniority of people undertaking the work. A further breakdown of the fees was requested.

**Action:** Head of Internal Audit to provide breakdown of fees
Date: July 2018

6.7. It was agreed that the plan would be updated to take account of comments from Committee members, along with final comments from the Executive team.

7. **External Audit Update**

7.1. Sasha Lewis presented an interim progress report, noting that some information remained outstanding to support completion of the audit work; most notably in relation to Income and expenditure and for payroll testing in relation to employment contracts. In response to a query from Committee members, Sasha Lewis reported that the main issue in relation to personnel files related to the geographic dispersion of file, particularly in the case of long-term employees. Committee members expressed discomfort around this position, particularly in light of the new General Data Protection Regulations coming into effect; it was requested that an assurance statement be provided by the Paul Draycott as to the Trust’s position.

**Action:** Director of Workforce, Organisational Development & Communications to provide assurance to the Committee regarding the controls in place for management of personnel files

Date: July 2018

7.2. It was reported that there remained some information outstanding relating to Directors remuneration; a further meeting with Anna Williams was scheduled to review these files.

7.3. In terms of property valuation, it was confirmed that the work had been undertaken earlier, which had meant that the Trust was ahead of where it would normally be.

7.4. It was confirmed that the quality indicator that had been selected by the Council of Governors for audit was the Duty of Candour indicator. Anna Williams noted that the Council of Governors had additionally requested that an audit of the indicator relating to patient and family involvement in risk assessments and crisis contingency plans be included in the Internal Audit plan for 2018/19.

7.5. Committee members noted the Trust’s readiness and continuing engagement to meet the required timetable.

8. **External Recommendations**

8.1. The Committee received and discussed the report; it was highlighted that the paper tracked only those reports with overdue recommendations.

8.2. In discussion, the following points were raised:

8.2.1. In relation to the Next of Kin reporting, it was suggested that there was a national performance target that was higher than the 80% indicated within the update position. Paul Streat noted that the 80% was an internally determined target;

8.2.2. It was anticipated that the costing system audit would be complete by Quarter 1 2018/19;
8.2.3. The required policies in response to the patient travel claims and corporate credit cards recommendations were out for consultation and would then come forward for approval.

8.3. The Committee noted this report; it was proposed that a column be added to track the anticipated completion date and senior management sign off to confirm this.

**Action:** Company Secretary to update External Recommendations tracker to include the anticipated completion date and senior management sign off

**Date:** July 2018

9. **Counter Fraud Reports**

9.1. Apologies were given for the late circulation of the complete report, noting that this had arisen at the point of distribution of the papers, which had been duly received by the Corporate Governance team.

9.2. Andy Morley presented the report, highlighting the proactive work undertaken by the team; this included reviews of fit notes, management of patient monies and single tender waivers. The planned work on conflicts of interest had not yet been completed; the Committee asked that every effort be made by management to ensure that this work be completed as near to the end of March as possible.

9.3. In discussion of the reactive work; Andy Morley highlighted the ongoing work in relation to the case relating to a former member of staff who had worked for the Trust using her sister in law’s identity; the case was due to be heard at Oxford Crown Court in the summer.

9.4. It was reported that the workplan had been reviewed by the NHS Counter Fraud Authority, as per the requirements, with positive feedback reported. Key highlights for the forthcoming year included pre-employment checks, with a particular focus on management consultants; gifts, hospitality and sponsorship; and salary overpayments.

9.5. With reference the review of patient travel claims; David Kelham highlighted concerns with the Trust’s system for expense claims process that he had observed, notably in relation to discrepancies between the shortest route and the fastest route, suggesting that the policy needed to be sufficiently agile to allow for the most appropriate route to be undertaken.

9.6. There was discussion regarding the process for policy review; Paul Streat confirmed that there was a live register in place that ensured policies were updated regularly. Anna Williams outlined the intention for a full review of the policy management process via the Senior Management Committee; it was suggested that a report be provided to the Committee following consideration by the Senior Management Committee.

**Action:** Assurance report on policy management to come forward following Senior Management Committee review

**Date:** July 2018

9.7. In terms of the patient monies review; it was queried whether a patient incident had triggered this work. It was confirmed that this was not the case.
9.8. Committee members sought assurance as to where Bribery Act training was delivered; it was confirmed that this was referred to at induction, and awareness raising via roadshows. David Kelham advocated the introduction of online training for staff.

9.9. Andy Morley reported on the fit notes proactive work, noting the conclusion had identified some areas of concern; he confirmed that the outstanding response had now been received by management. Committee members asked that this be circulated for information.

**Action:** Trust response to fit notes proactive exercise to be circulated to Committee members

**Date:** 22.05.2018

10. **Counter Fraud Annual Plan**

10.1. The Committee received the Counter Fraud Annual Plan; Kim Perry reported that this had yet to receive formal consideration by the Executive. Committee members supported the plan in principle, but asked that this be circulated to the Executive for comment, prior to formal approval by the Committee.

**Action:** Deputy Director of Finance to circulate the Counter Fraud Plan for Executive comment prior to Committee approval

**Date:** 22.05.2018

11. **Board Assurance Framework and Risk Report**

11.1. The Committee received the Board Assurance Framework and risk report; David Kelham invited the respective Committee Chairs to highlight any key points raised in discussion at other Committee meetings.

11.2. In relation to SR1 and SR4, Dr David Hicks observed that there was improved ownership, and that following review there was a more realistic view of the risks in place, including improved targets and timeframe for completion of actions.

11.3. Jeni Bremner reported on the progress in relation to the management of risks assigned to the Service Performance & Transformation Committee, commenting in particular on the development of the People & Organisational Development strategy.

11.4. There was general consensus for the need for focus and pace to ensure delivery of actions to mitigate the identified risks. There was acknowledgement that this was an area that was being strengthened, evidenced by the audit work that was now underway in relation to NICE compliance, and the formal recognition and escalation to the Board of risks in relation to Ravenswood derogation.

11.5. David Kelham noted that SR5 had been expanded following feedback from the Committee at the last meeting; he expressed concern however that there remained weaknesses that were not reflected, such as the volume of data provided to the Board with inadequate conclusions and assurance. He commented on the narrative assurance provided to the Board in relation to out of area beds, as an example of this.
Action: Executive review of SR5 to take account of the comments from Committee

Date: 22.05.2018

11.6. Andrew Jackman commented on the improved focus and use of the Board Assurance Framework, but recognised that there was still more to do. There was the acknowledgement of the need to develop a shared understanding and agreement within the Board in relation to the Trust’s risk appetite.

11.7. In discussion of the report, there was challenge from Committee members in terms of the layout of the framework document, with observations that in some areas there were gaps in control identified with no identified actions to close these.

11.8. It was suggested that the wording in relation to SR5 be further expanded to reference patient demand and service demand, as there was currently inadequate reference of the triangulation of money, workforce and service user need. It was agreed that SR5 be reviewed further, in light of the progress with the Trust’s Workforce Strategy.

Action: Executive review of SR5 to take account of the development of the Trust’s Workforce Strategy

Date: 22.05.2018

11.9. In conclusion, there was a general view that the framework was improving, but further work was required. The need for consistent understanding of the framework, and agreement of the Trust’s risk appetite would be considered by the Board seminar in May. Committee members acknowledged the improved position in terms of targets in place, and that the evidence and assurance identified continued to progress; the need for the framework to be a useful tool to guide Board consideration on key issues was emphasised.

12. Risk Appetite Statement and Risk Management Policy

12.1. The Committee considered and supported the proposal to recommend to the Board an extension of the current Risk Appetite Statement to June 2018, to allow for full Board engagement on the review.

12.2. Paul Streat sought views from Internal Audit on this proposal, in light of the audit work underway on risk management systems within the Trust; Nick Atkinson confirmed that overall the draft report provided positive assurance, but recognised that there was still further work required, particularly to develop shared understanding and agreement amongst the new Board.

13. Codes of Conduct review

13.1. The Committee received the Codes of Conduct and agreed to recommend the adoption of the current Codes of Conduct to the Board.

14. Constitution & Standing Orders
14.1. The Committee noted the progress on the review of the Constitution and Standing Orders.

15. Review of Standing Financial Instructions
15.1. The Committee noted the progress on the review of the Standing Financial Instructions and took assurance that no urgent or immediate changes were required in the interim.

16. Review of Scheme of Delegation & Board Reserved Powers
16.1. The Committee noted that the review of the Scheme of Delegation & Board Reserved Powers had not yet commenced, and was predicated on the review of the Constitution and Standing Orders, but took assurance that no urgent or immediate changes were required in the interim.

17. Going Concern declaration
17.1. The Committee considered the report and approved the policy wording and the recommendation that the 2017/18 Trust accounts be prepared on a going concern basis.

18. Procurement Compliance Report
18.1. The Committee considered the report; members sought clarification as to the 75% compliance for use of purchase orders as reported. It was confirmed that this related to 75% of eligible expenditure. David Kelham suggested that it would be helpful for future reporting to be by both volume and value to aid interpretation.

Action: Finance Director to include volume and value of purchase order usage to aid interpretation of compliance
Date: July 2018

18.2. The Committee acknowledged the skew that was attributable to out of area beds; Fiona Maton advised that this had arisen from the failure to raise waivers, but assurance was provided that work was underway to remedy this. She apprised Committee members of the plan that was in place to ensure that future procurement of out of area placements was via Purchase Order. Committee members sought assurance that there was management control to ensure that when people were placed out of area this followed due process; it was suggested that Mark Morgan was the best placed to respond to this.

Action: Director of Operations (Mental Health & Learning Disabilities) to provide assurance that due procurement process was followed for the purchase of out of area beds
Date: July 2018

18.3. Fiona Maton acknowledged that many Trusts spot-purchased out of area placements, and noted that work was underway via the procurement hub to support this.
18.4. Committee members sought clarification as to the instances when waivers were used; it was noted that this was generally in cases where provider continuity was critical, such as for IT provision, and where timescales genuinely precluded competitive tendering, such as in the case of urgent remedial safety works. Fiona Maton noted that the Trust sought to put frameworks in place wherever possible, so as to minimise waiver usage.

18.5. Fiona Maton highlighted the reduction in invoices over £10k approved without a Purchase Order being in place; assurance was provided that in the instances where this occurred there was individual follow up with responsible managers to seek assurance that a competitive process had been followed.

18.6. Committee members emphasised the importance of having good controls on expenditure and that the management processes supported compliance.

19. Off Pay-roll engagements and use of management consultancy

19.1. It was noted that the paper circulated within the Committee pack was the incorrect report; it was requested that the correct paper be circulated to Committee members.

Action: Finance Director to circulate updated report on off payroll engagements and use of management consultancy

Date: 22.05.2018

20. Banking arrangements

20.1. The Committee received the report, and took assurance on the banking arrangements in place.

21. Losses and special payments

21.1. The Committee noted the report. David Hicks sought clarification on the decrease reported between 2017/18 from 2016/17; it was confirmed that this related to a severance payment paid to the former Chief Executive.

22. General Data Protection Requirements

22.1. Lesley Barrington, Head of Information Assurance, presented the report, outlining the Trust’s readiness position for the implementation of the General Data Protection Regulation (GDPR) from May 2018. The Information Team were actively monitoring NHS specific guidance, and work was underway to ensure that the Trust was compliant with the Data Security Standards published in response to the National Data Guardian’s review. It was anticipated that the Trust would be in a position to make a compliant declaration to NHS Improvement in terms of readiness, although it was acknowledged that the online portal was not yet live.

22.2. David Kelham noted that a query had been raised by a Governor regarding the GDPR requirements on the Trust in relation to the information held on the Membership database. Paul Streat indicated that the advice received to date suggested that the Trust could seek to make some amendments to the website to make the process to opt out more transparent, but that no proactive action was
required to require members to “opt in”. It was proposed that a further discussion be held with the Membership Engagement Group of the Council of Governors to apprise them of the Trust position.

23. Accounting Policy and Critical Judgements Update

23.1. The Committee received the report on accounting policy and critical judgements; the proposed approach was supported by Committee members.

23.2. It was agreed that a note be included within the accounts disclosing the GP partnership arrangements, but that there was no requirement for group accounts to be prepared.

24. Policy on provision of non-audit services

24.1. This item was deferred; Nick Atkinson offered to share examples of good practice from other providers with the Trust for consideration.

Action: Finance Director to provide recommendation on policy of provision of non-audit services

Date: July 2018

25. Review of Terms of Reference, Agenda Framework & Committee Effectiveness

25.1. The Committee supported the recommendations within the report, namely:

25.1.1. That the Council of Governors be consulted on the draft Terms of Reference for the Committee prior to recommendation to the Board;

25.1.2. Approval of the draft Agenda Framework for the Committee; and

25.1.3. That consideration be given by the Committee Chair, Director of Finance and Company Secretary to the approach to the review of committee effectiveness that would be undertaken during the summer.

25.2. The need to ensure that there was adequate time allowed to give due consideration of items on the agenda was noted.

Post meeting note: The HFMA publication of the specimen Terms of Reference for an NHS Audit Committee on 21.03.2018 led to a further review of the Terms of Reference being undertaken to ensure alignment with best practice

26. Any Other Business

26.1. There was no other business reported.

27. Governor feedback

27.1. Andrew Jackman observed the strengthened focus on assurance through the new Committee membership; he commented however on the high volume of papers, and notably the number of papers received late.
27.2. David Kelham invited feedback from NHS Improvement and colleagues from Internal Audit and External Audit in attendance:

27.2.1. It was observed that whilst there had been generally good progress, the committee discussion had slowed at the risk management discussion, and there was the need for a common understanding of risk amongst members;

27.2.2. There had not been strong Executive attendance at the meeting; however, this was considered to be unusual, and due to the conflict with the rescheduled court hearing;

27.2.3. Further comments from NHS Improvement would be provided to the Trust outside of the meeting, as part of the broader work to support the review of governance arrangements within the Trust.

28. Items for Reporting to Board

28.1. It was agreed that the following items would be reported to the Trust Board:

- The review of the Board Assurance Framework and intention for a Board seminar on risk appetite
- The discussions on the Internal Audit Plan and Counter Fraud work plan in readiness for sign off of these
- The work underway on the year-end process
- The position on GDPR readiness

29. Close

29.1. David Kelham thanked Committee members for their attendance and closed the meeting at 13:15.

Certified as a true record of the meeting

Committee Chair – David Kelham

Date
Minutes of the Mental Health Legislation Sub-Committee meeting  
Tuesday 16 January 2018  
11:00 – 13:00  
Conference Room, Sterne 7, Tatchbury Mount, Calmore, Southampton, SO40 2RZ

Members:  
David Monk   Non-Executive Director (Chairman/Committee Chair)  
Jeni Bremner   Non-Executive Director  
Sarah Constantine Interim Medical Director  
Siven Rungien Mental Health Act Manager  
Julie Dawes Director of Nursing & Allied Health Professionals

In Attendance:  
Lynne Hunt Chair

Observing:  
Andrew Jackman Public Governor  
Josie Metcher Public Governor  
Susie Scorer Public Governor

Apologies:  
Dr Nick Broughton Chief Executive

Secretariat:  
Amanda Bryant Corporate Governance Manager

1. Chair’s Welcome and Meeting Protocol  
1.1. David Monk welcomed members to the inaugural meeting, which he opened at 11:00.  
1.2. He highlighted that this was a new Committee for the Trust which would look at the Mental Health Act and Mental Health Legislation, and how they were being implemented and monitored within the Trust.  
1.3. The Committee discussed its purpose, noting the importance of the Mental Health Act and the need for Board level awareness. It was noted that this was core to everything to Trust did and therefore had an enormous impact on everyone the Trust came into contact with.  
1.4. In response to a question raised by David Monks, it was agreed that a masterclass on the Mental Health act and legislation would be arranged for all Governors.

Action:  
Interim Medical Director to run a masterclass for Governors and interested Board members on the Mental Health Act and the Mental Health Legislation

Date:  
01.05.2018

180605 TB 22.2 App 7
2. **Apologies for Absence**

2.1. Apologies were noted from Dr Nick Broughton.

3. **Declarations of Interest**

3.1. There were no declarations of interest relating to items on the agenda.

4. **Themes arising from other Committees**

4.1. The Committee discussed where its position was in the Governance framework for Trust, and how it would report into the Quality & Safety Committee and the Board. It noted that the work of the Committee would actively link in with the work of the Service Performance & Transformation Committee and Quality & Safety Committee, and that themes would be also be raised through this agenda item at those meetings.

5. **Committee Terms of Reference**

5.1. The Committee discussed the draft Terms of Reference, suggesting changes prior to submission to the Board. It was agreed that reporting lines of the Committee to the Board and Quality & Safety Committee were to be made clearer and the list of attendees should be expanded to ensure the right staff were in attendance. It was agreed that the name of the Committee would be changed to the Mental Health Legislation Sub-Committee and that the purpose of the Committee would be further expanded and reworded for clarity.

* Lynne Hunt joined the meeting *

5.2. The duties were also discussed and further emphasis was included on the need for the Trust to be involved in consultation on changes to the act, as well as to the need to listen to the experiences of service users, families and carers on their experiences of the use of the act.

5.3. The Committee discussed how the Trust worked with local partners and stakeholders, and noted that the Crisis Concordat and the Mental Health Act Committee had regular attendees from local authorities, the police and service users. It was agreed that local partners or service users could be invited to a future Committee meeting to assist in discussing a specific subject matter if required, but that they would not be included as a regular attendee at this time.

5.4. Andrew Jackman questioned how the Trust received feedback on the impact of the Mental Health Act in practice. The Committee discussed whether they would like to invite someone with lived experience to come to a future meeting, or if the meetings commence with a patient story. It was agreed Sarah Constantine would look into this further.

**Action:** Interim Medical Director to look into a way of ensuring the Committee could gain a real understanding of the impact of the Mental Health Act on people’s lives.
5.5. In response to a statement from Susie Scorer, the Committee asked Susie to link in with the Recovery College and see whether they would be able to help obtain a true feel for the impact of the Mental Health Act on people’s lives.

**Action:** Susie Scorer to speak to her contacts at the Recovery College to see how they could help identify the impact of the Mental Health Act on their lives

**Date:** 10.04.2018

7. **Current Mental Health Act Activity**

7.1. The Committee received a report outlining the Trusts’ activity against the mental health act, specifically looking at the admissions on sections; community treatment orders; section changes; and transfers.

7.2. In response to a query from David Monk, Sarah Constantine confirmed that the Trust was actively looking at the community treatment orders, specifically section 17 leave, as well as how people were moving between the Act.

7.3. The Committee agreed that it wanted to be able to see how the use of the Act impacted on the length of stay in the Trust, whether there was any impact on bed usage, or if there was a pattern on the use of the act with clinicians.

7.4. In response to a number of questions in relation to the terminology and language used within the report, it was agreed that a glossary would be produced and appended to the reports for future meetings.

**Action:** Glossary to be produced and appended to the reports for future meetings

**Date:** Ongoing

7.5. The Committee discussed the figures within the report, noting that further discussions were required to provide assurance to the Committee as it was unclear whether the figures reported were assurance for the Committee, or should be a concern.

6. **Priorities and Focus for 2018/19**

6.1. As a result of the review of data and discussions which took place, it was agreed that the four areas identified below would be a priority for the Committee:

- Gaining assurance that the Trust’s administration of the Mental Health Act and Capacity Act was of the highest quality meeting all the standards lay down within the code/s;
- Gaining assurance that the Trust is meeting the new standards (amendments) set out for s136 the 72 to 24 hour time for an assessment;
- Deep dive on the use of section 136; and
- Deep dive on Section 17 leave.
6.2. It was agreed that Section 136 and Section 17 leave would be the priorities looked at in detail at the next meeting and that this would include a review, where possible, on the use of section by consultant role.

6.3. Sarah Constantine informed the Committee that the Care Quality Commission were undertaking Mental Health Act Visits, and that she would provide update reports to the Committee when they become available.

**Action:** Interim Medical Director to provide regular reports to the Committee on the CQC Mental Health Act Visits

**Date:** Ongoing

6.4. It was also agreed that regular reports would be provided to the Committee on any recent or imminent changes to the law/legislation.

**Action:** Mental Health Act Manager to provide regular reports to the Committee on recent or imminent changes to the Act, law or legislation.

**Date:** Ongoing

8. **Cycle of Committee Business**

8.1. It was noted that the agenda framework for the Committee was being discussed as part of a wider review of the Board and Board Committees. This would be presented to a future meeting for approval.

9. **Any Other Business**

9.1. There was no other business reported.

10. **Governor Feedback**

10.1. Andrew Jackman, Josie Metcher and Susie Scorer fed back that they were really pleased about the Committee being established. They indicated their keenness for the Governor Patient Experience & Engagement Group to link into some of the discussions taking place around the impact of the Mental Health Act on people’s lives.

11. **Items for Reporting to Board**

11.1. It was agreed that the following items would be reported to the Trust Board:

- The purpose of the Committee
- The Review of the Terms of Reference
- Current Mental Health Act Activity and priorities for 2018/19

12. **Close**

12.1. David Monk thanked members for their attendance and closed the meeting at 13:00.
Certified as a true record of the meeting

Chair / Committee Chair – David Monk

Date
Minutes of the Quality & Safety Committee meeting
Tuesday 20 March 2018
13:30
Conference Room, Sterne Road, Tatchbury Mount, Calmore, SO40 2RZ

Members:
Dr David Hicks  Non-Executive Director (Committee Chair)
Jeni Bremner   Non-Executive Director
David Monk   Non-Executive Director
Julie Dawes  Director of Nursing & AHPs

In Attendance
Bryony Cooper Programme Lead (Quality Governance)
Dr Sarah Constantine Acting Medical Director
Mayura Deshpande  Associate Medical Director (Quality)
Julie Lake  Associate Director of Nursing & AHPs
Helen Ludford  Associate Director of Quality Governance
Caz Maclean  Associate Director of Safeguarding
Mark Morgan Director of Operations (Mental Health, Learning Disabilities and Social Care)

Apologies:
Paula Anderson  Finance Director

1. Chair’s Welcome and Meeting Protocol
1.1. Dr David Hicks welcomed members to the meeting, which he opened at 13:30.

2. Apologies for Absence
2.1. Dr David Hicks reported the apologies received.

3. Declarations of Interest
3.1. The Register of Interests was noted.

4. Minutes of the meeting held on (20.02.2018) and matters arising
4.1. Mayura Deshpande requested that paragraph 6.5 read…. ‘problem across the country had arisen from a change in’ …..

4.2. The Committee discussed the next steps as a result of the discussion at paragraph 10.5 relating to Ravenswood. Dr David Hicks confirmed that he had informed the Board of these discussions at part of his Board Committee update. He
understood that further discussions would continue to take place at future Board meetings.

4.3. Subject to these amendments, the minutes were agreed as an accurate record of the meeting held on 20.02.2018.

4.4. In consideration of the action log it was agreed that the following actions were closed.

<table>
<thead>
<tr>
<th>Date</th>
<th>Ref</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/09/2017</td>
<td>19.1</td>
<td>Director of Nursing and AHPs to develop an ‘at-a-glance’ matrix for action plans.</td>
</tr>
<tr>
<td>16/01/2018</td>
<td>9.3</td>
<td>Director of Operations to provide an update on the capital bid for ligature works at Parklands Hawthorn 2</td>
</tr>
<tr>
<td>16/01/2018</td>
<td>13.3</td>
<td>Director of Nursing &amp; Allied Health Professionals to include more detail on the Tissue Viability deep dive in the next report</td>
</tr>
<tr>
<td>16/01/2018</td>
<td>15.3</td>
<td>Medical Director to present a detailed report to the May meeting on the work around the NICE Guidelines</td>
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5. Themes arising from other Committees

5.1. Dr David Hicks informed the Committee that NHS Improvement were observing all of the Board Committees and that feedback would be shared with the Board once received.

5.2. Jeni Bremner informed the Committee that the purpose of the Service Performance & Transformation Committee had been reviewed, and that it had been agreed that a new sub-committee would be established to focus on workforce, called the Workforce & Organisational Development Sub-Committee. She confirmed that this meant that the Service Performance & Transformation Committee would change its name to Finance & Performance and that the Terms of Reference for both meetings were being agreed and would go to the Board for approval.

5.3. David Monk reported that the next Mental Health Legislation Sub-Committee was due to meet in April 2018 and that he had attended the last Governor Development Day where Governors had feedback that they had felt welcomed and involved in the discussions at Board Committee meetings.

6. Review of Terms of Reference, Agenda Framework, Committee Effectiveness and Committee Annual Report to Board

6.1. Amanda Bryant presented the report, highlighting that the draft agenda framework would be discussed in more detail with the Committee Chair at a meeting arranged for 27.03.2018.

6.2. David Monk suggested that the 2.1 of the terms of reference be split into two sentences so that Health & Safety and Clinical Quality were under two separate
sentences. He also suggested that the reference to Patient Safety, in the same paragraph, be made more specific.

6.3 Subject to the change indicated above, the Committee approved the Terms of Reference for presentation to the Board, and agreed to the proposed approach for the annual review of the Committee.

7. Risk Report

7.1 Julie Dawes presented the report, outlining in detail progress made against the two strategic risks reportable to the Quality & Safety Committee, as well as providing an overview of the refreshed Board Assurance Framework.

7.2 Julie Dawes reported that NICHE were due to come back to visit the Trust in April/May 2018 to undertake a deep dive into the investigations reports. She confirmed that she would share the feedback received with Committee members when available.

Action: Reports received from NICHE in relation to their deep dive into the investigation reports, to be shared with the Committee

Date: 17 July 2018

7.3 The Committee discussed the Borderline Personality Pathway and indicated that it wished to gain a greater understanding of the pathway. It suggested that consideration also be given as to how this fitted in with the Quality Improvement methodology currently being rolled out across the Trust and that a presentation on this be undertaken at the July 2018 meeting.

Action: Presentation on the Borderline Personality Pathway to the July 2018 meeting

Date: 17 July 2018

7.4 In relation to Strategic Risk 4, ‘There is a risk that patients have a poor experience or level of engagement with our services’, Julie Dawes informed the Committee that Dawn Buck had been appointed as the new Head of Patient Experience, Engagement and Involvement, and that she would be looking to revise the Trust’s Patient Experience & Engagement strategy and plan for next year as a priority. David Monk requested that a wide range of service users, families, carers and Governors be invited to help revise this strategy, ensuring that it was void of jargon and was in a language which was easy to read and understand. It was agreed that the draft Patient Experience and Engagement Strategy would be presented to the Committee for consideration ahead of a final draft being received.

Action: Draft Patient Experience & Engagement Strategy to be presented to the Committee, ahead of formal approval

Date: TBC

7.5 Dr David Hicks provided an overview of discussions held around the Board Assurance Framework at the March Audit, Risk & Assurance Committee meeting. He indicated that there would be a Board Seminar meeting held in May 2018, where the Board Assurance Framework and how it might look going forward, would be discussed in more detail.
7.6. In response to a query from Jeni Bremner, Julie Dawes indicated that the original risk 872, had been resolved, but that other risks with the same heading had been added, but the date of the risk had remained the same. She confirmed that the Trust had mitigated this risk, but that further work was required to bring the risk score down. She reported that funding had not caused a delay in mitigating the risk and confirmed that this risk would be considered by the Executive Team and rescored as appropriate.

8. Improvement Action Plan Updates

8.1. Bryony Cooper provided overview of the report, highlighting that the CQC action plan was 68% complete, the family involvement plan was 57% complete and that 157 of the 171 actions from the Mental Health Action Plan had been completed.

8.2. In response to a query from Dr David Hicks, Bryony confirmed that a considerable amount of progress had been made against the actions plans, and that progress could be shown on the actions that weren’t completed by the time the CQC visited in the summer.

8.3. The Committee received assurance from the report and noted the progress made in completing the actions on all of the plans.

Bryony Cooper left the meeting

9. Quality Report

9.1. Helen Ludford presented the report, highlighting that its aim was to provide assurance against the monitoring of quality governance activities and operational performance since the last meeting. The Committee discussed in detail the risks and challenges as outlined in the paper, focusing on the upcoming CQC Inspection, the Northumberland, Tyne and Wear visit to Antelope House and the outbreak of Legionella at Melbury Lodge.

Mark Morgan joined the meeting

9.2. The Committee thanked Helen for the report. It suggested that a thematic review of the serious incidents takes place, and that this is shared with the Committee when available.

Action: Thematic review of serious incidents to be shared with the Committee when available

Date: 18 September 2018

10. CQC: Trust self-assessment of readiness

10.1. Julie Dawes provided an overview of the report, highlighting the amount of work undertaken to complete the PIR in preparation for the CQC visit. She reported that the CQC were expected to carry out the full comprehensive review of the Trust in May/June 2018, and that they would be inspecting the Trust’s core services against their five domains.

10.2. Julie reported to the Committee that the Trust had been working with NHS Improvement to carry out a Well-led review and that a Board Seminar session took place in February to discuss this further.
10.3. The Committee thanked Julie and her team for all their hard work with staff to help the Trust prepare for the inspection. It was agreed that a further discussion on progress and preparedness for the CQC visit was required at the May 2018 meeting.

Action: Report on the CQC Visit to be presented to the May 2018 Committee meeting

Date: 08 May 2018

Peter Prichard-Smith joined the meeting

14. Fire Safety Report

14.1. Peter Prichard-Smith joined the meeting to provide an update on progress made within the Trust following the Hampshire Fire and Rescue Service inspections at Petersfield and Gosport Hospitals in March 2017. He outlined the joint work as part of the Primary Authority Scheme with Hampshire Fire and Rescue Service supporting the Trust to help improve fire safety throughout the Trust.

14.2. Peter Prichard-Smith reported that the inspection had resulted in 11 recommendations/actions for the Trust to implement. He confirmed that the majority of those had been delivered, or were on track to be delivered within the agreed timescale.

14.3. In response to a question from Dr David Hicks, Peter Prichard-Smith confirmed that consideration needed to be given to the skill mix of the team as there was currently two staff who were employed on a fixed term contract. He indicated that there was a need to ensure that the Trust remained focused on this after the actions had been implemented, to ensure it remained complaint.

14.4. In response to a question from Jeni Bremner, Peter Prichard-Smith confirmed that all sites/wards had sufficiently trained fire wardens and the Trust was therefore 100% compliant with the requirement.

14.5. In response to a query by David Monk, Peter Prichard-Smith confirmed that there was a risk around lone working and service users potentially setting alight to their homes/buildings. Caz McLean thanked Peter and his team for the support received in terms of safeguarding those staff to help service users should the need arise.

14.6. The Committee confirmed that they had received assurance from the report, noting the hard work of the team.

Peter Prichard-Smith left the meeting

11. Incident, Serious Incident and Mortality Report

11.1. Helen Ludford presented the report, highlighting that in February the Trust had achieved 97% compliance to mortality panels within 48 hours, 100% compliance against the evidence of the correct decision making as a result of panels, and 83% compliance for submission to STEIS within 60 days. She also reported that the Family Liaison Officer was supporting 17 families on a regular basis.

11.2. Julie Dawes brought to the attention of the Committee the restriction of lithium batteries at Bluebird House, and informed them that the Trust was revising this
restriction as it had been included on the Risk Register; she confirmed that controls were in place such as room searches.

11.3. Julie Dawes reported that Leigh House had seen an increase from 20 incidents in January 2018 to 47 in February 2018, the majority of which related to a specific complex patient who undergoes nasogastric feeding**redacted personal information**. She confirmed that there were care plans in place to address these challenges.

11.4. In response to a suggestion from David Monk, Julie Dawes confirmed that she would review the report and add in further explanations of the serious incidents detailed within the table. She also confirmed the she would review the report to ensure it was easier to follow, specifically around the serious incident figures/graphs on page 130 of the report.

11.5. The Committee discussed the report in detail, discussing the criteria for Never Events, the differences between the recommendations and actions within the report, as well as the learning from the serious incidents. The Committee confirmed that it had received assurance from the report, with the amendments as discussed.

12. Safeguarding Quarter 2 & 3 report

12.1. Caz McLean presented the reports to the Committee, providing an overview of the work of the Safeguarding and Children in Care Teams during quarters 2 & 3. She highlighted the reasons for the delay in the quarter 2 report, confirming that the Trust was now on back to time with the reports.

12.2. The Committee discussed the levels of training compliance, noting that all areas were non-compliant with Safeguarding Children Level 3 training. Caz McLean confirmed that this was as a result of the levels of delivery/capacity within the Corporate Safeguarding Team and that this had been added to the risk register, as well as being overseen by the Safeguarding Forum.

12.3. The Committee discussed in detail the work of the Multi-Agency Safeguarding Hub, noting the higher than forecasted referral rates into the team and the capacity issues of the staff to underrate the research as per the original specification.

12.4. In response to a question from Dr David Hicks, Caz McLean confirmed that the Trust had escalated these issues with the Quality Oversight Committee and the Health & Wellbeing Board. Julie confirmed that she would work with Caz MaClean to help continue to raise awareness and resolve.

13. Medicines related errors

13.1. Dr Sarah Constantine presented the report, highlighting that the Trust was compliant with the NHS England Patient Safety Alert stage 3: ‘improving medication error incident reporting and learning March 2014’.

13.2. Dr Sarah Constantine informed the Committee that there was one patient safety alert regarding valproate that was overdue for completion. She highlighted the trends and types of medicines management incidents reported by the Trust for quarter 3.
13.3. The Committee discussed the trends and medicines management incidents, noting the increase in insulin incidents and the release of the 'learning from incidents' bulletin. It requested that future reports did not include any embedded documents and instead that the content was included within the full report if relevant.

15. Approval of Annual Clinical Audit Programme

15.1. Dr Sarah Constantine requested approval for the contact and implementation of the 2018/19 Clinical Audit Programme. She confirmed that the core content of the audit programme reflected the Trust’s commitment to the commissioners and internal quality priorities, and had been compiled to focus on quality targeted audits.

15.2. Helen Ludford confirmed that once completed, the clinical audits were presented and discussed by the Clinical Effectiveness Group. She noted that the minutes of this group were presented to the Quality and Safety Committee on a regular basis.

15.3. Dr David Hicks noted that this had been discussed at the Audit Risk & Assurance Committee and it had been agreed there that there needed to be consideration given to the learning aspect of the audits. It was agreed that Dr Sarah Constantine, Julie Dawes and Helen Ludford would discuss this further outside of the meeting.

Action: Dr Sarah Constantine, Julie Dawes and Helen Ludford to discuss how the learning from the Clinical Audit Programme was captured and shared

Date: 08 May 2018

16. Safety sub-group Report

16.1. Helen Ludford presented the report from the Patient Safety Group, highlighting the reports which had been approved since the last meeting and the patient’s stories which had been presented to the Group.

16.2. The Committee noted the report.

17. SAFER Forum

17.1. Mayura Deshpande provided an update from the SAFER Forum, highlighting the new restraint training package the Trust now offered, the work with Merseycare to reduce violence and aggression within the Trust, and the use of seclusion.

17.2. The Committee discussed in detail the work with Merseycare and the potential options being considered by the Executive Team to reduce the level of violence and aggression within the Trust. She highlighted that one of the options being considered was the introduction of Clinical Advisors who would be on call to help any teams to deescalate a situation should it arise. She confirmed that this could be over the telephone or face to face if necessary.

17.3. The Committee requested that future reports show a breakdown in the type of restraint used with benchmarking information where applicable.
Action: Future SAFER Forum reports to include a breakdown of the type of restraint used, as well as benchmarking information
Date: 17 July 2018

18. Any Other Business
18.1. There was no other business reported.

19. Governor Feedback
19.1. Dr David Hicks reported that Governors had prior commitments and therefore were unable to attend the meeting. He confirmed that they would continue to be invited to observe and contribute at future meetings.

20. Items for Reporting to Board
20.1. It was agreed that the following items would be reported to the Trust Board:
   - Assurance on the Strategic Risks reportable to the Committee;
   - Visit by Northumberland Tyne and Wear to Antelope House;
   - CQC preparation work;
   - Fire Safety Report;
   - 100% STEIS reporting; and
   - Concerns around the Multi-Agency Safeguarding Hub.

21. Close
21.1. Dr David Hicks thanked Board members for their attendance and closed the meeting at 16:00.

Certified as a true record of the meeting

Committee Chair – Dr David Hicks

Date
Minutes of the Senior Management Committee meeting  
Wednesday 25 April 2018  
09:00 – 12:00  
Conference Room, Sterne 7, Tatchbury Mount

**Members:**
- Dr Nick Broughton  Chief Executive
- Paula Anderson  Director of Finance
- Sara Courtney  Deputy Director of Nursing
- Sue Damarell-Kewell  Associate Director of Planning & Performance
- Julie Dawes  Director of Nursing & AHPs
- Paul Draycott  Director of Workforce, Organisational Development & Communications
- Chris Fokke  Chief Clinical Information Officer
- Paula Hull  Acting Director of Integrated Services
- Dr Karl Marlowe  Medical Director
- Mark Morgan  Director of Operations (Mental Health & Learning Disabilities)
- Andy Mosley  Associate Director of Estates
- Tom Westbury  Associate Director of Communications

**In Attendance:**
- Anna Williams  Company Secretary & Head of Corporate Governance
- Lorna Squires  NHS Improvement
- Sarah Spooner  Corporate Governance Coordinator
- Raj Parekh  Chief Pharmacist (Item 17)
- Carl Partridge  Deputy Chief Pharmacist (Item 17)
- Andrew Betteridge  Head of Programme Delivery (Items 12, 16)

**Apologies:**
- Dr Mayura Desphande  Associate Medical Director (Quality)
- Dr Sarah Constantine  Associate Medical Director (Revalidation)
- Lisa Franklin  Director of Technology & Chief Information Officer
- Dr David Kingdon  Clinical Director
- Julia Lake  Acting Deputy Director of Nursing (ISD)
- Kim Perry  Deputy Director of Finance

1. **Chair’s Welcome and Meeting Protocol**
   1.1. Dr Nick Broughton welcomed members to the meeting, which he she opened at 09:00. Introductions were made, and Lorna Squires and Sarah Spooner, who were both observing the meeting, were welcomed.

2. **Apologies for Absence**
   2.1. Anna Williams reported the apologies received; it was noted that Dr Karl Marlowe and Dr David Kingdon would be joining the meeting shortly.
3. **Declarations of Interest**

3.1. There were no declarations of interest relating to items on the agenda.

4. **Minutes of the meeting held on 14.03.2018 and matters arising**

4.1. The minutes were agreed as an accurate record of the meeting held on 14.03.2018.

4.2. The Committee considered the action log; the actions completed and the target dates for submission of items to the Board and relevant Committees were noted.

4.3. The following updates were noted:

271 – Invitation to Quality Health to present the findings of the Mental Health Community Services User Survey to be taken forward with presentation to Service Performance & Transformation Committee.

272 – Mark Morgan to work with Susannah Preedy / Chris Ainsworth to bring forward Trust action plans in response to Mental Health Community Services User Survey in May.

286 – Work was underway, supported by a dedicated member of the Estates team. The priority was deemed to be inpatient units, but good coverage across the Trust was required. Support from the Communications team in raising awareness was agreed. Paula Anderson agreed to discuss with Mark Morgan whether any further specific support was required. Monitoring was via divisional / business unit performance meetings.

287 – A standard approach to the development of risk assessments was being agreed through the Record Keeping Group.

290 – A report on pharmacy supply was on the agenda; action closed.

296 – The Trust was engaged with the system meeting in relation to the Gosport War Memorial Hospital Independent inquiry; action closed.

297 – CQC system reports to be shared once received; action closed

299 – A full discussion on Out of Area bed usage was planned by the Committee

300 – Meeting arrange with OSC Chair for Dr Nick Broughton and Dr Mayura Deshpande; action closed.

301 – Secure Services included on agenda framework; action closed.

303 – Update on financial planning on agenda; action closed.

304 – Report on waivers on agenda; action closed.

305 – Draft IPR document to be shared with Governors following meetings with Executive.

306 – Draft Performance & Accountability Framework to come back to Committee in May.

307 – Report from GMC visit to be provided to Committee on receipt.
311 – Capital prioritisation list included in papers; action closed.
312 – Report on system access controls on agenda; action closed.
4.4. Dr Nick Broughton indicated the intention for a focused discussion on Out of Area Placements, as part of the operational report.

5. Chief Executive’s Update
5.1. Dr Nick Broughton informed Committee members of changes and new appointments to the Executive team. He welcomed Dr Karl Marlowe, and noted that Barry Day would be joining the Trust in the summer. Mark Morgan and Julie Dawes would be leaving the Trust in May and in the summer respectively. Interviews for the Director of Nursing position would be held in June. He congratulated Tom Westbury on his substantive appointment as Associate Director of Communications.

5.2. The pace of progress on the wider system work was commented on, including a visit from Clare Murdoch to the STP Mental Health Programme; the focus of which had been on the investment in mental health services, which remained a challenge. Whilst commissioners had sought to meet the Five Year Forward View commitments, there had not been any uplift to the contracts to reflect the demand increase.

5.3. There was a planned CQC preparation session for circa 100 staff in readiness for the forthcoming CQC review that afternoon; all Executive team members would be attending for part.

6. Communications report
6.1. Committee members received the report; the main focus in terms of recent coverage had been the sentencing decision in relation to the prosecution by the Health & Safety Executive. This had also received comment in Prime Minister’s Questions, with the response making reference to the Trust’s forthcoming CQC inspection.

6.2. A recent Health Service Ombudsman report had featured a case relating to a former service user of the Trust.

6.3. There had been some positive coverage of the Trust, including in relation to the expansion of perinatal mental health services, the appointment of Dr Karl Marlowe and other local initiatives.

6.4. Internal work focused on supporting CQC readiness, the promotion of the transformation programme and the secure services development. Support was also being provided to the Annual Report summary document. The annual Star Awards nominations process was being launched in May.

6.5. Forthcoming media attention was expected in response to the Gosport War Memorial Hospital inquiry and the NMC hearings. The Trust had also been contacted by the BBC in relation to a documentary at Bluebird House.

6.6. In relation to the forthcoming NMC hearings, Sara Courtney highlighted the likely operational impact on staff within the Trust. Assurance was sought that appropriate support was being provided to staff; this was confirmed. Julie Dawes
agreed to provide a full brief to Dr Nick Broughton in relation to these cases, including consideration of the Trust’s response to these.

**Action 313:** Dr Nick Broughton & Julie Dawes to discuss forthcoming NMC cases  
**Date:** 31.05.2018

7. **Integrated Performance Report**

7.1. It was noted that the Integrated Performance Report was not available for this meeting; the delay was attributable to the year-end work. This would come forward for consideration at the informal Exec meeting.

**Action 314:** Integrated Performance Report to be presented to Informal Exec  
**Date:** 02.05.2018

8. **Divisional Update: Mental Health & Learning Disabilities**

8.1. The Committee received the divisional update from the Mental Health & Learning Disabilities division, including the minutes of the business unit meetings, and also of the Divisional Board.

8.2. Discussion focussed on the significant deterioration in performance in relation to out of area placements, which had peaked at 58 the week prior; this required urgent management focus. Dr Karl Marlowe was now engaged in supporting this work. The contributory issues were deemed to be multifactorial, with acknowledgement of the risk that this had become normalised practice.

8.3. Committee members discussed the following actions:

8.3.1. Dr Karl Marlowe had met with senior nursing staff, to ensure support from both senior nurse and doctor leaders to engender shared leadership for these issues;

8.3.2. It was agreed to focus on holding the position in relation to extra contractual bed usage, and focus on reducing the 100% bed occupancy reported internally;

8.3.3. Consideration be given to bringing in additional support for teams to allow sufficient attention to be given to this;

8.3.4. The need to increase the capacity of the Home Treatment Teams as a matter of urgency;

8.3.5. Whilst the issue was consistent across the Trust’s inpatient units, the drivers for the use of out of area placements differed. Therefore, local solutions needed to be identified and good practice shared across the Trust.

8.3.6. Consideration be given to suspending routine appointments for Community Mental Health Teams, to allow for discharge of inpatients to community teams with appropriate support;

8.3.7. The need for actions to align with the current intensive support programme at Antelope House;
8.3.8. The need for a further review and clarification of the DToC criteria, noting that there remained some issues with the local authority in terms of DToC reporting;

8.3.9. The need for decisions in relation to the use of out of area beds to take account of single sex accommodation, particularly in relation to PICU beds was emphasised.

8.4. The Committee discussed the actions being taken to mitigate ligature risks. Andy Mosley noted that work was underway with anticipated completion in July for Antelope House. Dr Nick Broughton asked that this work be expedited. Mark Morgan suggested that it was inappropriate to implement a Trust-wide solution, and that any decisions should be locally determined, taking account of the nature of the unit, the estate and with due consideration given to issues relating to privacy and dignity of service users. Dr Nick Broughton noted that there was significant senior expertise within the Trust to support the focus and resolution of this issue; he asked that Emma Wadey and Dr Karl Marlowe work with Andy Mosley, with a meeting to take place in the next week to gain further traction on this work.

**Action 315: Andy Mosley, Dr Karl Marlowe, Emma Wadey and Mark Morgan to meet to agree action plan in relation to anti-ligature works**

**Date: 02.05.2018**

8.5. In terms of the reported position in relation to the iTalk service provision, Mark Morgan confirmed that the Trust would be seeking to accelerate the service provision to meet the required 5 year target.

8.6. The intention not to move away from local terms and conditions for staff at Crowlin House was supported; this had been discussed at the informal Executive meeting.

9. **Divisional Update: Integrated Services Division**

9.1. The Committee received the divisional update from the Integrated Services Division, including the minutes of the Monthly Operational Meeting. Paula Hull noted that due to a conflict with another event, the meeting had not been quorate. Items for decision would be brought back to the next meeting, or virtual approval sought in the case of urgency.

9.2. Key points for attention of the Committee were highlighted:

9.2.1. Bespoke Health & Safety training was being delivered for champions and ambassadors within the division;

9.2.2. There were no escalations from the divisional Quality & Safety meeting;

9.2.3. The final draft of the system report from Newton on DToCs would be considered by the MOM and then shared with the Senior Management Committee at the next meeting. Anstey Ward was highlighted as an area of good practice, where actions taken had yielded a 50% reduction in delayed transfers of care. The separate work being undertaken in the South East system, led by PricewaterhouseCoopers was noted;
9.2.4. There was good engagement in the development of the Estates strategic plan;

9.2.5. In terms of workforce, there was a focus on reducing staff turnover, and also in increasing the number of exit interviews undertaken.

10. CQC & Mazars

10.1. Julie Dawes confirmed that the report for the whole system review was awaited.

10.2. At the Progress Review Meeting with NHS Improvement, it had been recommended that the undertaking in relation to the Mazars report be lifted.

10.3. Chrissie Cooke, from Niche, was undertaking a follow up review of investigations.

10.4. Julie Dawes outlined the approach for Trust-wide readiness for the CQC inspection, noting the importance that teams were familiar with information submitted via the Pre Inspection Review process, and that there was adequate learning from recommendations arising from prior reviews. Executive support to teams in terms of prioritisation to meet conflicting demands was emphasised; alongside the need for improved engagement from general management.

11. Policy Governance

11.1. Helen Ludford presented the report, outlining the policy governance arrangements in place, and highlighting further actions to strengthen the current review processes, most notably:

11.1.1. Assignment of an accountable director for each policy, in addition to the policy author. It was noted that individuals needed to be designated by role, rather than name;

11.1.2. Agreement of the defined consultation group and proposed approval Committee / Group;

11.1.3. Improved Executive oversight of the likely expiration of policies by individual reminders being issued;

11.2. It was agreed that the table of policies within the report be recirculated to Committee members for feedback;

11.3. The appetite to rationalise policies where possible was supported by the Committee.

Action 316: Company Secretary to circulate policy spreadsheet to Committee members with feedback to be provided to Associate Director of Quality Governance

Date: 23.05.2018

12. Trust System Access Controls
12.1. Andy Betteridge presented the report, noting that this had arisen in response to a concern raised from the Audit, Risk & Assurance Committee relating to access to the Whistleblowing module of the Ulysses system. As a consequence, a full review of access controls to key systems had been undertaken.

12.2. Support was sought for:

12.2.1. The completion of the Privacy Impact Assessment Tool across the Trust

12.2.2. The proposal by the Audit, Risk & Assurance Committee of the transfer of the management of the Ulysses system to the Technology team.

12.3. Dr Nick Broughton sought assurance that the identified weaknesses in relation to access to the whistleblowing module had been addressed; this was confirmed.

12.4. In discussion of the proposal to transfer the management of the Ulysses system, the Committee supported that the system remained under the management of the Quality Governance team, with strengthened support from the Technology team.

12.5. In consideration of the identified actions relating to the actions required to strengthen the controls for the PLICs & Reference Cost systems, Paula Anderson confirmed that these systems did not contain sensitive data and the identified weaknesses were considered easy to remedy.

12.6. Paula Hull sought assurance as to whether there was confidence in the level of system access controls within the clinical systems; Andy Betteridge confirmed that the planned Privacy Impact Assessment should identify areas of risk. The need to ensure that this process encompassed all relevant systems, whether outsourced or provided in-house, was emphasised.

**Action 317: Progress update on Trust system access controls action plan to be provided to SMC**

**Date:** 27.06.2018

13. **Smoke Free**

13.1. Dr Karl Marlowe presented the report; in summary, it was noted that whilst the Trust had made a policy declaration to be smoke-free, there was some inconsistency in application across the Trust’s Estate and grounds. This was not considered to be acceptable by the Committee.

13.2. In consideration of the recommendations set out within the report, the Committee:

13.2.1. Supported the relaunch of the Smoke Free status, but sought further clarity as to the commitment for additional resource prior to agreement thereof;

13.2.2. Supported the review of the NRT products;

13.2.3. Supported refresher training for staff in terms of managing engagements with patients in this regard;
13.2.4. Supported that work be undertaken with families and carers.

13.3. Additionally, it was agreed that a formal evaluation of the current status of implementation of the policy be undertaken to ensure there was a clear baseline for monitoring progress, with Dr Karl Marlowe and Emma Wadey to be involved in this work. It was proposed that this be completed within the next month.

**Action 318: Dr Karl Marlowe to provide an update on the implementation of the Smoke Free Policy**
**Date:** 23.05.2018

14. **Overview of plans for NHS 70**

14.1. Tom Westbury presented the report, highlighting the various benefits and opportunities through the celebration of the 70th birthday of the NHS. He outlined the Trust activities planned, plus the engagement in wider system events. The Committee noted the report.

15. **STP / LDS Update**

15.1. Mark Morgan reported on the Southampton System Chiefs meeting that he had attended.

15.2. It was noted that a new programme director had been appointed for the South East Hampshire Local Delivery System.

16. **Clinical Services Strategy & Transformation – Transition Board**

16.1. The Committee received an update report on the Clinical Service Strategy and Transformation Programme Board.

16.2. In consideration to the proposal within the report as to the approach to identification for future cohorts for the QI training, the Committee agreed the following principles:

- **16.2.1.** The need to align training to the needs of the Trust;
- **16.2.2.** Training needed to be aligned to strategic priorities for the Trust;
- **16.2.3.** The application process required strategic oversight;
- **16.2.4.** Backfill should be decided on a case by case basis, but with a clear commitment for this where required;
- **16.2.5.** Paula Anderson suggested work to focus on the reduction of violence & aggression within the Trust.

16.3. In terms of the discussion point within the report on the Challenged Trust Fund; Dr Nick Broughton confirmed that he had discussed the potential for the Trust to submit a bid for funding for 2018/19 with Dean Garrett.

17. **Pharmacy Supply Options Appraisal**

17.1. Raj Parekh and Carl Partridge attended to present the report.
17.2. Raj Parekh noted that four options had previously been identified, and there had been support for a tender exercise to be undertaken. However, to date there had not been progress in relation to the tender exercise, and he sought views from Committee members as to whether this was still the preferred option. Carl Partridge outlined the various models considered, and the relative pros and cons of each approach.

17.3. In discussion, Committee members discussed the following:

17.3.1. The need to centralise clozapine dispensing within the Trust as a safety and operational priority with consideration being given to the use of the current Trust-operated pharmacy service at Lymington New Forest Hospital;

17.3.2. The importance of reviewing status in relation to issues raised by the CQC in 2014;

17.3.3. The need for alignment where possible with future pharmacy intentions across the STP;

17.3.4. The financial cost of the proposal; Carl Partridge confirmed that it was anticipated that the in-house option could be delivered within the current financial envelope.

17.3.5. The need to ensure that consideration of in-house provision took account of whether the Trust could provide this service at the required level of quality. If not, the most appropriate solution would be to outsource this;

17.3.6. The interface with the Trust’s digital agenda, most notably in relation to e-prescribing.

17.4. In conclusion, the Committee agreed:

17.4.1. That it was critical to address the outstanding recommendations in terms of medicines management arrangements within the Trust;

17.4.2. That the risk relating to Clozapine should be formally reported onto the Trust’s risk register and that a solution needed to be identified to ensure consistent provision of Clozapine to services;

17.4.3. To establish a Task and Finish Group, led by Dr Karl Marlowe, with a comprehensive options appraisal to be brought back to the Committee in two months.

Action 319: Dr Karl Marlowe (Raj Parkeh) to add risk relating to Clozapine provision to Risk Register
Date: 02.05.2018

Action 320: Dr Karl Marlowe to lead Task & Finish Group to review medicines management provision and present a full options appraisal to the Committee for decision
Date: 27.06.2018

18. Secure Services
18.1. The Committee received the update report; in discussion the following points were highlighted:

18.1.1. A meeting had taken place with Julian Lewis MP, with a good level of support received for the proposal;

18.1.2. A presentation to the HASC was scheduled for 18 May.

18.1.3. Assurance was sought as to the timescale for remedial works at Ravenswood House relating to the installation of the perimeter fence; enabling works were expected to commence in the early summer, with installation from October. There had been good communication to staff regarding these plans;

18.1.4. Paula Anderson offered support to the team to meet the required timescales, noting the importance of ensuring due governance processes be followed and that the Full Business Case be considered via the Service Performance & Transformation Committee and Trust Board in June, so as not to delay the implementation of work;

18.1.5. The Full Business Case would also come to the Senior Management Committee in May, with sufficient time to be allocated on the agenda for consideration of this.

19. 2018/19 Operating Plan

19.1. The Committee received the draft 2018/19 Operating Plan; this was due for submission to NHS Improvement by 30.04.2018. Sue Damarell-Kewell provided an updated copy of the report, noting that there were some changes to the numbers within the previously circulated report.

19.2. Initial feedback had been provided from NHS Improvement; these specific questions had been responded to.

19.3. The intention for improved engagement in the planning process, including closer alignment to the Trust’s strategy, was noted.

19.4. Comments provided from the Committee on the report were as follows:

19.4.1. Input to be provided by Paula Hull to ensure strategic intentions on community physical health services were appropriately reflected;

19.4.2. Feedback on the terminology used within the report, most notably, to ensure congruence with other public statements, including in relation to the anticipated outcome in terms of the well-led assessment.

19.5. Final comments were invited from Committee members in advance of the submission to NHS Improvement.

Action 321: Committee members to provide comments on draft Operating Plan to Sue Damarell-Kewell

Date: 26.05.2018

20. Memorandum of Understanding
20.1. The Committee received a copy of the draft Memorandum of Understanding that had been developed in conjunction with commissioners, in relation to the provisions of community and primary care services.

20.2. Comments were invited on the draft document, noting that this continued to be developed in partnership with the relevant commissioning bodies.

20.3. The Committee supported the principles of the document, noting that Board approval of the final Memorandum of Understanding would be required.

21. 2018/19 Finance Plan

21.1. The Committee received the report, noting that this provided an update position from the last meeting and as reported to the Board.

21.2. Key highlights were reported as follows:

21.2.1. The Trust had delivered a £0.9m surplus at the end of 2017/18 which was £2m short of plan. This was attributable to the financial impact of the prosecutions. The final quarter STF target had not been achieved, however, an allocation of £920k had been allocated to the Trust, resulting in a final year position of £1.8m surplus.

21.2.2. The CIP target required to deliver the 2018/19 control total surplus was £13.1m.

21.2.3. Discussion took place as to the level of confidence in the Trust’s ability to deliver the required agency ceiling for 2018/19. The key management attention for this work would be the reduction of medical locums.

21.3. Thanks were given to Paula Anderson and the finance team for their support in oversight of delivery of the 2017/18 financial position.

21.4. The Committee supported the final 2018/19 plan for submission to NHS Improvement by 30.04.2018.

22. Waivers Report

22.1. Paula Anderson presented the report, noting that there had previously been criticism of the level of non-purchase order expenditure and the use of waivers. The report highlighted the improved position in terms of purchase order usage, although there remained more to do in this regard.

22.2. In consideration of the recommendations set out in the report, the Committee:

22.2.1. Noted the waivers reported in the previous month;

22.2.2. Endorsed the ban on retrospective waivers, including the write off of missing waivers and consideration of inter-provider SLAs as an exception;

22.2.3. Approved the escalation to senior line managers where managers continued to approve spend without a purchase order and requested that a report on the failure to comply with purchase order by type of expenditure be provided to the Next-In-Lines.
23. Report from Health & Safety Forum

23.1. The Committee received the minutes from the Health & Safety Forum; the relatively strong attendance from the corporate teams and poorer attendance from the operational divisions was highlighted.

24. Capital Programme Update

24.1. The Committee received the update from the Capital Programme and noted the priorities as set out in the appendix.

24.2. Dr Nick Broughton sought assurance that there was sufficient resource allocated for ligature reduction work; Paula Anderson confirmed that £1.5m was currently allocated, but there was sufficient flex should further action be required following review by the Ligature Management Group.

24.3. The Terms of Reference for the Capital Operating Group were approved, with the request that the name be amended, so as to avoid confusion with the Council of Governors.

25. Executive Risk & Assurance Group

25.1. The Committee received the minutes and summary from the Executive Risk & Assurance Group. The need for sufficient Executive and management review of risks prior to the meeting to optimise the effectiveness of the group was highlighted.

26. Any Other Business

26.1. The Committee received a paper on statutory and mandatory training compliance; key areas of non-compliance were highlighted, with assurance sought as to the action being taken in relation to Supporting Safer Services (or equivalent) training, along with confirmation that there was adequate capacity to deliver the requirements for resus refresher training and other critical training.

26.2. It was requested that a risk be added to the risk register in relation to Resuscitation training compliance.

Action 323: Paul Draycott to provide confirmation on actions being taken in relation to sSs training and capacity to deliver critical training

Date: 23.05.2018

Action 324: Paul Draycott to add risk relating to training compliance for Resuscitation training and sSs to Risk Register

Date: 02.05.2018

26.3. There was no other business reported.
27. New risks identified

27.1. Two new risks had been identified at the meeting; for reporting and action by the relevant leads:

27.1.1. Clozapine provision

27.1.2. Mandatory training compliance, specifically in relation to resuscitation training and sSs

28. Review of meeting

28.1. It was noted that this was only the third meeting of the Committee in this new format and as such, the arrangements continued to develop. The intention for papers to be submitted in a timely manner for circulation to Committee members was noted.

29. Items for Reporting to Board

29.1. It was agreed that the following items would be reported to the Trust Board, via the relevant Directors’ reports:

- Memorandum of Understanding
- Out of Area placements

30. Close

30.1. Dr Nick Broughton thanked Committee members for their attendance and closed the meeting at 12:00.

Certified as a true record of the meeting

Committee Chair – Dr Nick Broughton

Date
Minutes of the Service Performance & Transformation Committee meeting  
Monday 26 March 2018  
12:30 – 14:30  
Conference Room, Sterne 7, Tatchbury Mount

Members:  
Jeni Bremner Non-Executive Director (Committee Chair)  
Dr Sarah Constantine Acting Medical Director  
Dr David Hicks Non-Executive Director  
David Kelham Non-Executive Director

In Attendance:  
Paul Draycott Director of Workforce, Organisational Development & Communications  
Kim Perry Deputy Director of Finance  
Dean Garrett Acting Head of Business Development  
Paula Hull Acting Director of Operations (Integrated Services)  
Mark Morgan Director of Operations (Mental Health & Learning Disabilities)  
Sarah Olley Resilience Programme Manager  
Lorna Squires NHS Improvement  
Paul Streat Director of Corporate Governance  
Anna Williams Company Secretary & Head of Corporate Governance  
Dr Mayura Deshpande Clinical Service Director – Bluebird and Adult Forensic  
Nicky Bennett Associate Director of Nursing – Specialised Services  
Andy Macmillan Finance Business Partner - Mental Health, Specialised Services and Learning Disabilities  
Paul Johnson Programme Manager: Secure Services Capital Project  
Nicki Brown Associate Director – Forensic Services.

Apologies:  
Dr Nick Broughton Chief Executive  
Paula Anderson Director of Finance

1. Chair’s Welcome and Meeting Protocol  
1.1. Jeni Bremner welcomed members to the meeting, which she opened at 09:30.

2. Apologies for Absence  
2.1. Jeni Bremner reported the apologies received.

3. Declarations of Interest
3.1. There were no declarations of interest relating to items on the agenda.

4. Minutes of the meetings held on 23.01.2018 and 13.03.2018 and matters arising

Minutes of the meeting held on 23.01.2018

4.1. Mark Morgan noted that at paragraph 9, the agreed action had been for a presentation at the Part 2 Board prior to consideration of the Outline Business Case once developed; an action would be added to this effect.

4.2. It was requested that the final sentence of paragraph 15.2 be refined for further clarity.

4.3. It was agreed that an action be attributed to paragraph 11.4, relating to the capacity of the contracting team.

4.4. Subject to these amendments, the minutes were agreed as an accurate record of the meeting held on 23.01.2018.

Minutes of the meeting held on 13.03.2018

4.5. Apologies had been received from Mark Morgan and Dean Garrett.

4.6. Subject to this amendment, the minutes were agreed as an accurate record of the meeting held on 13.03.2018.

Action log

4.7. The Committee considered the action log; the actions completed and the target dates for submission of items to the Board and relevant Committees were noted.

4.8. The following updates were noted:

SPTC 09.11.2017/6.5 Risk SR4 had been reviewed by the Director of Operations (Mental Health & Learning Disabilities). The action was closed on the basis that a further action be added as required.

SPTC 09.11.2017/7.4 An updated version of the Integrated Performance Report was presented to the Committee for included more focussed narrative. The action was closed on the basis that a further action be added as required.

SPTC 09.11.2017/8.3 The meeting of the Committee held in March had focussed on review of this strategy; this would be presented to the Board in April. Action closed.

SPTC 23.01.2018/7.3 Feedback had been provided; the Associate Director of Planning & Performance had met with Non-Executive Directors. Action closed.

SPTC 23.01.2017/15.4 A response had been provided at the Board meeting by the Director of Nursing & Allied Health Professionals; action closed.

5. Themes arising from other Committees

5.1. There was nothing reported at this item; consideration would be given through the meeting to any inter-relationships as these arose.
6. Review of Terms & Reference, Agenda Framework and Committee Effectiveness

6.1. Anna Williams presented draft Terms of Reference for the proposed establishment of a Finance & Performance Committee, as a successor to the Service Performance & Transformation Committee.

6.2. In discussion, the following points were made:

   6.2.1. Assurance was sought that recommendations from previous governance reviews had been taken on Board in the drafting of these Terms of Reference; this was confirmed;

   6.2.2. It was proposed that the Director of Nursing & Allied Health Professionals be a member of the Committee, and the Chief Information Officer be invited to attend;

   6.2.3. The need for greater clarity on the role of the Committee in relation to the review of quality as an element of the Integrated Performance Report, separate to the assurance role of Quality & Safety Committee;

**Action:** Company Secretary to update Terms of Reference to take account of feedback from Committee members

**Date:** 15.05.2018

6.3. In consideration of the draft agenda framework, the following points were made:

   6.3.1. The need for a greater focus on forward looking visibility; Paul Streat highlighted that a quarterly report on performance against the business plan would be presented to the Committee;

   6.3.2. The need to identify the critical path for key decisions required in the year should be mapped and incorporated;

   6.3.3. A quarterly report from the Workforce & Organisational Development Sub-Committee would be added;

   6.3.4. It was proposed that a 6-monthly report on diversity and inclusion be provided to the Committee, along with an annual report on the staff survey, with monitoring via the Workforce & Organisational Development Sub-Committee.

6.4. Committee members asked that Executive Directors provided input to the agenda framework, based on their areas of responsibility, with a focus on ensuring this was forward-looking.

**Action:** Company Secretary to update Terms of Reference to take account of feedback from Committee members

**Date:** 15.05.2018

7. Board Assurance Framework
7.1. Paul Streat presented the report, which contained the risks allocated for monitoring by the Committee. He noted that the focus of the Board seminar in May was on a review of the Board Assurance Framework and risk appetite statement.

7.2. In terms of the risks identified for monitoring by the Committee, updates were provided and comments received as follows:

*SR2:* There is a risk that we fail to continually improve the services provided by the Trust.

7.3. There had been positive indications from commissioners in terms of intentions relating to future commissioning of services;

7.4. The Integrated Performance Report provided a structured programme to move forward on the Data Quality standard;

7.5. Work continued on the appointment for clinical leaders to the QI programme;

*SR3:* There is a risk that we cannot recruit and retain sufficiently skilled staff.

7.6. Committee members suggested that the description of the workforce risk need further refinement, in particular to align with the draft Workforce & Organisational Development Strategy.

7.7. It was requested that the report provided greater indication as to the level of confidence that the Trust would deliver the required year-end target on bank and agency staff usage.

7.8. In conclusion, Committee members took partial assurance from the report, noting that further refinements were required to SR3 to more closely align to the Workforce Strategy work.

8. Integrated Performance Report

8.1. Paul Streat presented the report, highlighting key changes to the proposed new format, including:

8.1.1. The intention to present performance split by divisions;

8.1.2. The removal of the indicative self-assessment rating in the Executive summary section;

8.1.3. A greater focus on identifying and pulling out areas of concern and providing detail on these;

8.1.4. The inclusion, where possible, of national benchmarking data.

8.2. In discussion of the proposed format, there was general consensus from Committee members that this showed a significant improvement. David Kelham requested that further context be given to numbers when presented within the report. It was suggested that a clear indication be provided as to whether targets were internally or externally set, and that a glossary be included also to aid interpretation.

8.3. David Kelham challenged the inconsistent reporting of bank and agency usage, noting that this was rated interchangeably on page 50 of the report as both red and green; an explanation was provided outlining the different indicators that led to these ratings being attributed based on whether these were considered from a financial or workforce perspective. In terms of the workforce metric, the rolling 12
month bank and agency target was being exceeded; from a financial perspective, agency costs were showing a downward trajectory and were below the internal plan and the monthly NHS Improvement ceiling.

8.4. Committee members observed that Turnover was rated as green on the summary page, although this had been flagged as an area of concern. It was confirmed that this remained an area of focus, but performance was within the agreed parameters.

8.5. In terms of financial performance, Committee members noted that temporary staffing expenditure and non-achievement of CIP had remained static. The key variable in terms of financial performance related to out of area placements; David Kelham sought a view as to the level of confidence that the required reduction in out of area placements could be achieved. Mark Morgan indicated that this represented a conservative position in relation to out of area bed performance; he noted that this had remained broadly around 25. David Kelham agreed to speak further with Mark Morgan outside of the meeting.

Action: David Kelham to speak with Director of Operations (Mental Health & Learning Disabilities) regarding the level of confidence in the delivery of the out of area placements
Date: 17.04.2018

9. Workforce Strategy

9.1. There was no further update under this item on the basis the previous meeting had focussed on this.

10. 2018/19 Financial Plan / Budget setting

10.1. Kim Perry presented the report, highlighting that the planning process had commenced earlier this year than in previous years, with a series of updates provided via the Senior Management Committee to ensure engagement in and commitment to the underlying assumptions.

10.2. She highlighted key points for Committee members’ attention, namely:

10.2.1. The assumption that there would be additional funding to support the new pay settlement and the expectation that this would be cost neutral;

10.2.2. There had been significant focus on the 2018/19 CIP programme, with 77% of schemes identified. The Quality Impact Assessment process was yet to be undertaken across all schemes;

10.2.3. The impact of the HSE prosecution on the year end position would need to be taken into account. A £600k provision had been made in 2016/17, with the remaining costs from the prosecutions by the CQC and HSE, and the fines levied impacting in 2017/18. It was expected that the impact of this would be that the Trust would miss the projected £2.9m surplus position by £3.1m.
10.2.4. There remained some other areas of risk, including the lack of a resolution in relation to two patients under the care of the Older People’s Mental Health service who had been placed out of area.

10.3. David Kelham suggested that it would be useful to have greater visibility by division, and to see current year spend against current year budgets, with particular attention given to corporate and estates expenditure.

10.4. In discussion of the recommendation to accept the control total target of £3.4m for 2018/19, Committee members sought clarification as to whether this would change in light of the fine arising from the recent sentencing decision. Kim Perry confirmed that the fine impacted on the 2017/18 financial year, and therefore the proposal to the Board would be to accept the control total surplus of £3.4m for 2018/19.

10.5. Mark Morgan suggested that the planning process had been more rigorous than in previous years, with an improved process and controls around the sign-off of budget statements. As such, he expressed greater confidence in the achievement of budgets for the year.

10.6. The Committee supported the recommendations set out in the report for presentation to the Board, namely:

10.6.1. Acceptance of the Trust’s revised control total surplus of £3.4m for the final plan submission to NHS Improvement by 30 April 2018; and

10.6.2. Approval of the Trust’s revenue and capital budgets for 2018/19.

13. CAMHS Secure Service & Learning Disability re-provision

13.1. Mark Morgan introduced the item, noting that this was an update since the presentation provided to the Board seminar on 13.03.2018.

13.2. Mayura Deshpande presented the report, observing that the key driver was the increasing demand for the provision of Low Secure Unit CAMHS services; the current interim arrangements were insufficient longer-term.

13.3. She outlined the various options considered, highlighting that the preferred option included the provision of a 14 bed adolescent Low Secure Unit being provided on the current Woodhaven site, and the development of the Rufus Lodge site to provide a 10 bed Learning Disability Low Secure Unit.

13.4. Assurance was sought from Committee members that the preferred approach had support from the Senior Management Committee; this was confirmed.

13.5. In terms of engagement, Committee members advocated that whilst it may not be necessary to undertake a formal consultation, the Trust should seek to maximise opportunities for informal engagement with the local authority Health Scrutiny Committee; it was confirmed that Dr Nick Broughton, Mark Morgan and Dr Mayura Deshpande were due to meet with Councillor Huxstep. It was suggested that Governors be kept informed of these plans.

13.6. The Committee supported the Outline Business Case coming forward for consideration by the Board, to consider approval to move to a Full Business Case.
11. Business Development Programme

11.1. The Committee received the report; the following points were noted:

11.1.1. The intention by commissioners to direct award the contract for NHS 111 for a 3 year contract; the Trust was supporting South Central Ambulance Service NHS Foundation Trust in this bid;

11.1.2. The changing context of Urgent Treatment Centres based on NHS England guidance; this would have an impact for the Trust in terms of service provision at Lymington New Forest Hospital and Petersfield Hospital;

11.1.3. The need for further consideration as to whether the Trust should pursue the contract for prison healthcare. It was agreed that a view should be provided via the Senior Management Committee to inform forward decision-making.

Action: Senior Management Committee to provide a recommendation as to whether Trust should submit a bid for prison services healthcare

Date: 17.04.2018

12. Business Plan

12.1. Paul Streat presented the report, highlighting:

12.1.1. The strategic priorities would be widely cascaded to staff in a “plan on a page” format;

12.1.2. Key Performance Indicators had been developed to track delivery;

12.1.3. This would be presented to the Board on 27.03.2018 for approval prior to publication.

12.2. In consideration of the draft plan, the following comments were made:

12.2.1. The need for greater focus on the Quality Improvement work;

12.2.2. Further refinement to the “Transformation” priority was required, to better reflect the Trust’s strategic intentions in relation to the provision of community services;

12.2.3. The need to ensure alignment with the draft Workforce & Organisational Development Strategy;

12.2.4. A challenge that the aspiration for turnover rates

12.2.5. A request that the table at page 113 of the pack be expanded

12.2.6. That the reference to risks (at page 114 of the pack) be further clarified.

14. Any Other Business

14.1. Sarah Olley provided an update to the Committee on the system wide work being undertaken by Newton in relation to Delayed Transfers of Care; the diagnostic
work had included interviews with senior leaders. Work had commenced in March, and was expected to conclude in late April.

15. **Items for Reporting to Board**

15.1. It was agreed that the following items would be reported to the Trust Board:

- Progress with the development of the Business Case for the CAMHS and Low Secure Services provision (to the confidential session of the Board);
- The ongoing work on the People & Organisation Development Strategy; this would come forward to the focussed Board meeting in April, with circulation to Committee members prior to this;
- The intention for further consultation on the draft Terms of Reference for the proposed Finance & Performance Committee Terms of Reference;
- The review of the Integrated Performance Report and the Board Assurance Framework;
- The financial plan.

16. **Close**

16.1. Jeni Bremner thanked Committee members for their attendance and closed the meeting at 14:30.

Certified as a true record of the meeting

Committee Chair – Jeni Bremner

Date
REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Purpose &amp; Action Required</th>
<th>The Board is asked to agree the recommendations set out in this report.</th>
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</thead>
<tbody>
<tr>
<td>Executive Director Overview</td>
<td>This paper presents the process for reviewing and agreeing the Trust’s Risk Appetite Statement and associated Risk Management Policy. The current statement is due for review in June 2018, which will not be completed. Following the Board Seminar in May, the committee is asked to extend the Risk Appetite Statement for one month to allow for a full review.</td>
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<tr>
<td>Previously considered by:</td>
<td>N/A</td>
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<thead>
<tr>
<th>Strategic Priorities this paper supports:</th>
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<tr>
<td>Quality</td>
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<td>Transformation</td>
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| Does this impact any Board Assurance Framework / Corporate Risks | SR5: There is a risk that we have ineffective governance which prevents effective decision making. |
1. **Purpose**

1.1. The Trust Risk Appetite Statement sets out the level of risk the Board is prepared to take in delivering organisational aims and objectives. Further, it provides guidance on the level and types of risk and services are empowered to take and manage to deliver local objectives.

1.2. This document forms part of the response to Mazars and CQC recommendations to ensure key risks to the organisation drive the senior management team and Board agendas. The Appetite Statement was reviewed and approved by the Trust Board in October 2016, and is due for review in June 2018.

2. **Proposal**

2.1. The Trust recognises it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Through the identification and application of the trust Risk appetite the organisation is able to take risks in a controlled manner and reduces its exposure to a level deemed acceptable by the Board and in line with external regulations and relevant legislation.

2.2. As part of the Trust annual Business Planning Process the Trust Board will identify and agree its definition of risk appetite and tailor the risk appetite to different risks. This will be set out in the Risk Appetite Statement which will be cascaded throughout the organisation.

2.3. The Board seminar in May focussed on strategic risk and risk appetite, which allowed for a robust discussion on the level and types of risk the Board are prepared to tolerate. This will be articulated in a revised Risk Appetite Statement, to be presented to the Board in July for approval.

3. **Next Steps**

3.1. The Board will be asked to review and approve the revised risk management appetite and supporting policy at the meeting on 31st July 2018.

4. **Recommendation**

4.1. The Board is asked to approve the extension of the Risk Appetite Statement until the end of July 2018.