Agenda
Solent NHS Trust In Public Board Meeting

Monday 3rd February 2020 – 9:30 – 13:00

Lecture Room 1, C Block, St Mary's Hospital, Milton Road, Portsmouth, PO3 6AD [inc. directions from Fratton Park]

Item	Time	Dur.	Title & Recommendation	Exec Lead / Presenter	Board Requirement
1	09:30	5mins	**Chairman's Welcome & Update** • **Apologies to receive**	Chair	To receive
			Confirmation that meeting is Quorate *No business shall be transacted at meetings of the Board unless the following are present;* • *a minimum of two Executive Directors* • *at least two Non-Executive Directors including the Chair or a designated Non-Executive deputy Chair*	Chair	-
			Register of Interests & Declaration of Interests	Chair	To receive
2	09:35	10mins	***Minutes of the meeting held 2nd December 2019, matters arising and action tracker**	Chair	To agree
3	09:45	30mins	**Staff Story and reflection** *Joined by: Lynn Salmon and Tim Trebble, Adults Services Portsmouth*	Chief People Officer	To receive
4	10:15	10mins	**Safety and Quality First and Feedback from Board to Floor Visits**	Chief Executive / Chief Nurse	To receive
5	10:25	10mins	**Break**		
Strategy & Vision					
6	10:35	30mins	**Chief Executive's Report** - including • *Partnership updates* • *Update on Portsmouth Military Mental Health Alliance*	Chief Executive	To receive
7	11:05	30mins	**Performance Report** *Including:* • *Operations* • *Quality* • *Financial* • *Workforce* • *Research* • *Self-Declaration*	Executive Leads	To receive
8	11:35	10mins	**Information Governance and GDPR Update and Annual Report**	COO Southampton and County	To receive

Reporting Committees and Governance matters					
9	11:45	10mins	**Risk Management Framework – risk appetite**	Chief Nurse	To agree
10	11:55	10mins	**Workforce and OD Committee Exception Report-** *verbal update from 30th January 2020*	Committee chair	To receive
11	12:05	5mins	**Community Engagement Committee –** *verbal update from meeting held on 27th January 2020*	Committee chair	To receive
12	----	-----	**Mental Health Act Scrutiny Committee Exception Report** *No meeting held to report. Next meeting 23rd March 2020*	Committee chair	To receive
13	----	-----	**Audit & Risk Committee Exception Report –** *no meeting held to report. Next meeting 6th February 2020*	Committee chair	To receive
14	12:10	5mins	**Charitable Funds Committee Exception Report -** *update from 23rd January 2020 meeting*	Committee chair	To receive
15	12:15	5mins	**Complaints Panel Exception Report -** *update from 03rd December 2019 meeting*	Committee chair	To receive
16	12:20	5mins	**Assurance Committee Exception Report-** *update from 23rd January 2020 meeting* *Including:* - *Safe Staffing report (6 monthly)*	Committee chair	To receive
17	12:25	10mins	**Governance and Nominations Committee - update from 13th December 2019 meeting** *Including:* - *Terms of Reference* - *Standing Orders*	Committee chair	To receive To approve To approve
18	12:35	5mins	**Finance Committee - non-confidential update if required**	Committee chair	To receive
Any other business					
19	12:40	5mins	**Reflections** • *lessons learnt and living our values* • *matters for cascade and/or escalation to other board committees*	Chair	-
20	12:45	10mins	**Any other business & future agenda items** • *Flu Vaccine Reminder*	Chair	-

21	12:55	---	**Close and move to Confidential meeting** The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'" (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)	Chair	-

---------- break ----------

Board itinerary;

- Lunch break- 13:00-13:30
- Board members invited to join LGBT+ History Launch Event- 13:30-14:00
- Following the Confidential Board meeting (starting at 14:00), Board members are invited to tour St Mary's B Block

Date of next meeting:

- *Thursday 2nd April 2020 – In Public Board Meeting*

Item 2

Minutes

Solent NHS Trust In Public Board Meeting

Monday 2nd December 09:30am-13:35pm
Kestrel 1&2, Highpoint Venue, Bursledon Road, Southampton, SO19 8BR

Chair: Catherine Mason, Trust Chair (CM)	
Members: **Andrew Strevens,** Director of Finance (AS) **Sarah Austin,** Chief Operating Officer, Portsmouth and Commercial Director (SA) **David Noyes,** Chief Operating Officer Southampton and County Wide Services (DN) **Jackie Ardley**, Chief Nurse (JA) **Helen Ives**, Chief People Officer (HI) **Mick Tutt,** Non-Executive Director (MT) **Jon Pittam,** Non-Executive Director (JPi) **Mike Watts,** Non-Executive Director (MW) **Stephanie Elsy,** Non-Executive Director (SE)	**Attendees:** **Rachel Cheal,** Associate Director of Corporate Affairs and Company Secretary (RC) **Jayne Jenney,** Corporate Support Manager and Assistant Company Secretary (JJ) **Sam Stirling**, Corporate Affairs Administration (SS) **Apologies:** **Sue Harriman,** Chief Executive (SH) **Jonathan Prosser,** Interim Medical Director (JPr)

1	**Chairman's Welcome & Update, Confirmation that meeting is Quorate, Register of Interests & Declarations of Interests**
1.1	CM welcomed attendees to the In Public meeting and apologies were received from Sue Harriman, who was attending an exclusive national training programme. CM welcomed GK to his first Trust Board meeting. There were no further updates to the register and declaration of interests and the meeting was confirmed as quorate.
1.2	CM confirmed that Jonathan Prosser (JPr) had been appointed as Interim Medical Director and would be joining future Board meetings.
2	**Patient Story and reflection**
2.1	JA introduced Peter, a patient from the Central Community Independence Service and Naomi Longbotham, Clinical Manager (NL) to the Board. Peter shared his experiences and explained assistance from the Community Independence Service, following challenges obtaining appropriate equipment through the Wheelchair Service. Peter emphasised the psychological effect of these challenges and the importance of maintaining his independence.

2.2	The Board were informed of use of the charity 'Remap' for designing bespoke equipment and Peter commented on the exemplary professional support received from the service and for encouraging new ideas to ensure the maximum level of independence possible. NL highlighted clinical challenges however emphasised the importance of understanding and working in collaboration with patients. Peter further reiterated excellent work of the service and the support provided. *MW joined the meeting.*
2.3	CM thanked Peter for sharing his inspirational story and praised his attitude for driving innovation. MT commented on positive partnership working between the service and patient and the need to aspire for co-operative working across all services. Peter agreed however highlighted the importance of recognising patient differences.
2.4	SE queried potential improvements that the Trust could have made and Peter reiterated concerns regarding the Wheelchair Service waiting list. NL shared on-going challenges regarding contact and funding streams from a clinical staff perspective and CM provided assurance of full oversight at Board level. AS suggested discussions with the corporate finance team regarding potential independent funding requests.
2.5	AS commented on innovative and fascinating uses of technology and encouraging demonstration of traditional care and compassion. JA highlighted clear delivery of Solent values in this service and thanked Peter and NL for attending. **The Board noted the Patient Story.** *Peter and NL left the meeting.*
3	**Staff Story and reflection**
3.1	HI introduced Claire Tromans (CT), Occupational Health & Wellbeing Practitioner from the Optimising Wellbeing & Lived Experience of Staff (OWLES) Group. CT shared her own lived experience and how this was used throughout her role. CT emphasised the importance of reducing stigma around mental health across the Trust and explained work of the OWLES Group to normalise by implementing initiatives, such as workplace champions.
3.2	SA thanked CT for her honest and brave disclosure and commented on the positivity of workplace champions, at every level, to effectively support staff wellbeing. JA emphasised the importance of honest discussions and providing appropriate training to ensure that leaders can effectively respond and understand. CT highlighted the need for those with lived experience to support colleagues.

3.3	MT commented on the positive and equally inspiring contrast between physical and mental health, presented in the patient and staff stories. MT also queried links with Solent MIND and CT explained current development of 'The Hub', using the OWLES framework to provide mental health support. **The Board noted the Staff Story.** *CT left the meeting.*
4	***Minutes meeting 7th October 2019, matters arising and action tracker**
4.1	The minutes of the last meeting were agreed as an accurate record.
4.2	The following actions were confirmed as complete: AC001433, AC001334, AC001435, AC001436
5	**Safety and Quality First and Feedback from Board to Floor Visits**
5.1	Special Care Dental Service- Isle of Wight CM briefed the Board on the visit attended and commented on improved team cohesion and facilities. Challenges were shared regarding accessibility of the location and DN informed of planning to relocate to a new clinic facility.
5.2	End of Life Continuing Care CM explained visit to a patient and circumstances regarding the care required. CM commented on positive activity observed and highlighted adaptations the family had made for care. Concerns were raised regarding management of the service through an informal voluntary on-call rota and explained the negative impact on staff. It was confirmed that considerations were being made by the Matron to improve.
Strategy & Vision	
6	**Chief Executive's Report**
6.1	AS presented the Chief Executive Report on behalf of SH. Allied Health Professionals (AHP) Conference- 10th October 2019 The Board discussed positive feedback and invitation to partner organisations, including the South Central Ambulance Service (SCAS). Positivity of Schwartz round held and the level of staff engagement was highlighted. JA informed of a conference being held on the 4th March 2020 to celebrate the work of staff that do not provide direct patient care.
6.2	St Marys' Hospital Redevelopment It was confirmed that refurbishment had been completed and the first patient treatment was expected on 16th December. JPi noted congratulations to AS and the team for delivering the redevelopment to time and budget.

6.3	Risk Pyramid An overview of on-going work regarding demand and capacity and understanding mental health requirements in Portsmouth was discussed.
6.4	Emergency Planning- Winter Preparedness AS shared positivity of full accreditation by NHS England.
6.5	Trust Management Team Meeting (TMT) update AS informed of discussions held regarding the Learning Disabilities Strategy. AS also briefed on session held to trial different listening styles and the mixed feedback received.
6.6	Flu Update It was confirmed that vaccines had been received and the percentage of vaccinated had increased to 53%. JA informed the Board that the 'Solent Flu Song' was due to be released to promote and encourage further staff vaccinations.
6.7	Staff Survey HI commented on improved position from last year and confirmed that the 62% target had been met. GK queried if the surveys were submitted anonymously and HI confirmed this to be the case.
6.8	Portsmouth System Update SA reported a delay in the opening of the Positive Minds walk in service and delays to the Mental Health Network visit as a consequence. **The Board noted the Chief Executives Report.**
7	**Performance Report**
7.1	The Board discussed the positive changes made to the report, including the use of SPC charts and trend lines. CPMO • AS informed the Board of completion of the half year review of objectives, with the majority of objectives in progress. • MW queried the accumulative impact of objective slippage and AS confirmed aspects to address.
7.2	Operational • SA briefed the Board on the well managed relocation of the Oakdene and Limes units. SA confirmed that a report would be submitted to Directors regarding the loss of resilience of beds at Oakdene. • The Board were informed of spend agreed and SA commented on challenges resulting in the Crisis Team being transferred back to the Orchards.

7.3	<u>Portsmouth Care Group</u> • CM asked if waiting list numbers were due to a high service demand or vacancies and temporary staffing issues. SA explained challenges between the high demand and vacancy rates and shared particular challenge regarding unexpected absences of those in highly specialist roles. CM queried contingencies in place and SA confirmed workarounds and recruitment being undertaken where possible. • JA commented on the need to ensure clarity regarding expectations of specialist roles and AS highlighted potential additional investment that may be available. • AS informed the Board that a discussion would be held in the confidential meeting regarding work on LTP assumptions.
7.4	<u>Quality</u> • JA reported two well managed cases of Norovirus unknowingly passed from University Hospital Southampton (UHS). • The Board were informed of actions required following a Mental Health Act visit and solutions being considered regarding current alarm systems. JA raised concerns regarding defective ceiling tiles and close review with the Estates team to resolve. • JA commented on vacancy within Occupational Health and work to ensure appropriate skill level. • JA confirmed completion of an Ofsted visit across Childrens Services in Portsmouth. JA also confirmed local authority visit in Southampton and highlighted concerns raised that were outside of the Trust's care. • MT queried continuous complaint themes in relation to clinical care and staff attitude and JA confirmed national challenges across the NHS. JA commented on review of learning and AS highlighted the need to consider the complainants perception and expectations. • MT asked about the decrease in complaint rates and SE explained early interventions through reporting of service concerns. MT confirmed request of Assurance Committee to review secondary complaints and JA commented on Community Engagement work that may affect overall complaint reporting.
7.5	<u>Finance</u> • AS confirmed that the Trust had achieved the Quarter 2 control total. • CM queried potential loss of capital funds following delay of the Adelaide Reconfiguration project. AS confirmed possibility and informed of bid for additional money. Heavy emphasis on delivering this year's control total was also highlighted. • The Board noted positivity of Solent cash flow position and thanked AS and the Finance Team. • JPi commented on the potential need for a transformation shift and SA confirmed that the Trust would not see an in year impact. • RC queried Cost Improvement Plan (CIP) benchmarking against previous years. AS confirmed that wider discussions would be held at the Confidential Board.

7.6	Workforce • HI informed of discussion that would held in Confidential Board regarding lack of adequate workforce funding and workarounds to mitigate shortages were shared. • An overview of sickness rates and consideration of seasonal fluctuation was discussed. It was confirmed that the Workforce and OD Committee (WOD) would continue to monitor. • HI raised concerns regarding challenges of retention and sickness rates combined. HI reported introduction of an exit interview process, sourced from Shared Business Services (SBS), which would assist in informing retention issues. • The Board were informed of close work with IT to ensure appropriate set up of the E-Learning system. • CM commented on the positivity of reduced vacancy rates and HI confirmed monitoring in line with increased turnover. • HI assured the Board that 'Improving People Practices' was being monitored by the WOD Committee.
7.7	Communication and Engagement JA informed of intention to provide a regular summary to Board in the form of 'newspaper snippets' and shared acknowledgment of the need to reinvest in the team to ensure delivery of the vision. **The Board noted the Performance Report.**
8	**Professional Leadership and Engagement Report (inc. professional strategic framework and nurse revalidation)**
8.1	JA commented on the exemplary workforce and importance of continuing to share work taking place. The Board discussed the positivity of the Clinical Career Development Task and Finish group in ensuring correct skill placement and appropriate processes in place.
8.2	MT highlighted gap in similar reporting for the medical workforce and the importance of potentially raising the profile. It was agreed that AS discuss with JPr outside of the meeting for consideration. **Action- AS.** **The Board noted the Professional Leadership and Engagement Report.**
9	**Health & Safety Six Monthly Report**
9.1	AS provided an overview of the key compliance and assurance areas reported a confirmed that 3 were RAG rated as amber and 1 red. It was confirmed that these would be completed by the end of the financial year. Regarding health and safety workplace inspections, CM queried if there was a tracker for outstanding items. It was agreed that AS check the processes in place outside of the meeting. **Action- AS.**
9.2	MT commended initiative for providing pop up ligature training sessions to ensure full staff inclusion. MT also shared positivity of concerns addressed regarding Medical Devices following continuous, extensive discussions at Assurance Committee.

9.3	CM queried the risk identified in relation to the lack of a Falls Thematic Lead following termination of this position. JA informed of job matching taking place for a clinical specialist role and confirmed current arrangements in place to ensure support of patients. JA highlighted plans to think differently about delivery of champions and suggested an update of wording within the report.
9.4	MW asked about potential risk regarding the Disability Discrimination Act (DDA) assessment delays. Risk management and on-going monitoring was confirmed. **The Health & Safety Six Monthly Report was noted.**
10	**Compliance with NHS Constitution**
10.1	**The Board noted the Compliance with NHS Constitution report.**
11	**Emergency Planning Resilience Response Update – Winter Plan**
11.1	DN presented the report and confirmed high level of assurance of the framework and planning, with learning built in from previous years. DN shared the risk based approach developed and highlighted escalation processes.
11.2	Review of the on-call rota to ensure appropriate cover was confirmed. **The Emergency Planning and Resilience Response Update was noted.** *SW joined the meeting.*
12	**Schwartz Round Steering Group Annual Report**
12.1	SW provided an overview of the Schwartz Rounds and the positive feedback received. A video was shared and the Board discussed the importance of sharing experiences from a learning perspective. AS reflected on the positive Schwartz round held at the recent AHP conference.
12.2	AS queried how Schwartz would develop going forward. SW confirmed continued sessions and potential emphasis on storytelling, whilst encouraging more staff to attend.
12.3	MW asked if the Schwartz round were for staff internally only. SW commented that this was currently internal in order to ensure a confidential and safe space was provided to raise issues and ensure open and honest conversations.
12.4	SE emphasised the importance of these sessions and highlighted the link to mental health and wellbeing. SW agreed and commented on the need for further promotion and acknowledgement that staff can attend and not speak up. **The Board noted the Schwartz Round Annual Report.** *SW left the meeting.*
Reporting Committees and Governance matters	
13	**Assurance Committee Exception report from 21st November meeting**

13.1	MT highlighted concerns raised regarding car parking provision at St Mary's Hospital, which had been escalated from QIR due to staff morale and clinical care challenges. AS informed of mitigations introduced, including additional parking permits for Fratton car park, park and ride and trial of pool-car systems. MT confirmed that Assurance Committee would continue to monitor.
13.2	• Considerations of a new format for the Learning from Deaths Report were discussed. • JA explained the learning that had taken place following previous submission of the Infection Prevention Control Annual Report. • Approval of the revised Terms of Reference (ToR) was confirmed. **The Board noted the Assurance Committee Exception Report.**
14	**Workforce and OD Committee Exception Report from 7th November meeting**
14.1	MW provided an update from the inaugural meeting. Challenges were shared and MW provided an overview of business cases created. It was confirmed that two key actions regarding the different types of resourcing modules- is this 'models'? would be discussed at the Confidential meeting.
14.2	MW queried the NED engagement at a wider STP level and an overview of the current active groups was provided. **The Board noted the Workforce and OD Committee Exception Report.**
15	**Complaints Panel next meeting 3rd December 2019**
15.1	No further update was provided.
16	**Community Engagement Committee – verbal update from 27th November meeting**
16.1	JA briefed the Board on the Community Engagement pilots and interesting demographics created. **It was agreed to circulate the pilot information to the Board for information. Action- JA.** It was suggested that the Board receive a presentation on pilot work in March. **The Board noted the update.**
17	**Mental Health Act Scrutiny Committee Exception Report from 14th November Meeting**
17.1	The Board noted the following exceptions: • Two unlawful uses of s5.2. • Potential article 8 human rights implications regarding a relative prevented from visiting a resident on the Orchards. • Two occasions on the s136 suite where more than 24 hours were required for practitioners to complete a mental health assessment. It was confirmed that since a reduction in the threshold in late 2018, there were only five incidents (including these 2) reported. • MT confirmed that the MHASC had been assured that the two unlawful uses of s5.2 had been subject to duty of candour and that no further action was required.

17.2	MT informed the Board of a c.50% reduction in the use of restraint and seclusion and the positivity of the National Quality Improvement initiative in attributing to the reduction. MT noted formal thanks to front-line practitioners for their efforts in applying this initiative.
17.3	AS reflected on excellent training session provided by someone with lived-in experience. **The Board noted the Mental Health Act Scrutiny Committee Exception Report.**
18	**Finance Committee – non confidential verbal update from 22nd November meeting**
18.1	CM queried delegated authority levels and it was agreed to ensure alignment of the ToR to the Scheme of Delegation. **The Board noted the Finance Committee ToR subject to amendment and the verbal update provided.**
19	**Audit & Risk Committee Exception Report from 7th November meeting**
19.1	**The Board noted the Audit and Risk Committee Exception Report.**
20	**Charitable Funds Committee Exception Report from 24th October meeting**
20.1	**The Board noted the Charitable Funds Committee Exception Report.**
21	**Governance and Nominations Committee**
21.1	No meeting held since the last report.
Any other business	
22	**Reflections**
22.1	JA reflected on the value of including the Patient and Staff stories together at the In Public meeting where possible.
22.2	JPi commented on the extensive improvement of reports being submitted to Board and Committees.
23	**Any other business & future agenda items**
23.1	CM confirmed that MT would stand down at the end of January, with the new Non-Executive Director starting at the beginning of January to ensure a smooth transition period. CM commented on the vast impact that MT has had and commitment since joining the Trust. The Board formally noted their thanks and well wishes. MT emphasised thanks to the entire Solent workforce for their advice, kindness and support and reflected on how much he has learnt since joining the Trust.
23.2	No other business was discussed and the meeting was closed.
24	**Close and move to Confidential meeting**

Action Tracker

Overall Status	Source Of Action	Date Action Generated	Minute Reference/ Additional URN	Action Number	Title/Concerning	Action Detail/ Management Response	Action Owner(s)	Latest Progress Update
On Target	Board meeting - In Public	07/10/2019	11.3	AC001434	Board - In-Public	Portsmouth MH - Black, Asian and Minority Ethnic BAME communities - MT queried the challenges reported and discrepancies between this and the assurance provided to the MHASC. It was agreed that JA review outside of the meeting. Action: JA	Jackie Ardley	25/11/2019 25/11/2019 - JA has confirmed that this was national data and not local. 23/01/2020 - action complete
On Target	Board meeting - In Public	07/10/2019	13.2	AC001435	Brexit Update	Brexit Update - MT queried consideration of how Brexit affects volunteers within the workforce planning. It was agreed that JA/HI consider outside of the meeting. Action JA/HI	Jackie Ardley	25/11/2019 25/11/2019 - JA has requested that the Associate Director of Community Engagement discuss and consider at the next Community Engagement meeting being held next week. 23/01/2020 - To be discussed under 'any other business' at the CEC
On Target	Board meeting - In Public	07/10/2019	24.3	AC001436	Reflections - engagement opportunities	CM commented on the need for further consideration of opportunities that the Trust offers including volunteering, shadowing and secondments. SH agreed usefulness from a community engagement perspective and queried opportunities already offered by the Trust. It was agreed that JA consider inclusion within the next Community Engagement Report. Action: JA		25/11/2019 25/11/2019 - Further consideration to be given at the next Community Engagement meeting on Wednesday 27th November. 23/01/2020 - To be discussed at the January meeting under 'any other business'
On Target	Board meeting - In Public	02/12/2019	9.1	AC001480	Board In Public- Health and Safety Six Monthly Report	Regarding health and safety workplace inspections, CM queried if there was a tracker for outstanding items. It was agreed that AS check the processes in place outside of the meeting. **Action- AS.**	Andrew Strevens	
On Target	Board meeting - In Public	02/12/2019	8.2	AC001481	Board In Public - Professional Leadership and Engagement Report	MT highlighted gap in similar reporting for the medical workforce and the importance of potentially raising the profile. It was agreed that AS discuss with JPr outside of the meeting for consideration. **Action- AS.**	Andrew Strevens	
On Target	Board meeting - In Public	02/12/2019	16.1	AC001482	Board In Public- Community Engagement update	JA briefed the Board on the Community Engagement pilots and interesting demographics created. **It was agreed to circulate the pilot information to the Board for information. Action- JA.**	Jackie Ardley	27/01/2020 Documents sent to the Board for information. Complete.

CEO Report – In Public Board

Date: 27th January 2020

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

Section 1 – Things to celebrate

NHS England/Improvement and NHS Elect Patient Experience Awards

In December, Solent's patient representative network, Side-by-Side, won two award categories at the Patient Experience in Quality Improvement Awards, hosted by NHS Elect in partnership with NHS England and NHS Improvement.

Attending the conference in London, two representatives from the group collected awards in the Community Health Provider categories for Patient Experience and Communications, and Excellent Teamwork. Side-by-Side member, Mary Ramsay, and Solent's Clinical Lead for Dementia, Kate Legg, picked up the Excellent Teamwork award for a project that looked at improving nutrition and eating on an older person's mental health ward. Led by Mary, the project introduced the use of coloured plates and involved a strong collaboration between patients, families, residents and all staff, including the catering teams.

Paula Tyler, who is a mum of two boys diagnosed with Autism, has been working on improving access to care with our services, and collected the Patient Experience and Communications award on behalf of a group of patient and carer representatives. The group was recognised for their co-design and delivery of a training package aimed at helping patients and families to get involved in improvement work.

Positive Minds

PositiveMinds, which is a partnership between the local NHS, Solent Mind, Portsmouth City Council and voluntary organisations, opened its doors in December. Funded by the NHS, Portsmouth City Council and the Armed Forces Covenant, the service is a new-style service for people, who live in Portsmouth, facing difficulties and distress in their lives. The service provides support for people who are living through low mood, anxiety, or who feel overwhelmed and helpless in face of problems such as money, housing, relationships, work,

bereavement, leaving the Forces, or living away from home at university. It provides a welcoming, accessible environment for people who may find it hard to reach out for help, including our armed forces community.

National WRES Team

On 6th January 2020 we were joined by Yvonne Coghill, OBE, and members of the National Workplace NHS Workforce Race Equality Standard (WRES) Team.
The team, together with our Board and members of the senior leadership team took time to explore reasons for tackling workforce race inequality in the NHS, WRES indicators of workplace experience and opportunities. We will be reflecting on discussions held in our people practices.

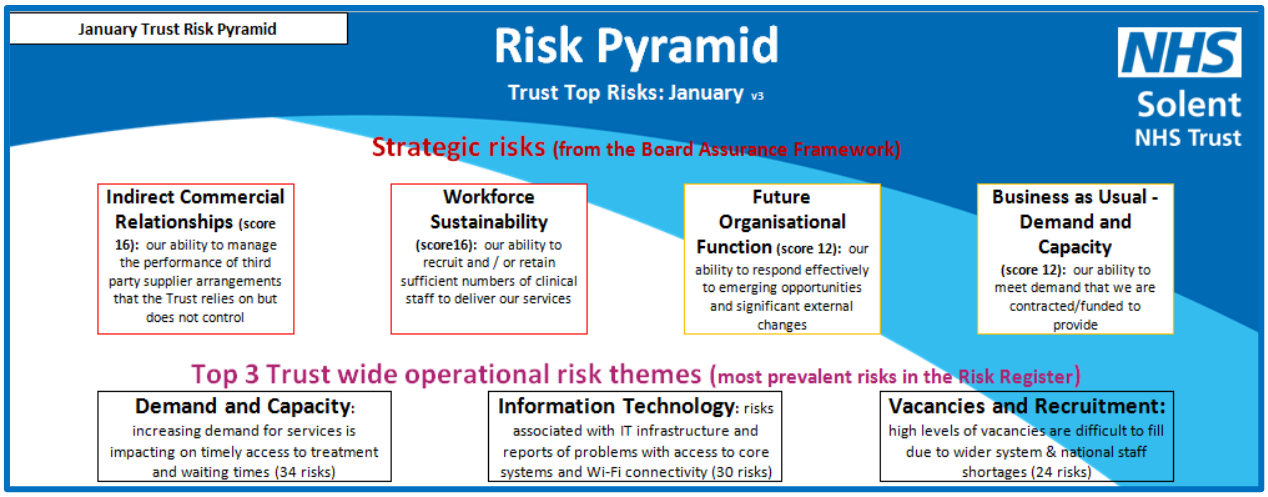
Section 2 – Internal matters (not reported elsewhere)

CQC inspection

We have received notification from the CQC of their intention to undertake a Well-Led and a minimum of one core service inspection and we look forward to welcoming the inspection team back to the Trust. We are currently working to collate all the necessary documentation required to meet the submission deadline of the Provider Information Request (PIR) by 7th February 2020.

Operational Risk Register / Board Assurance Framework

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



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

Over the last few months the Board has been considering its Risk Appetite and Tolerance and an updated Risk Management Framework is presented for Board approval.

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

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

Winter Preparedness

The Board reviewed and endorsed the Trusts winter plan at the December 2019 meeting. Across the Trust each service line's business continuity arrangements have been reviewed and updated to reflect learning and development from previous winters; this includes a risk based approach to how we could adjust our services in order to create some additional community capacity (at the expense of other provided services) in the event of a significant crisis.

We have also been engaged in the creation of system escalation and winter plans in both cities, and this in turn has fed into an over-arching Hampshire and Isle of Wight (HIOW) system winter escalation plan. We are already experiencing very high levels of activity in both systems and have put in place some additional capacity to assist. The HIOW STP has recruited a specific Winter Director, and all the system Chief Operating Officers have met (Dec 19) to discuss and agree priorities and approach for the forthcoming winter period. The Trust also attended a NHS South regional workshop in London along with representatives from across the region, to share learning, approaches and hear from key senior NHS officials about their strategic objectives for this winter.

Update from Trust Management Team (TMT) meeting

The next TMT meeting is being held on 29th January 2020 – a verbal update will be provided at the Board meeting.

Signings and Sealings as reported to Finance Committee since last Board meeting

Now incorporated within the Finance Committee exception report to Confidential Board.

Flu update

December 2019 position is showing that 72% of front line workers have been vaccinated to date.
Our campaign is still in progress and we are actively seeking to increase the uptake further and to collect data on the reasons for vaccination being declined.

Staff Survey update

The results to the national staff survey will be published on 18th February 2020. A report will be presented to the April Board meeting. The survey response rate was 63%, up from 59% last year. We are especially pleased with this level of participation as the average response rate across all trusts in 2018 was 46%.

Improving People Practices Update

The Improving People Practices programme, which is based on the Dido Harding recommendations was

thoroughly reviewed by the Workforce & OD Committee and will deliver a refreshed set of policies and processes which have been co-produced with our people and are progressive and person-centred. This will be supported by further training for our managers.

Brexit Planning

The Trusts Brexit Planning Group met on 19th December and reviewed the national situation following the results of the General Election. We have been planning for the most disruptive outcome for more than 12 months now and believe we remain as well placed as we can be to manage any transition arrangements. Our biggest risk associated with Brexit (the risk associated with transport disruption on and around Portsea island) is hugely diminished in light of the national transition arrangements; and we have actions in place to manage all other risks as previously briefed to the Board. Although the situation now appears to offer more certainty; the group agreed that to communicate again the small number of EU nationals in our workforce who have not yet taken forward registration, to remind them of their options and of the support we would provide for them.

We will retain the resilience and emergency planning governance framework we have implemented following our EU leave date of 31 January 2020 and I would like to commend the hard work and robust preparatory work conducted to date.

Shifting the Mindset – Healthwatch

In line with the recent publication from Healthwatch, 'Shifting the Mindset – A closer look at NHS complaints', we will be reviewing both our complaint and serious incident processes, to note we will be working with patients and families as part of the process.

Regional Talent Pools

We have put forward three nominations to the Regional Talent Pools (two for COO and one for CPO) and have also offered up four assessors. The CEO and Chief People Officer have been selected as assessors and the CEO also sits on the Regional Talent Board. This is an opportunity to really shape the future of system leadership for our region.

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

Portsmouth Military Mental Health Alliance

We continue to develop our work with Veterans and are very excited about the opportunities to work with partners both locally and nationally on this agenda. Please refer to Appendix 1 for further information.

IOW Mental Health Partnership

We continue to work positively with our partners and have established workstreams devoting resource to understand the current opportunities and improvement potential.
By the end of March, each of the worksteams will have identified, in collaboration with the IOW Trust, a programme of support to help deliver sustainable transformation, that will lead to improved quality, finances and services for both the residents and people who use services on the island.

Southampton Systems update

The Southampton system, and our partners in University Hospitals Southampton (UHS) NHS Foundation Trust in particular, have experienced very significant pressure in the early weeks of late autumn/early winter with huge demand on our urgent care services.

We continue to support with additional capacity and capability in the out of hospital system, including the introduction of an advanced physiotherapy practitioners and 7 day in-reach service, to help alleviate flow and bed pressures in the acute hospital.

Portsmouth and South-East Hampshire (PSEH) Systems update

Urgent Care

A few significant and unusual peaks of demand over the Christmas and New Year coupled with ongoing high occupancy levels in the acute beds at Portsmouth Hospitals Trust (PHT) has resulted in a pressurised January for the system. Both Hampshire and Portsmouth Systems continue to respond with more capacity and improved processes. The impact has been a significant reduction in occupied beds days, but total numbers of Medically Fit patients continue to be above target. More capacity is now on stream, coupled with streamlined leadership of pathways which should yield further improvement. The Portsmouth system has maintained very good performance up until January but has been impacted by the peaks of demand, and needs to now build some 'in house' resilience into the bridging service (PRRT) so it can flex capacity further.

Jubilee House

Solent has temporarily let a wing of Jubilee House to the Hampshire system to enable further discharges from the hospital. The ten beds opened in January.

Podiatry – Portsmouth

We are conducting an extensive patient engagement exercise and are regularly reporting to Portsmouth Health and Overview Scrutiny Panel (HOSP) on the potential benefits of delivering more podiatric services from the new clinic facility at St Mary's. This work is underway and will conclude in February with a view to returning to HOSP in March with a recommended way forward, once we have been able to analyse and assess feedback received.

Hampshire & Isle of Wight Sustainability & Transformation Partnership (HIOW STP) including the Strategic Delivery Plan (SDP)

The HIOW STP will transition to an Integrated Care System in 2020 in line with NHS England / Improvement expectations, it is anticipated this will be in September 2020 if all the necessary assessments are completed successfully. The STP is considering how this transition will happen; the role and function of the STP must change to become an effective ICS, it is likely that skills and roles will be needed to support strategic planning, delivery and performance management. At the time of writing this paper the National Planning Guidance had not been published, the guidance will greater clarity of the roles and expectations of ICS's.

The SDP was submitted to NHSI in quarter three last year and has been subject to Regional review and scrutiny. There remains a significant financial gap in the plans for 20/21 and all partners in the STP are working to find further efficiencies, a further period of time has been agreed to close the financial gap.

Item 6.2

Portsmouth Military Mental Health Alliance
Briefing provided by Sarah Austin (COO/ Commercial Director)
Solent NHS Trust Board
February 2020

Our challenge: to meet the needs of Veterans in Portsmouth

- Portsmouth has a population of around 230,000 with a high concentration of military bases and personnel. The estimated size of the armed forces community in Portsmouth is 24,772, of which **10,501 are veterans** and **8,432 spouses/dependents of veterans**. There are **8,103** veterans **registered with a Portsmouth GP**.
- Yearly average of **153 personnel left** The Royal Navy, Air Force, Marines and Army **with a Portsmouth permanent home** at point of exit (source: The Armed Forces Community Within the Solent - Needs Assessment report - Solent Armed Forces Covenant Partnership Board – October 2018.)
- In 2017-18 Solent NHS has treated **145 veterans via the IAPT service "Talking Change"** , with a **64.5% recovery rate**.
- Veterans groups tell us there are **many whose trauma and crisis is not being responded to** and there is a need to **offer rapid and specific support** for veterans in crisis.
- Veterans tell us that a **'treatment approach'** to trauma **doesn't create long term resilience** and expecting serving personnel and veterans to navigate through the complex pathways and relying on referrals from GPs doesn't work.

Our partners and advisors

What are the aims & ambitions of MMHA?

To develop services for and designed by, our armed forces community that provide lifelong support to enable good health and wellbeing.

- **Phase 1 – deliver 3 new services to provide rapid and specific support for veterans and their families in crisis**:
  - Open access to the new veteran-specific section of **Positive Minds – Opened *December 2019***
  - Crisis intervention and on-going support from trained peer volunteers with lived experience - **The Quick Reaction Force – *Pending***
  - A new veterans' curriculum at the **Solent Recovery College** (SRC) – ***September 2019***
- **Phase 2 – extend the reach of the 3 new services in phase 1 out to the families of serving personnel in Portsmouth –** RNRMC additional funding received to add specific roles to the Positive Minds offer for families of serving personnel and to provide inreach support for addiction to the serving community
- **Phase 3 – building on phases 1 & 2 develop a regional high intensity stress programme and potentially a trauma centre in Portsmouth for veterans and develop Portsmouth into a *"Trauma Informed City"* –** *to be confirmed*
- ***Phase 4- providing longer term support in the city through employment-*** *the Lumps Fort Project- awaiting lease*

Funding

- The Veterans offer (***Phase 1*** *of our ambition*) is grant funded **(£697k**) by the **Armed Forces Covenant Fund for 2 years** and directed by the Alliance
- Our **second Phase** has received additional funding from the RNRMC in October 2019
- **Phase 3** - HIS is funded by NHSE if bid successful.
- **Phase 3** -Trauma centre will be developed through partnership.

The Veterans Offer Phase 1

Positive Minds- from December 2019

- The Positive Minds offer is available to Portsmouth's the veterans community. Working with individuals/families to identify the **cause of their distress** and put together a **bundle of support** e.g. 1:1 peer support, community groups, life skills and coping classes, receiving psychological therapy or being **supported into secondary care** mental health.
- Positive Minds includes **military veterans with lived experience** as part of the team of wellbeing advisors who can ***"talk the same language"*.**

Solent Recovery College- open from the autumn term 2019

- Veterans will also be able to access the **veterans tailored curriculum** of Solent Recovery College to help them sustain their recovery.

Quick Reaction Force- due to commence TBC

- Veterans in crisis will be supported by the **Quick Reaction Force (QRF)**, a group of **volunteers working with first responders** to **place an arm around the veteran**, help to **deescalate** and **facilitate access** into Positive Minds.

Positive Minds

- Positive Minds is a **partnership** between Solent MIND, Solent NHS Trust, NHS Portsmouth CCG and Portsmouth City Council with a **wide network** of other organisations **across the City** working together.
- Positive Minds is a **new service** to support **resilience** and **mental wellbeing** in a **welcoming, safe space** providing **emotional & practical support** under one roof. It will be staffed by a **team of wellbeing advisors** led by Solent MIND who have **lived experience of mental ill health and military service** with support from Solent NHS mental health services.
- Positive Minds can be an **alternative to a GP appointment** for people experiencing **distress, social crisis or low level mental health** issues including **military veterans, their families and carers**.
- Primary care "Care Navigators" will be able to redirect people to Positive Minds.
- The service will **improve the interface** between primary care and A2i, crisis services and Talking Change.
- The service is based in the city centre and is open 6 days per week

Solent Recovery College

- An established method of rehabilitation
- Joint venture with Portsmouth University
- People enrol and are taught by those with lived and learned experience
- Most develop to become the next group of peer trainers
- Armed forces curriculum developed with those who have lived experience example below

Progression 1 – Understanding Recovery

Understanding PTSD	Understanding Anxiety	Supporting Veterans
Introduction to First Steps to Recovery	Understanding Obsessive Compulsive Disorder	Introduction to Skills for Civilian Life

Progression 2 – Developing Knowledge and Skills

Living with PTSD	Living with Anxiety	Substance use and its impact on mental health – 2 hour session
First Steps to Recovery – 7 part Programme – focus on substances, diet and health	Knowing Your Rights Introduction to Mental Health Law - 2 hour session	Skills for Life – Coping with intense emotions

Progression 3 – Next steps

Adjusting to Civilian Life	Developing a Veteran Peer Support Group	Preparing for the Future

Quick Reaction Force – under development

- Model co-produced with veterans organisations
- Staffed by trained **volunteer peer support workers** who will go to the support of a family or individual in crisis – “an arm around the shoulder”.
- Work alongside **first responders**, Police, Ambulance and local Crisis Teams.
- The QRF will have a **number of pathways** for support through Positive Minds including **early intervention** to mitigate issues that are causing escalation into crisis.
- Key will be the ability of the QRF peer worker to **communicate in terms familiar to the individual/family** creating a close association through shared lived experiences. – *“speak the same language”.*
- QRF peer worker will be trained in Military Mental Health First Aid & de-escalation.
- **Rolling recruitment** through local veterans community.

Future Phases

1. Phase 2- Funding received from RNRMC to provide in reach support to serving personnel with help for addiction challenges
2. Phase 2- RNRMC investment into Positive Minds specifically for the families of serving personnel
3. Phase 3- NHS England currently in procurement for providers of a High Intensity Stress Service * model on next slide.
4. Phase 3- Veterans Residential Trauma centre- expression of interest into the market in Jan/Feb 2020 for a partner to design, build/refurbish and support manning.
5. Phase 4- In discussion with Portsmouth City Council about opportunity to develop a historic building to be run by veterans to provide employment for veterans.

health&care portsmouth

Summary

- Our ambition is to create a city of excellence in supporting our armed forces mental health and wellbeing.
- We will provide a comprehensive and networked portfolio of services led by those with lived experience.
- Our services will provide opportunity for prevention and early intervention, but will also be there for individuals and families in crisis.
- We will provide support for long term recovery
- We recognise that for some, a residential offer may provide the best outcome
- Our ambition is to extend this model across other areas in the South

Item 7

Presentation to	X	In Public Board Meeting		Confidential Board Meeting								
Title of Paper	Trust Board Performance Report – December 2019											
Author(s)	Sarah Howarth			**Executive Sponsor**		Andrew Strevens						
Date of Paper	24/01/2020			**Committees presented**		TMT						
Link to CQC Key Lines of Enquiry (KLoE)	X	Safe	X	Effective	X	Caring	X	Responsive	X	Well Led		
Well Led KLoEs	**W1** Leadership Capacity & Capability		**W2** Vision & Strategy		**W3** Culture		**W4** Roles & Responsibilities					
	W5 Risks and Performance		**W6** Information	X	**W7** Engagement		**W8** Learning, Improvt & innovation					
Action requested of the Board	X	**To receive**		**For decision**								
Link to BAF risk	BAF #59 concerning Demand and Capacity											
Level of assurance *(tick one)*	Sigificant		Sufficient	X	Limited		None					

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

Board Recommendation

The Board is asked to receive the report.

Assurance Level

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

Table of Contents

Solent NHS Trust

1.1 Business Plan Quarter 3 Report 2019/20

Corporate Portfolio Management Office (CPMO)

By Aaron Scott and Matthew Rowsell

1.0 Executive Summary

This report provides an overview of quarter 3 performance against all business objectives across the Trust covering service lines and corporate teams.

There was one business objective completed in quarter 3 and there are 67 business objectives due for completion by March 2020. Of the 67 business objectives that are still live for quarter 4, there are 14 objectives that are currently experiencing issues as a result of internal or external factors and therefore at risk of not being achieved by year-end (see 6.1, 6.2). Some of these objectives experiencing issues have interdependencies across multiple service lines and corporate teams and therefore it is vital that they are achieved by year-end.

Quarter 3 is generally a challenging period for Solent NHS Trust as teams across the Trust prepare for winter pressures, which can affect patients and staff alike. There has been a gradual increase of 52+ week waiters across Solent's services since quarter 2 and staff sickness in December 2019 was at its highest level since April 2019 at 5%. Additionally, the large vacancy factor for clinical staff and difficulty recruiting to nursing and clinical grades means there continues to be a high spend on bank and agency across the Trust, particularly in Adults Southampton and Mental Health Services. Despite overall bank and agency requests decreasing over the last six months, combined spend is currently £7.5million, with a year-end forecast of £10million, against an original plan of £6million for 2019/20. As a result, the People and Organisational Development team are working closely with service lines to try and reduce overall bank and agency use through the roll-out of the Roster Improvement Programme, which involves more scrutiny and more efficient use of rosters.

Despite an increasing demand on services, there have been some notable successes against a number of business objectives and large scale transformation projects which have helped improve patient care. Services endeavour to mitigate the high demand through two key drivers, as identified within the NHS Long Term Plan, by ensuring people receive the right care in the optimal care setting and by improving upstream prevention through supported self-management. A Long Term Conditions Hub pilot is now operational in Adults Portsmouth which combines elements of traditional primary and secondary care whilst also incorporating existing community service provision (see 3.3). Additionally, Primary Care Services are also focusing on a transformation of their Musculoskeletal (MSK) services to improve access to services and clear pathways of care, in order to accommodate the increased demand and provide patients with more options for self-care and self-management (see 4.0).

Following on from a demanding summer period during what are usually the quietest months of the year, services have predominantly focussed efforts on business as usual to ensure patient care is not compromised, whilst preparations for winter planning are underway. As a result, there were 62 milestones that were scheduled to complete in quarter 3 which have been re-aligned to the final quarter of 2019/20. Therefore, it is possible that not all 2019/20 business objectives will be able to meet their intended targets due to the increased workload. Consequently, the CPMO will maintain regular face to face contact with service and corporate leads throughout quarter 4 so that any issues can be escalated accordingly and discussed at the appropriate forum.

2.0 Introduction

By the end of quarter 3, the Trust had successfully delivered seven (10% total year-to-date) business objectives across all service lines and corporate teams. As the Trust moves in to quarter 4, the majority of projects aligned to the business objectives are now in full progress ahead of their forecasted fruition by March 2020. All business objectives underwent a quarter 3 review by service leads and the CPMO to assess the progress of each objective and to ensure that quarter 4 milestones (260 in total) were still realistic and achievable.

Figure 1: A summary of quarter 3 activity:

Several key system programmes and developments for quarter 3 across the Southampton and Portsmouth Care Groups are shown below:

Southampton and County Wide Care Group:

Primary Care Services continue to be engaged in the development and delivery of services within the Primary Care Networks (PCNs). Musculoskeletal (MSK) services are working with partners around the increasing demand for MSK services and reviewing treatment pathways to ensure patients are receiving the most appropriate treatment for their MSK condition. In Portsmouth the proposal to the PCN is a Solent NHS Trust offer to support the continued delivery of the First Contact Practitioner service under the PCNs, and in Southampton the proposal to the PCNs is a collaborative model with Southampton Primary Care Limited (SPCL). Adults Southampton are currently working to support the integration agenda across the city. The team are working with partners and the wider PCNs, with a focus on the out of hospital model, particularly admissions avoidance and reducing length of stays whilst supporting the winter pressures. Specific schemes have been initiated to increase patient flow and alleviate pressure on the acute hospital for the winter period.

Portsmouth Care Group:

Portsmouth Care Group are working with system partners with a key focus on the integration of services across Portsmouth and South-East Hampshire as part of the Multi-specialty Community Provider agenda. Adults Portsmouth are focussing on raising the level of acuity in the community where an Integrated Community Model is being developed to deliver more holistic support, based on a shared assessment across the city. The Enhanced Care Home work stream, Interventionist Project and implementation of the Integrated Winter Plan with system partners, to maintain flow during times of system escalation, will continue to progress over the next quarter. Mental Health Services continue to work with system partners to look at ways in which Solent can support older patients and are also reviewing models of care provided in other parts of the country.

3.0 Quarter 3 Business Objective Summary

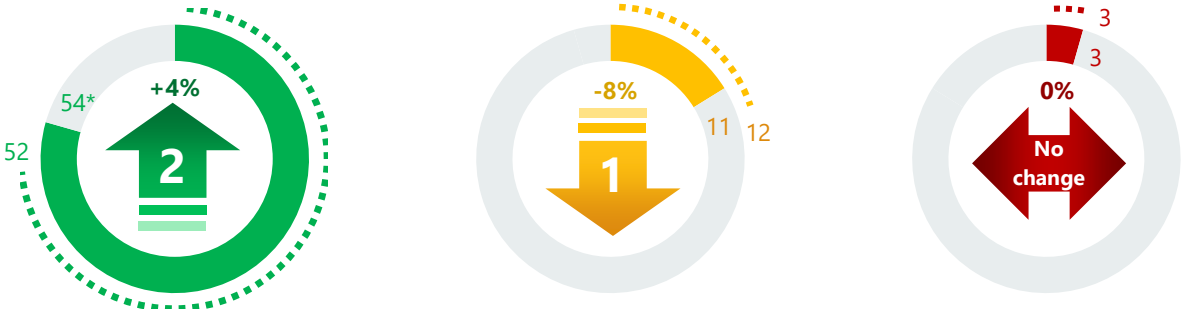
3.1 2019/20 Business Objective Progress

Business objectives are given a colour status in order to provide a quick reference to the health of the objective. The figures below provide the overall position at the end of quarter 3 for 2019/20 objectives:

- 54 Objectives (80%) are rated as green indicating they are on target for completion by intended dates.
- 11 Objectives (16%) are highlighted as amber, indicating that they may be experiencing difficulty or delay, however this delay should not be detrimental to the overall success of the objective.
- 3 Objectives (4%) are currently rated as red. This means that these objectives have one or more milestones outstanding that have a significant impact on achieving the intended outcomes of the objective.
- *1 Green objective successfully met all the planned milestones and the business objective is now complete (see 3.2).*
- *1 Objective has been removed as no longer viable. See Appendix D (6.4).*

Figure 2: A comparison of RAGs from quarter 2 in 2019/20 to quarter 3 in 2019/20:

Key: Dotted line = Quarter 2 position *Solid line* = Quarter 3 position



*Includes 1 complete objective

Business objectives (2019-20) that are currently red or amber in quarter 3 are detailed in Appendices A and B.

Figure 3: An overview of the 2018/19 Business Objectives currently outstanding:

There are three business objectives from 2018/19 not yet completed that continue to be monitored. There is one amber objective, indicating that it is currently experiencing problems, however there is mitigation in place to deliver it and two objectives are rated green indicating that they are due to deliver in quarter 4. See Appendix C (6.3).

3.2 Quarter 3 Successes

During quarter 3 there was one business objective that met all of the planned milestones and successfully completed on schedule:

Adults Southampton – The team have worked with system partners in order to reduce admissions and Delayed Transfer of Care (DTOC) through system integration. A new pathway for home IV patients has been established which should prevent admissions / increase discharges and improve the flow in and out of hospital for the local health economy. Additionally, the national red and green day tool has been implemented within the wards and has generated a reduction in length of stays. Although the programme remains on-going to refine the process, it is hoped that with further development greater improvements can be achieved.

3.3 Quarter 3 Key Developments

Although not yet complete, there has been positive progress made across a number of business objectives, key examples are shown below:

Adults Portsmouth – The Long Term Conditions (LTC) Hub pilot is now operational and combines elements of traditional primary and secondary care whilst also incorporating existing community service provision. Under the leadership of a Multi-Disciplinary Team, activities traditionally conducted in general practice or secondary care are now undertaken in the community/LTC Hub. The LTC Hub provides enhanced diagnostic assessment and personalised care planning as part of a standardised, evidence-based approach to care management. The LTC Hub brings together a range of professionals so that patients are provided with support that extends beyond physical healthcare and includes a broader wellbeing assessment and the availability of psychological therapies.

Pharmacy and Medicines Management – The Trust's Electronic Prescribing and Medicines Administration project (EPMA) continues to progress. During quarter 3 the Trust specification for an EPMA system was finalised, detailing the main requirements our patients and staff have, in order to gain optimum benefit from the system. The process of selecting the right software supplier will take place in quarter 4. Implementation of EPMA will fully digitalise the medicines process within Solent from prescription through supply and preparation to administration and audit. This greatly improves safety for our patients and will also provide cost-efficiencies for the Trust.

Special Care Dental Services – The service has reviewed all of Solent's General Anaesthesia (GA) sites across Hampshire and the requirement to provide x-ray facilities in theatre. There are some patients that can only tolerate X-rays being taken under GA and upon review it is clear that there are some sites that do not have this facility available for such patients. The service plans to fully implement this facility by the end of January 2020 to ensure that all patients are treated with the same levels of compassion, respect and dignity and are able to have the necessary treatment across all sites.

4.0 Transformation in Focus

There are a number of transformation projects taking place across the Trust from clinical service lines and corporate teams. These high level change projects often involve large scale changes of processes, systems, workforce and ICT across the whole Trust in order to achieve measurable improvements in areas such as efficiency, effectiveness and stakeholder satisfaction. A few examples are shown below.

Adults Portsmouth – Enhanced Intermediate Care Service:

A project to develop and implement an enhanced Intermediate Care Service is being facilitated to improve the support available to people in Portsmouth. The strategy is underpinned by the development of a Practitioner-led service and the team have recruited consultant and advanced nursing and therapy practitioners who are now leading the service and continuing developments. The services have previously included the role of a paramedic and a pilot to introduce increased diagnostics at the point of care is now commencing. This, along with the increased use of specialist interventions in the community and the reconfiguration of community inpatient services will facilitate a reduction in the dependence on and conveyance to secondary care.

Adults Southampton – Ensuring patients have the right Stoma products:

A review was carried out with stoma patients and it was identified that some patients were not on the most economic product formulary for managing their care. The Stoma Care Nurse specialist assessed 52 patients and this involved following the stoma care formulary to ensure patients have the correct stoma products and quantities. This has resulted in 54% of these patients having had a reduction in the cost of products required, with an average saving of £230 per year per patient and a total saving £13k for the year. All of the 52 patients now have the correct and right amount of stoma products, to support them to live well with a stoma.

Estates and Facilities – Re-opening of Jubilee House to support winter pressures:

The Portsmouth and South East Hampshire (PSEH) system has come together to open an additional 10 step down beds at Jubilee House to support the timely discharge of patients from Queen Alexandra Hospital from January 2020. The Solent estates team worked with system partners to deliver a number of key works in a very short timescale to ensure compliance of the East Wing's ward environment, following recommendations from a Care Quality Commission (CQC) inspection in early December 2019. This is a positive example of the local health and care system working collaboratively for the patients' needs over the challenging winter period. The integrated service will run until 31 March 2020.

Information and Communications Technology – Windows 10 Upgrade:

The Windows 10 upgrade project started in quarter 3 and will run until May 2020. This project will see all of the Trust's devices receive some updated hardware components and the Windows 10 operating system. These upgrades will result in devices which start up, login and perform more quickly and are more stable when running our applications. Being on Windows 10 ensures that the Trust remains

supported by Microsoft and can therefore benefit from security updates as they are released helping to ensure confidentiality.

Mental Health Services – Solent and Isle of Wight partnership:

In October 2019, plans to positively transform mental health services on the Isle of Wight were announced. A flagship partnership between Solent NHS Trust and Isle of Wight NHS Trust has been agreed and in line with the NHS Long Term Plan, the partnership aims to make a difference to patients by having a strong focus on providing care out of hospital, keeping people safe, well and independent, or close to home. This is a positive opportunity for both Trusts and will be a key area of focus throughout quarter 4, as it enables best practice and ideas to be shared across services for the benefit of residents across Hampshire and the island.

Pharmacy and Medicines Management – Improving the patient offering:

The St Mary's pharmacy team completed a move into newly refurbished B block at St Mary's Hospital in quarter 3, this brings the team together and will facilitate more productive working relationships, improve operational efficiency and team well-being which ultimately provides a better service to patients. The new clinical trials dispensary enables the provision of dispensed clinical trial medicines; this greatly expands the scope of clinical trial research our patients are able to access at Solent. All of these facility developments support an expansion of the medicines management services we can offer our NHS partners.

Primary Care Services – MSK Transformation:

The Solent NHS Trust Musculoskeletal (MSK) Services provide upper and lower limb and specialist MSK pathways across five CCG's. The MSK services have commenced a transformation of services which intends to support increased access to services and develop innovative practice including digitalisation and clear pathways of care. The transformation will aim to provide long term sustainability across the MSK pathway and develop new pathways across the system. It is anticipated that the transformation will provide clear career pathways and opportunities for specialism across upper and lower limb pathways and specialist MSK.

Special Care Dental Services - Improving Patient Experience and Accessibility:

The Special Care Dental Services have made some positive changes to some of the clinics across the Trust in order to improve patient experience. The service reviewed all of the clinics and provided bariatric facilities within three of their clinics at Somerstown, Royal South Hants Hospital and the Isle of Wight. There are also plans to put bariatric facilities in place at clinics in Andover and Hythe when the buildings are re-provided in the near future. The service wants to ensure that all patients are treated with the same levels of compassion, respect and dignity and are able to have the necessary treatment when needed.

5.0 Looking Ahead

5.1 Completing 2019/20 Objectives

The next quarter will see the service lines make a focussed effort to complete the remaining objectives for 2019/20.

As a number of objectives had milestones that were re-aligned to the final quarter, a greater number of objectives are scheduled to come to fruition by year-end. In some cases, the cause for the re-alignment has been due to the rationale for the business objective naturally evolving as the year progressed, in keeping with changes that integrated partnership working bring. This will ultimately mean that some objectives will be reviewed at year-end to ensure they are included as part of 2020/21 business plans. A number of them involve third parties or are part dependent on wider projects across the local health economy and regional stakeholders, however, will be closely monitored to ensure progress is made.

In relation to the three outstanding objectives from 2018/19, these will continue to be reviewed at Performance Review Meetings thereby gaining oversight from the relevant Chief Operating Officer for each Care Group within the Trust.

5.2 Business Planning for 2020/21

The 2020/21 Business Plans for all service lines and corporate teams are now being finalised. Service lines presented their business plans in December 2019 and corporate teams are due to present their plans in January 2020. There were a number of common themes that appeared across multiple service lines which will be key areas of focus in 2020/21:

Staff/Workforce – The current levels of staffing are causing a strain on services with recruitment and retention issues being felt across the Trust. The Roster Improvement Programme and the Hampshire and Isle of Wight Collaborative Bank projects that will have Trust-wide impacts should help see an overall reduction in agency use in 2020, whilst there will be an general view to improve career development and progression across various roles.

Change Management and Transformation – It was recognised that all service lines are currently implementing or are planning to implement a large amount change. The need to industrialise this process within the Trust will be a prominent factor in its future success.

ICT and Digital Solutions – This area of business is constantly evolving and the Trust will need to be forward thinking with how technology is utilised before technological advancements render any progress obsolete.

New Territories – It was recognised that a joined up approach is required to *how* and importantly *where* Solent NHS Trust provides its service in the future. This may mean securing further opportunities with the Isle of Wight and consolidating offerings in and outside of Hampshire.

6.0 Appendix

6.1 - Appendix A - Quarter 3 Issues for 2019/20 (Red objectives)

The following three objectives have been escalated to red as they are currently unlikely to achieve the intended outcome by March 2020:

Issue

Adults Southampton

Oct Nov Dec

We will deliver a financial recovery plan, reviewing all income and expenditure and by developing and remodelling our services to meet financial targets:

Whilst there have been improvements in the monthly financial balance of the service line and the budgeted rate is very close to being achieved, this does not substantially alter the forecast of the year end position which continues to be in deficit, largely due to overspend on bank and agency. There has been a higher than expected reliance on bank and agency primarily due to vacancies, particularly with Community Nursing East. This has significantly improved of late with Community Nursing having no planned agency and bank usage from November onwards. In order to improve the financial position, the services are currently carrying out a deep dive to identify immediate opportunities to make savings.

Mental Health Services

Oct Nov Dec

We will reconfigure the OPMH bed pathway model across PSEH through rationalisation and implementation of alternatives models of care for OPMH patients by March 2021:

Progress with this particular work stream has been slower than anticipated due to system complexities. The service will not meet the milestones for the end of the year so these will be extended and form part of the 2020/21 business plans. This work is also an interdependency of another 2019/20 business objective looking at a needs led community pathway in partnership with other healthcare providers.

Specialist Dental Services

Oct Nov Dec

We will increase the number of general anaesthetic sessions across Hampshire to meet demand by March 2022:

The number of long waiters has been reduced however this remains an issue. University Hospital Southampton Foundation Trust (UHS) have recently cancelled Solent's Adult Special Care lists for February and March due to their own pressures. As a result the team are currently in discussions with NHS England commissioners and UHS regarding on-going lists and have been working with Hampshire Hospitals Foundation Trust to gain additional sessions at Basingstoke. Good progress has also been made in preparations for starting an ad-hoc list at Lymington for adults.

6.2 Appendix B - Quarter 3 Challenges for 2019/20 (Amber objectives)

At the end of quarter 3 there were 11 business objectives which were considered amber. The commentaries below detail the challenge and mitigation in place for each objective:

Adults Portsmouth

Design and implementation of an 'Integrated community model' community model to safely manage people's health and social care needs by March 2020:

Due to an additional development request to TPP, the Trust's patient administration system, further work is required and therefore timescales have been delayed.

The additional development work is expected to be resolved by the end of January which will enable the objective to progress with the revised timescales.

Child and Family Services East

We will undertake a CAMHS review and redesign to develop a model which is sustainable and improves outcomes for children and young people in the future by March 2020:

This objective was raised to amber as progress has been slow. Service-wide next steps include the starting of two new services - Mental Health in Schools and Paediatric liaison.

It has been agreed with Portsmouth CCG to undertake further remodelling work in light of these new services to ensure that the multiple teams providing mental health services for children are co-ordinated and comprehensive in their offer. This will take place over the next 18 months and will involve opportunities given by further digital advancements.

Child and Family Services East

We will redesign and implement an integrated community based paediatric medical service offer which is sustainable and improves outcomes for children and young people by March 2020:

Following previous delays, recent progress has de-escalated this objective from red to amber.

Recent progress on the objective has included a transformation manager and clinical lead for the service undertaking a scoping exercise of clinical pathways and clinical demand to create an action plan in terms of what is required to meet this business objective. Portsmouth, Fareham and Gosport and South East Hampshire CCGs have been informed and a meeting was held in quarter 3 to review progress and next steps.

Child and Family Services West

We will undertake a CAMHS review and redesign to develop a model which is sustainable and improves outcomes for children and young people in the future by March 2020:

There is no external consultant currently appointed because no funding was forthcoming to support engagement.

An external consultant has not been identified but internal transformation continues with core and specialist services led by Service and Quality Manager. A business plan has been presented to commissioners to explore further opportunities for funding.

Child and Family Services West

We will review and redesign the Therapies Service to maximise efficiency to ensure a balanced position between East and West by December 2019:

This objective has experienced some delays in progress. Discussions have taken place across the East and West Therapies Service and discrepancies have been identified.

Therapy teams from East and West have met to start progressing an integrated model. Service and Quality Managers are leading on exploring a management and clinical lead structure.

Child and Family Services West

We will create an Eastleigh and Southern Parishes Delivery Hub to support a seamless service delivery and experience for our families via placed based care:

Progress within this objective has been is slow and there is difficulty finding a suitable solution that is affordable.

New venue has been scoped and worked up by Estates. Initial findings have been presented to Capital Assurance Group, however further work is required by the Estates teams in order to be fully signed off.

Child and Family Services West

We will redesign and implement an integrated community based paediatric medical service offer which is sustainable and improves outcomes for children and young people by March 2020:

There have been delays with this objective due to on-going work with re-designing the new model which has required further dialogue with the CCG.

In collaboration with commissioners workforce transformation is underway which will support new care delivery models.

People and Organisational Development

Increasingly raise the profile of the Trust externally in order to support the business strategy and engagement with communities by April 2020:

The project has been experiencing delays due to availability of resource.

Work is on-going in-line with developing the next phase of the community engagement strategy. The team are currently drafting the Public Relations (PR) Strategy and digital communications plan. There has been an increase in PR activity in order to raise profile of Trust, and coverage evident. PR Strategy due for presentation to Executives in January 2020.

Primary Care Services

We will review our workforce, to ensure diversification of workforce where possible and clinically appropriate; with clear development and career frameworks enabling an agile response to the changing landscape of primary and healthcare services by 2021/22:

On-going challenges with clinical vacancies are impacting the service line's ability to deliver workforce objectives due to the focus on clinical delivery.

These challenges are being focused on as part of the review for 2020/21 business objective planning and updates will be in line with the planning cycle.

Quality and Improvement

Develop and implement the Ulysses system to facilitate the effectiveness of risk management and organisational learning from complaints, feedback and incident trends by March 2020:

The roll out of the data warehouse has required unplanned, additional resource to ensure the hierarchy in the Ulysses system is compatible. This has delayed development of tailored incident forms, although the target date is still achievable.

It is anticipated the Business Intelligence tool will be available for the Quality team to begin development and building in April/ May 2020.

Sexual Health Services

The service will commence treatment by post to our clients:

The original objective has gone through multiple iterations which have caused delays due to items requiring additional testing. Final testing now extended to January 2020.

Developments included improvements to information governance and changes to the patient record system to improve the overall patient experience and journey.

6.3 Appendix C - 2018/19 Objectives to be completed in 2019/20

There are 3 business objectives (1 amber, 2 green) still outstanding that have carried over into the 2019/20 delivery year. These objectives do not form part of the 2019/20 planning cycle but will continue to be monitored and progressed through to delivery concurrently.

6.3.1 Amber 2018/19 Business Objectives

Estates and Facilities

We will deliver a robust, effective and value for money FM service through the continuance of our FM transformation project ensuring we deliver on quality by March 2019:

Changes to cleaning services have resulted in a delay to the consultation for FM transformation.

Due to increased demand on Estates and Facilities management capacity, consultation is now scheduled for February with implementation of changes to the workforce by the end of March 2020.

6.3.2 Green 2018/19 Business Objectives

Special Care Dental Services

We will provide accessible dental treatment for bariatric patients by working with NHS England in conjunction with the Managed Clinical Network by end of March 2019:

Waiting room and toilet facilities for bariatric patients have been addressed in two sites, Somerstown and Isle of Wight. Andover and Hythe are currently being re-provided and the necessary facilities have been incorporated in to the new builds.

Special Care Dental Services

We will ensure that the service provides 'Accessible Information' communication tools to meet the accessible information standard 2016 for patients, carers and parents by end of March 2019.

The teams are currently working on communication needs for patients who use different languages. Three dominant languages were identified from a task and finish group as Polish, Nepalese and Bengali. Initial work has begun in producing translated versions of 3 key leaflets which are expected to be printed and in place by the end of March 2020.

6.4 Appendix D – 2019/20 Objective Removed

The following business objective has been removed from the 2019/20 business plans as this is no longer viable for the service.

Child and Family Services East

We will undertake an estates rationalisation programme in Fareham and Gosport to implement a centralised Better Care Hub in the geography by March 2020:

Child and Family Services East have a need to identify and secure premise in the Fareham and Gosport area that will serve as a Child Development Centre. In this area, the service provides paediatric therapies, community paediatric medical services and children's community nursing. The current estate supporting these services consists of numerous disparate sites that has the impact of splitting admin and clinical staff and creates potentially numerous journeys for staff and patients to deliver and receive care. Furthermore, many of these sites are unsecured in terms of on-going occupancy and some are no longer fit for purpose.

To remedy this situation, a site is required in the Fareham and Gosport area for children's services. During 2019/20 a business objective for the service line was monitored to support this aspiration. Unfortunately, two sites which had previously been identified as possibilities during the year have not come to fruition. As a result, the Estates and Facilities team continue to work with the service in identifying alternative sites, which may include building a bespoke premise. This objective is unable to proceed in its current form and will not be achieved by March 2020, consequently this is being reviewed as part of next year's plans and will be added as a 2020/21 business objective.

2.1 Operational Performance Dashboard

Month: Dec-19

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Community / Mental Health	Accepted Referrals (in month)	I	14,213	14,492	?	
	Attended Contacts (in month)	I	68,688	71,160	?	
	Discharged Referrals (in month)	I	13,823	13,460	?	
	DNA'd Appointments (in month)	I	8%	3.9%	P	
	Rapid Response 2 hour compliance - Portsmouth	E	90%	89%	?	
	Rapid Response 2 hour compliance - Southampton	E	90%	93%	P	
Inpatients	Occupancy Rate (in month)	E	85%	92%	?	
	Delayed Patients (in month)	I	29	23	?	
	Delayed Days (in month)	E	4.5%	4.9%	F	
Performance	KPIs Achieved (YTD)	I	90%	83%	F	
	Waiting List Size - RTT (month end)	I	1,071	1,009	P	
	Referral to First Appt < 18 weeks	I	95%	98%	?	
	Referral to First Appt < 52 weeks	I	100%	100%	P	

Performance Hotspots

High Priority

- Waiting Time - CPMS / Pulmonary Rehab / CAMHS Neurodiversity
- Sexual Health Data Quality
- Speech and Language Therapy Capacity and Demand
- MPP Services Capacity and Demand

Medium Priority

- GA Theatre Availability for Specialist Dental Service
- Portsmouth SE Hampshire System Pressures - Impact on Delayed Discharges
- Delayed Discharges in Southampton
- Wheelchair Quality Concerns
- IOW Mobilisations - Sexual Health / 0-19 / School Aged Imms / Mental Health Partnership

Improving / Positive

- Waiting Times - CAMHS Extended Partnership
- Jubilee House Review Outcomes
- Rapid Response 2 hour Compliance

2.2 Performance Subcommittee Exceptions

Portsmouth Care Group

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

- Community Paediatric Medical Service (CPMS) performance continues to deteriorate, with waiting lists increasing and Looked after Children Health assessments completed within the statutory timescales declining. The CPMS waiting list currently has 270 children waiting; double the size of the waiting list from 12 months ago. The joint review with Portsmouth CCG has slowed and as a result, the CCG have been asked to support a different strategy to transform the service.
- The waiting list for the CAMHS Neurodiversity service is at the highest point since July 2019 with 136 children waiting and 2 children waiting for more than 52 weeks. The service has decided to suspend the current waiting list initiative for Neurodiversity in order to maintain the Single Point of Access. Recent recruitment has been successful and all new staff will be in post by the end of the financial year at which point the situation will be reassessed.
- The waiting lists for Adults Speech and Language Therapy (SLT) has increased for the past two consecutive months, with the waiting list back up to 319 patients (from 275 in October) and the longest wait for the service at 42 weeks, the longest for the past year. Nationally, Solent has a lower retention rate for staff in this service compared to our peers (85.2% vs. 87.6%) according to Model Hospital in December 2018. The capacity of the service is on our Risk Register and being monitored closely through our Performance Hotspots report. The quality review being undertaken across both our Portsmouth and Southampton services, led by the Chief Nurse is due to be concluded in January 2020.
- Pulmonary Rehab's waiting list continued to increase for the fifth consecutive month, with the waiting list now being the largest for the past 12 months. The service is reviewing the position to understand the surge of activity.

Waiting times for the CAMHS Extended Partnership service have improved consistently for 6 months, with the waiting list now down to a maximum of 16 weeks and only 42 children now on the waiting list. This is as a result of successful recruitment to all vacancies. It is hoped that this will be maintained in future months.

A recent review of Jubilee House showed a very positive outcome. It highlighted that new furniture was required, which has subsequently been purchased, and that staff morale required a continued focus.

Delayed Transfers of Care (DTOCs) have decreased significantly over the past two months, with only 5.2% of bed days lost to delayed patients in December, compared to 20% in October. However, the Portsmouth and South East Hampshire (PSEH) system continues to be extremely challenging, with Portsmouth Hospitals Trust being on Opel 4 status for the majority of December. This has made it difficult for Solent to achieve the Medically Fit for Discharge (MFFD) target and has resulted in our Community Hospitals having to be flexible with their admission criteria. This will likely have a subsequent impact on our delayed discharge performance from January.

Southampton and County Wide Care Groups

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

- As referenced above, Speech and Language Therapy services in Southampton have also been experiencing a mismatch between capacity and demand. Immediate action is being taken to mitigate the risks for vulnerable patients, however the waiting list has increased slightly during December, and there is still significant concerns over long waits (15 patients waiting more than 26 weeks).
- Increased demand and reduced capacity continues to be an issue across the range of MPP (Musculoskeletal, Pain and Podiatry) services, having a negative impact on KPI performance across a number of services. Recruitment is on-going, however the service are undertaking a deep dive and will prepare a full report for commissioner at the end of the financial year.

The availability of reliable data for the Sexual Health service continues to be a challenging issue being given significant focus. Work is being undertaken daily to investigate, resolve and mitigate issues from occurring, however there have been a number of influencing factors causing the numerous issues seen to date. It is hoped that the recent move to a new server will provide a more stable solution, however data transfer speeds are currently being investigated between the Business Intelligence Team and our ICT Provider as the data feed as not working as they should. This is causing significant pressure within the service with staffing and financial planning.

Capacity for theatre space continues to be a concern for the Specialist Dental service, heightened by recent winter pressures within UHS and the resultant reduced theatre capacity. Alternative sites are being considered and the service is considering increasing list sizes at other sites to reduce the backlog.

DTOC rates peaked in November with 10.1% of bed days being lost however this reduced slightly to 9% during December. This increase is mainly due to long term delays on Snowdon Ward and winter pressures affecting Fanshawe Ward.

The mobilisation of services on the Isle of Wight (IOW) is underway with both Sexual Health and the Mental Health partnership starting imminently, and 0-19 and School Aged Immunisations services due to start in August 2020. Services undergoing mobilisation are drawing on experience from the Specialist Dental service who already provide services on the IOW.

A shared learning event has taken place with all stakeholders of the Wheelchair service, which proposed to close all Solent's actions surrounding the issue. However, concern was raised that not all residual issues around supply and timeliness are fully resolved and therefore an action plan is being taken to Assurance Committee for discussion about closure. A new database has been put in place across all stakeholders, which is more accurate. Regular stakeholder meetings are now taking place to discuss the caseload between Solent and Millbrook, improving the communication between the two parties.

Local Performance (Operational Performance Dashboard, section 2.1)

Narrative is provided for items of significant negative exception and for any items which have newly been identified as a significant positive exception. The RAG ratings for these metrics are set to show as green where actual performance is within a 5% threshold of the same period in the previous year.

Significant negative exceptions on this month's Operational Performance Dashboard:

Delayed Days (in month)

As reported in the Southampton Care Group narrative above, winter pressures on Fanshawe Ward and long term delays on Snowdon Ward have impacted the number of delayed days this month. This has been flagged by the SPC indicators as a 'Fail' against the capability rating, meaning that without significant intervention, the target will not be achieved.

KPIs Achieved (YTD)

The KPIs achieved indicator shows that without significant intervention, this target will not be achieved. There are a significant number of KPIs that are now out-dated, are process rather than outcome based and do not reflect current practice or increasing demand on the services. There is a comprehensive service specification review taking place collaboratively between Solent and SCCCG, but little progress has been made in reducing and refining the KPIs in place. Consequently, a number of the historically set standards are no longer realistic or relevant to current service provision.

New significant positive exceptions on this month's Operational Performance Dashboard:

Rapid Response 2 hour compliance - Southampton

There are two new metrics on the Operational Performance Dashboard this month relating to the 2 hour target for Rapid Response services for older people. These have been included following NHS Improvement's communication that this will become a key metric as part of the NHS Long Term Plan. Performance is monitored in both cities. Southampton has achieved the target in month and has been consistently above the 90% target and their mean performance for the past 6 months, making this statistically significant and triggering a 'Pass' rating on the capability scale. Portsmouth has achieved 89% in month; however have achieved the target year-to-date with 92% compliance.

2.3 NHS Improvement Single Oversight Framework

Month: Dec-19

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Quality of Care Indicators						
Organisational Health	Staff sickness (rolling 12 months)	I	4%	5.0%	F	
	Staff turnover (rolling 12 months)	I	14%	14.7%	F	
	Staff Friends & Family Test - % Recommended Employer	I	80%	71.3%*	F	
	Proportion of Temporary Staff (in month)	I	6%	5.4%	?	
Caring	Written Complaints	I	15	8	?	
	Staff Friends & Family Test - % Recommended Care	I	80%	87.1%	P	
	Mixed Sex Accommodation Breaches	E	0	0	P	
	Community Friends & Family Test - % positive	E	95%	96.3%	P	
	Mental Health Friends & Family Test - % positive	E	95%	76.9%	?	
Effective	Care Programme Approach (CPA) follow up - Proportion of discharges from hospital followed up within 7 days - MHMDS	E	95%	97.9%	?	
	% clients in settled accommodation	I	59%	84.7%	P	
	% clients in employment	E	5%	5.4%	?	
Safe	Occurrence of any Never Event	E	0	0	P	
	NHS England/ NHS Improvement Patient Safety Alerts outstanding	E	0	0	P	
	VTE Risk Assessment	E	95%	95.0%	?	
	Clostridium Difficile - variance from plan	E	0	1	?	
	Clostridium Difficile - infection rate	E	0	1	?	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	E	0	0	P	
	Escherichia coli (E.coli) bacteraemia bloodstream infection	E	0	0	P	
	MRSA bacteraemias	E	0	0	P	
	Admissions to adult facilities of patients who are under 16 yrs old	E	0	0	P	

Operational Performance					
Maximum 18 weeks from referral to treatment (RTT) – incomplete pathways	E	92%	98.4%	P	
Maximum 6-week wait for diagnostic procedures	E	99%	99.0%	?	
Inappropriate out-of-area placements for adult mental health services - Number of Bed Days	E	0	0	P	
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	E	50%	75.0%	P	
Data Quality Maturity Index (DQMI) - MHSDS dataset score	E	95%	85.7%*	?	H
Improving Access to Psychological Therapies (IAPT)					
- Proportion of people completing treatment moving to recovery	E	50%	53.2%	P	
- Waiting time to begin treatment - within 6 weeks	E	75%	97.6%	P	
- Waiting time to begin treatment - within 18 weeks	E	95%	100.0%	P	

Use of Resources Score					
Use of Resources Score	E	2	2	?	

* Data collected 3 times per year in June, September and March. Most recent data reported

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

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

2.4 Regulatory Exceptions

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

Significant negative exceptions on this month's Single Oversight Framework (section 2.3):

Staff Sickness

The staff sickness indicator shows that without significant intervention, the target will not be achieved. Further narrative on Workforce metrics can be found in the Workforce Commentary (section 5.2).

Staff Turnover

The staff turnover indicator shows that without significant intervention, the target will not be achieved. Performance against this metric has reduced consistently for the past 2 months following a peak in October, and is now only slightly outside of the upper control limit. Further narrative on Workforce metrics can be found in the Workforce Commentary (section 5.2).

Staff Friends and Family Test - % recommend employer

This indicator shows that without significant intervention, the target will not be achieved. Whilst the 80% target is internally set, this is not something the Trust is likely to reduce in order to show achievement as this would not be in the best interest of our staff. The Friends and Family Test performance has been consistently above the mean for the past 6 periods (FFT data is collected three times per year), so the slight drop in September 2019 (71.3% compared to 73% in the previous period) is not deemed significant.

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

Data Quality Maturity Index (DQMI) - MHSDS dataset score

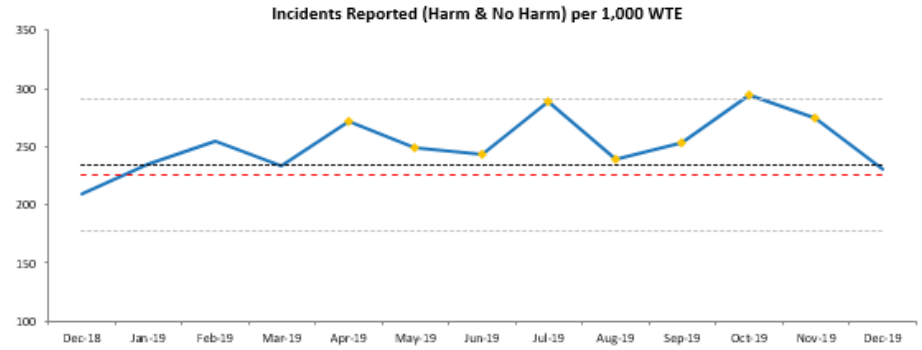
The DQMI indicator has triggered Special Cause for note in the variance category to reflect that performance has increased consecutively for six months. This is as a result of the focus being given to improving the Trust's DQMI score for the Mental Health Services Data Set (MHSDS) linked to the CQUIN for 2019/20. Whilst there is still further improvement to be made to reach the target level of 95%, the Trust has shown a significant improvement going from 72% in April, to 86% in September 2019.

3.1 Quality Performance Dashboard

Month: Dec-19

Safe

Incident Reporting Rates



YTD	Moderate & Above Incidents	
2019-20	207	
2018-19	158	▲ 31.0%

YTD	Serious Incidents (SI) Raised	
2019-20	43	
2018-19	60	▼ 28.3%

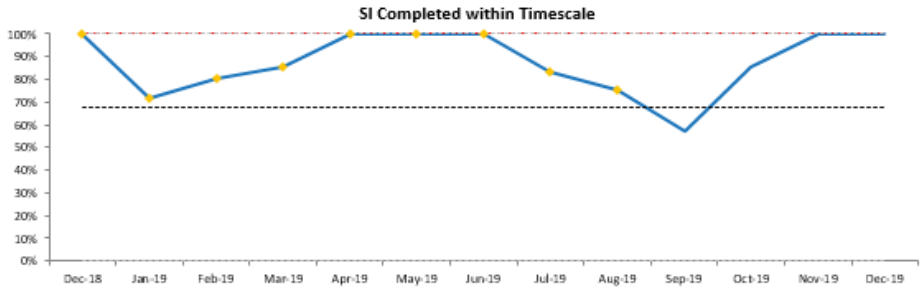
YTD	Physical/Verbal Assaults to Staff	
2019-20	515	
2018-19	477	▲ 8.0%

Narrative

Incidents reported remain within the upper and lower control limits. Less patient incidents have been reported and performance in December has dropped below the mean which is positive. The majority of incidents reported continue to be categorised as no harm or near miss incidents.
Incidents of moderate harm have increased compared to 2018/19, these relate to a variety of causes but are predominately pressure ulcers.
Adult Mental Health have seen an increase in the number of physical/ verbal assaults reported however these continue to occur in all Services.
Adult Mental Health are currently undertaking a deep dive into their incidents. The Associate Director of Quality and Governance is undertaking a review of the number of Serious Incidents reported in 2018/19 compared to 2019/20.

Effective

SI Investigation and Closure



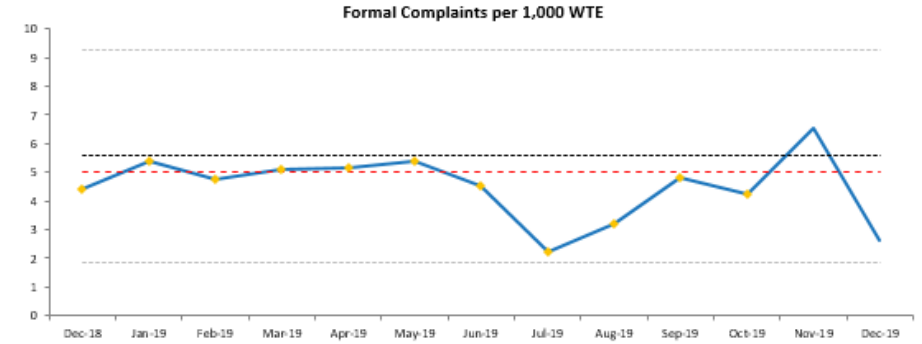
No associated data feed

Narrative

The aim to have 100% completed within the timescale has been achieved for two consecutive months.

Experience

Formal Complaint Rate



YTD	Complaints Received	
2019-20	114	
2018-19	134	▼ 14.9%

Complaints Closed to Timescale

Target	Actual	
80%	60%	●

YTD	Unsolicited Plaudits	
2019-20	1100	
2018-19	1141	▼ 3.6%

Narrative

Complaints have returned to below the mean although they remain within the upper and lower control limits. The main Complaint themes relate to Clinical Care and Staff Attitude. There has been a decrease for Primary Care complaints during this period.
In December the target to close complaints within timescale was not met. Further work is required with Services to understand why the delays in responding to complaints is occuring.
Unsolicited plaudits are slightly down on last year, this small decrease will continue to be monitored during January and February. The PALs and Complaints Team are reviewing the Plaudits reporting process to support the quality of reporting plaudits.

Key: Data | Benchmark | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | Rising/ Falling Trend (6 points)

3.2 Chief Nurse Commentary

Current Events to Note

The Trust has received notification from the CQC of their intention to undertake a Well-Led and a minimum of one core service inspection. The deadline for submission of our PIR is Friday 7 February 2020.

NHS England has contacted NHS Trusts regarding the Wuhan Novel Coronavirus in China with approximately 571 people identified with respiratory infections at the time of writing. Most reported cases are at the mild end of the spectrum; with no confirmed cases in the UK to date. NHS England has provided advice to Trusts and has provided a pathway outlining the initial assessment questions to identify a patient who may require isolation and testing. All primary and secondary healthcare providers have been advised to make arrangements for such patients to be identified immediately and isolated according to the Public Health England guidance. The information and pathway has been shared through the Trust CAS alert system in line with usual process. Should the situation change or other action be required this will be managed and communicated via the Interim Chief Medical Officer and/or the Chief Nurse.

There have been two confirmed cases of Clostridium Difficile in Jubilee House, one in November and one in December. The patient in November was in a shared room and became acutely unwell and was transferred to hospital. The patient sharing the room was followed up and was symptom free so there was no spread of infection. The patient in December was managed appropriately by the team however the review of both cases identified a delay in contacting the Infection Prevention and Control (IPC) team who would have been able to provide expert advice and support. There was similar learning from the case reported in October and the interim Head of IPC is working with the clinical team leads to address this.

There has been a confirmed case of Influenza A on Maples ward in December. The patient was transferred to hospital for a five day course of Oseltamivir (Tamiflu) but returned after 3 days as was symptom free. The infection prevention team (IPT) liaised with Dr Helen Chesterfield - Specialist, and it was agreed that any pregnant staff members who have had ‘significant contact’ with the patient during the infectious period should be offered prophylaxis, via their GP. The Occupational Health team was also made aware of the case.

On 1 April 2020 we will launch our new experience feedback system in partnership with Civica UK. The system provides greater opportunities for us to understand the experience of people who use our services, by using multiple accessible methods for people to share their views. A stakeholder event is planned for February and training will be provided in March.

In December the Trust were invited to bid for grant funding for whole system support for winter pressures. We received confirmation that the bid was successful on 24 December and were awarded a £25,000 grant to reduce the impact of winter pressures on our local community by making more creative use of volunteers and community based voluntary services. We plan to use the funding to:

- reduce the time from applicant to placement for volunteers
- increase the provision of social support in the community to those experiencing isolation, which we know increases the risk of hospital admission
- increase the availability of transport services to people attending preventative health service appointments

On 27 January we launch our Community Partners Programme, an inclusive and innovative approach to increase and improve community's participation in the design, delivery and monitoring of the services we provide. People will come together to help us take the first steps to developing a 5 year strategy for the Trust.

The Southampton and Portsmouth Community Nursing teams, supported by the Tissue Viability teams, will be taking part in a multicentre European Wound Management Association audit that will be presented at a European conference in summer 2020. The Tissue Viability teams will be providing full support throughout the audit process and the outcomes will be key in understanding the needs and improving the care of patients requiring wound management in the future.

The Trust has received confirmation that a complaint relating to clinical care (C1372) which was being considered by the Parliamentary Health Service Ombudsman (PHSO), will not be taken any further by the PHSO and has now been closed. Note: this is one of the cases referred to in the section on complaints below.

In January, colleagues from NHSI/E WRES (Workforce Race Equality Team) team, Yvonne Coghill CBE, Dr Habib Naqiv and Owen Chinembiri, facilitated a workshop for the Trust board and senior leaders. The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity, and to develop and implement robust action planning for improvement. WRES data for the last three years shows year-on-year improvement for BAME (Black, Asian and Minority Ethnic) staff on a range of indicators. Nationally the overall BAME workforce in the NHS is increasing; however this is not reflected at senior positions where there is an acute under-representation of BAME staff. At Solent NHS Trust we have made considerable progress with levels AfC 8d and 8a, however further work is needed to progress a longer term agenda; the next stages for Solent is to refresh our current staff data for the 10 year WRES aspirational plan and develop an action plan that will be implemented within our organisational strategy.

The Portsmouth CAMHS team has had confirmation that their tri-annual Royal Collage of Psychiatrists inspection will take place on 11 February. The team is experienced in these inspections and is currently completing their preparations.

Southampton City Council had an Ofsted inspection of children's Social Care services carried out in November 2019. Solent is a key partner with some staff; specifically the integrated early help team and the safeguarding team, being involved in the inspection process. Whilst the overall judgement for children's social care is 'Requires Improvement' it is pleasing to see the opening paragraph relating to the integrated early help and prevention service which positively reports that our practitioners are curious and knowledgeable and work alongside families to effect change and improve children's daily experience. We will continue to work with partners through the safeguarding partnership boards and committees to address the areas identified for improvement.

In December 2019 Portsmouth Children's services had a Joint Targeted Area Inspection (JTAI). The core element of the inspection was safeguarding and the themed element was mental health of children. This inspection involved a number of our clinical teams, including the CAMHS service and the Health Visiting and School Nursing teams, as well as colleagues who sit on strategic planning boards such as the Health and Well-Being board. The draft report has been received by the local authority for factual accuracy checking and the final report is expected toward the end of January/early February.

In December the Trust had success in the NHS Elect Awards in two categories. The Excellent Teamwork Award was presented to Brooker ward for Dementia Services led by Patient Representative - Kate Legg and Mary Ramsay (Volunteer), and the Patient Experience and Communications Award was presented to the Trust for Patient Representatives for QI Patient Training Programme - Paula Marsh, Roger Stevens & Alice Roath. Whilst not a winner, we are also proud of our Vocational Rehabilitation Service who were shortlisted finalists for the Co-created Award.

We are delighted that Pamela Campbell, Consultant Nurse Homelessness and Health Inequalities has been awarded an Honorary Fellowship of the Faculty of Homeless and Inclusion Health. This is in recognition for the work she has done to support and promote health services for the most vulnerable in our communities.

Complaints Update

In November and December 2019 the Trust received a total of 28 formal complaints which is similar to the previous two months. The complaints by service line are in the table below:

Service Line	November 2019	December 2019
Adults Portsmouth	1	0
Adults Southampton	1	0
Children's Services	7	3
Primary Care	3	0
Sexual Health	1	0
Adult Mental Health	7	2
SPA	0	0
Special Care Dentistry	0	3
Corporate	0	0
Infrastructure	0	0
Total	**20**	**8**

The main complaint themes relate to clinical care and staff attitude. In comparison to the previous period there has been a reduction in complaints to Primary Care and a slight increase for Special Care Dentistry. The other service lines remained consistent and it is noted that Child and Family services continue to have higher levels of complaints received which is specifically related to their CAMHS service. The service are undertaking a deep dive into complaints, service concerns and professional feedback in an effort to better understand the contributory factors and to triangulate with other metrics including incidents in order to determine the appropriate actions required to improve this position.

Two service concerns were escalated to formal complaints during this period, as the complainants remained dissatisfied following an initial attempt at resolution with the service directly. In contrast, the team de-escalated 3 complaints to service concerns following resolution with the services directly, and with agreement from the complainants.

There has been a significant decrease in Professional Feedback received, reduction from 8 to 3. The team closed 16 complaints in December, the highest amount of cases closed in a month over the last 6 months.

As at December 2019 there were two active cases with the PHSO; the provisional report for one case was received for comment with the proposed outcome being that the PHSO will not uphold the complaint, and the second remains in the initial review stage.

An updated version of the Complaints Policy was shared with services for comment. The team have

re-advertised a PALS Call Handler & Admin role for internal secondment to help the team manage the advice and sign posting contacts.

Incident Updates

The incident data for November and December indicates a slight decrease compared to the previous two months. There have been fewer patient related incidents reported and no trends have been identified. This will continue to be monitored during January and February. The majority of incidents continue to be categorised as no harm or near miss incidents.

November and December has seen a significant increase in the numbers of restraint and seclusion incidents which are at the highest level for 2019/20. All incidents of restraint and seclusion are formally reviewed by the Trust Lead and reported through Quality Improvement & Risk (QIR) group. The majority of the restraints are attributed to one patient and a large proportion of the increase in seclusions is related to the same individual.

The VTE assessments position has dropped slightly to 95% in December but remained within the 95% target and the year to date position is 98%.

Serious Incident (SI) Update

During November and December, eight Serious Incident investigations were registered which is an increase of 3 against the September/October position with no specific trends or themes identified. The categories are detailed below:

Category	November	December
Self-Harm	1	1
Delayed Diagnosis	1	0
Treatment Delay	1	0
Slips/Trips/Falls	1	0
Pressure Ulcer	1	0
Safeguarding Vulnerable Adults	0	1
Injury (Undetermined Intent)	0	1

The outcomes and learning from these investigations will be shared and discussed at the Serious Incidents and Learning from Deaths panels in February and March. The themes and learning identified will be reported in the Learning from Deaths Quarterly Report including SI's, Incidents and Patient Safety Quarter 2, 2019/2020. All serious incidents due for completion in November and December were submitted within the agreed timeframes.

In line with the recent publication 'Shifting the Mindset – A closer look at NHS complaints', working with patients and families we will be reviewing both our complaint and serious incident processes. We have made a number of changes to both, which include the role of Family Liaison Officer in the serious incident process and earlier face to face meetings with lead clinicians in our complaints process. We will keep the board informed through the assurance committee reports.

Friends and Family Test (FFT)

There has been a slight decrease in the number of FFT responses received for November and December, the latter being consistent with a drop for the same time in 2018/19 and which may be indicative of a seasonal effect. However, the percentage of patients/carers that would recommend the service remains consistent with 96% saying they would recommend the service they received.

Although the quantitative FFT results are encouraging the free text comments from patients/carers provide the richest source of information. All free text comments are reviewed and a sample of the current trends and themes are:

- Friendly, welcoming, home visit was great
- Very polite and very quick on what they had to do
- Staff very understanding and offered guidance that led to massive improvements in my life
- Staff are professional, informative and supportive

In addition to identifying the positive experiences patients and carers also help us to understand some of the challenges they face and this helps us to identify improvements. A summary of the themes in November and December are:

- Difficulty booking appointments
- Attitude of reception staff
- Progress slow
- Long waiting times

This feedback is shared with services. In response to the comment about attitude of reception staff, the specific service manager shared the feedback with staff and reminded them of the need to remain professional when receiving patients/visitors into the department. They also introduced a local feedback form and post box for people to provide immediate feedback to the team which is shared and actions taken as a result.

Patient Led Assessments of the Care Environment (PLACE)

The annual PLACE assessments were completed in October and November with the final visit held on 5 November 2019. Fourteen different areas were visited over the 5 days with forty five assessors supporting the process. The collections closed in December with NHS Digital currently undertaking validation and analysis in preparation for publication of results, expected around the 30 January.

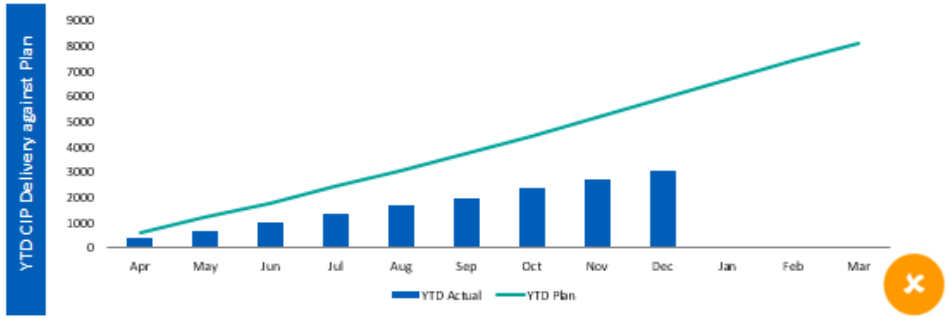
4.1 Financial Performance Dashboard

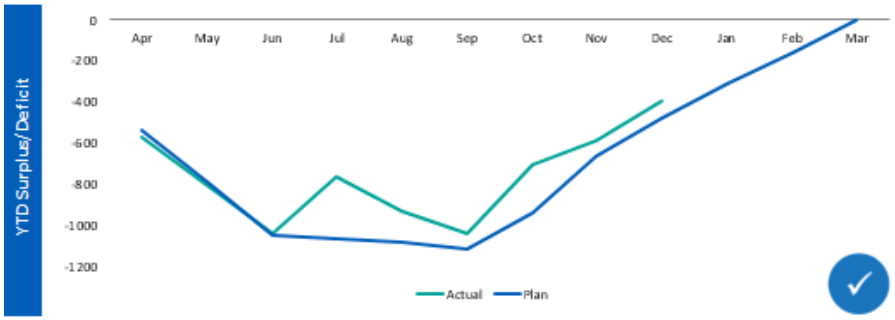
Month: Dec-19

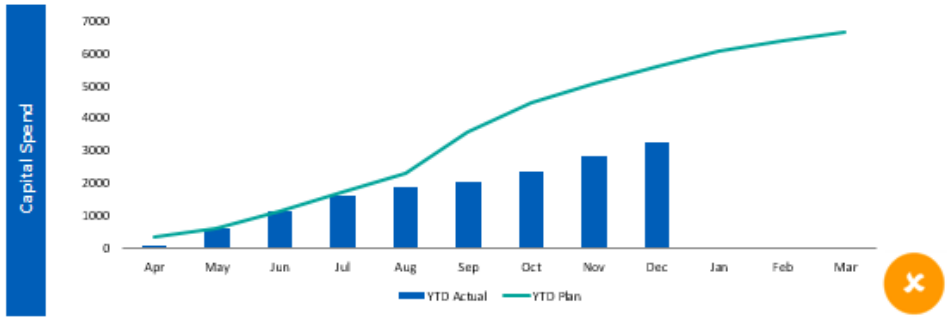
Key

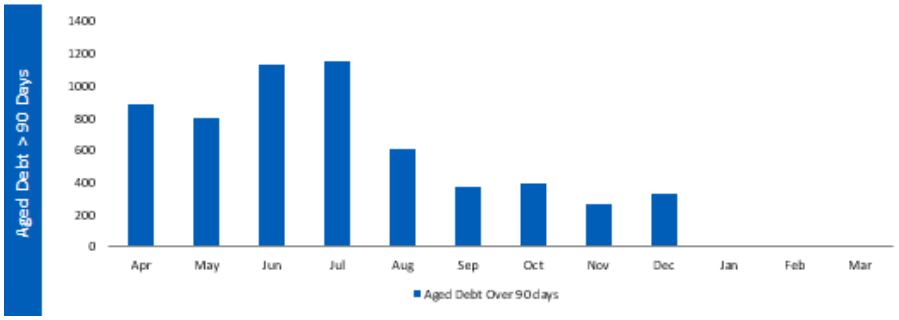
✓ Plan achieved in month/YTD

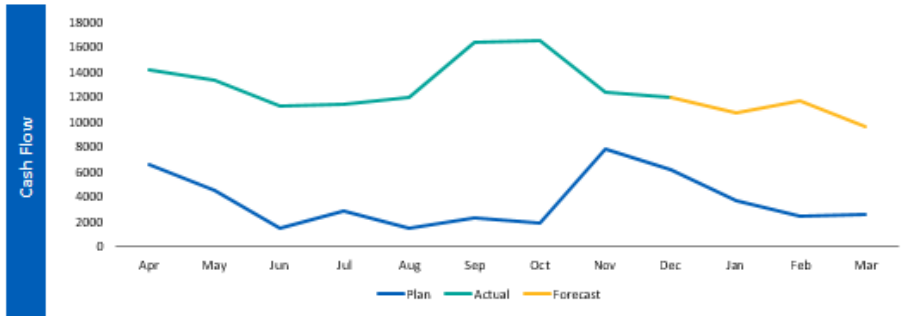
✗ Plan missed in month/YTD











4.2 Chief Finance Officer Commentary

Month 9 Results

The Trust is reporting an in month adjusted surplus of £198k for month 9, £19k favourable to plan and a year to date adjusted deficit of £392k, £87k favourable to plan. The Trust has achieved the quarter 3 control total and therefore has earned £1,595k Provider Support Funding (PSF) and Financial Recovery Funding (FRF) income in the year to date result. The Trust has received an additional £207k PSF for 2018-19 which is not included in the adjusted deficit.

Whilst the Trust has made a deficit of £392k in the first nine months of this year, the full year control total is breakeven, with Cost Improvement Plan (CIP) schemes planned for the remainder of the financial year and additional PSF and FRF income expected during quarter 4.

Discussions are on-going with specific services regarding their ability to deliver against plan; particular pressures lie in Adults Southampton, Adults Portsmouth and Estates.

Cost Improvement Plans (CIP)

CIP delivery in month 9 was £314k (£421k adverse to plan) and year to date £3,044k (£2,870k adverse to plan). CIP schemes are being under delivered across all service lines, although Mental Health, Childrens East and Childrens West are achieving their plans with non-recurrent underspends. It is recognised that CIP delivery is challenging in the current climate; therefore additional efforts are being made to ensure all CIP schemes are put through the Quality Impact Assessment (QIA) process, with the majority now approved.

Capital and Cash

Year to date capital expenditure at month 9 is £3,233k. Projects totalling £5,988k have been approved and are underway, and a further £845k of projects are currently within the approval process. Some of these projects may not commence until the next financial year as a result of reducing Capital Resource Limit (CRL) affected by lower depreciation due to delayed projects.

The Trust received £4,768k Public Dividend Capital (PDC) funding for the phase 2 project at St Marys and St James Hospitals in September which has been matched with actual expenditure. The phase 2 project was completed before Christmas with various teams moving into the newly refurbished premises.

The cash balance at 31 December 2019 was £11,888k, down from £16,455k at 31 October. The decrease is predominantly due to a £2,718k payment to NHS Property Services in November. The cash flow forecast reflects the agreed extension of two loans for £3,460k and £4,304k to July 2020 and August 2020 respectively. Discussions are on-going with NHSI with regards timing of loan repayments and potential further extensions.

Aged Debt

The Trust's total debt increased during December by £1.2m to £6.2m mainly due to £750k of NHSE monthly invoices being unpaid at month end, together with £300k for Health Visiting and £170k for

the Sexual Health contract for Southampton City Council being unpaid in the 1-30 days overdue bracket. As these are all regular invoice income payment is expected during January.

91+ day overdue debt at the end of month was £325k, an increase of £55k on the previous month. No particular debt caused this movement.

5.1 Workforce Performance Dashboard

Month: Dec-19

	Indicator Description	Internal / External Threshold	Threshold	Current Performance	Capability	Variance
Sickness	All Staff (in month)	I	4%	5.5%	F	
	All Staff (rolling 12 months)	I	4%	5.0%	F	
Retention	All Staff (in month)	I	1.2%	0.6%	?	
	All Staff (rolling 12 months)	I	14%	14.7%	F	
	Nursing & Midwifery (rolling 12 months)	I	14%	14.3%	F	
	Stability Index (rolling 12 months)	I	85%	85.6%	?	
Additional Staffing	Additional Staffing (%)	E	6%	5.4%	?	
	Bank Staffing (%)	I	4.0%	3.6%	?	
	Agency Staffing (%)	E	1.8%	1.8%	?	

	Number	Cost
Hours Requested (in month)	26,902	n/a
Hours filled by Bank (in month)	16,922	£449,013
Hours filled by Agency (in month)	7,834	£336,487
Variance to Agency Ceiling (in month)	n/a	£56,487

	Indicator Description	Threshold	YTD Performance
Training Compliance	Statutory and Mandatory	90%	85%
	Information Governance	90%	79%
	Appraisals	95%	72%
Vacancy Rate	All Staff	5%	2.6%
	Nursing & Midwifery	5%	1.4%
Health Roster	e-Job Plan (level of attainment)	4	No level
	e-Rostering (level of attainment)	4	0

		Number
Staff in Post	Staff in post (in month)	3,606
	FTE in post (in month)	2,993.2
	FTE Variance (since last month)	9.9
	New Starters FTE (in month)	29.6
	Leavers FTE (in month)	21.4

5.2 Chief People Officer Commentary

Sustainable Workforce

Full time equivalent (FTE) in post for December (M9) was 2,993.2 which is an increase of 83.1 FTE since the beginning of the year. This increase is due to successful recruitment in June and July, resulting in high numbers of new starters in September and October. As a result, our vacancy rate for December was 2.6%, a reduction from 6.6% in April. Our nursing vacancy rate is currently 1.4%, a significant reduction from 5.4% in April.

The sickness rate in month is 5.5%, which is a continued upward trend, which is not unexpected during the winter months. Additional interventions to support wellbeing have been launched. Average annual turnover is 14.7%, which is a decrease from 15.2% in November. Nursing turnover has also decreased to 14.3% from 15.8% in November.

Agency cost continues to be a concern, though it has been steadily decreasing over the last three months due to a reduction in off framework usage. Our agency staffing in month made up 1.8% of the workforce, which still compares favourably with the peer median of 3.9% in the NHS Improvement Model Hospital tool. The Hampshire and Isle of Wight (HIOW) Collaborative Bank continues its implementation; however benefits will not be seen until later in 2020.

Our Roster Improvement Programme continues, however, performance on e-roster completion remains inconsistent. The planned internal audit has been completed and we await the recommendations. Following on from the successful bid for capital funding, work is now progressing on implementation of e-job planning. This will help us achieve an increase in rating against the national rostering attainment standards.

Learning and Development

The statutory and mandatory training rate in December was 85.4% against a target of 90%. A plan to achieve the 90% target is in place and all staff groups are being encouraged to allocate staff time to complete any outstanding training. There are continued concerns around the accuracy of the compliance reporting from the e-learning system, and as mitigation to this the Learning and Development team are supporting the input of paper-based records to update the compliance tool, as well as having completed a bulk upload of data to ESR to improve the reported Appraisal compliance. Additional support has been put in place to increase the compliance for Information Governance training specifically. A new Learning Management System (LMS) procurement exercise has started and implementation will commence in early 2020. This will be a boost for morale, and will significantly improve our learning infrastructure and reported compliance.

From April 2020, all people working within the Agenda for Change NHS pay framework will be required to provide evidence of completion of their appraisal objectives to ensure they move to their next pay step point. Work to implement Manager Self Service in April 2020 will support this; ensuring people can record appraisals effectively.

The inaugural Learning Innovation ‘Unconference’ will take place on 16 March followed by the Annual Apprenticeship Awards. The event will be focused on sharing career development opportunities and will also be the launch of our new Learning and Development Strategy. We are delighted to welcome Charles Jennings as the keynote speaker..

Leadership, Culture and Values

We have held several successful engagement events to support the redevelopment of policies as part of the Improving People Practices programme.

The research we commissioned on the 'State of the Nation' review which is an independent look at our values, leadership and culture and will be reported to the next Workforce & Organisational Development (OD) Committee. Our Leading with Heart programme was recently recognised by the British Psychological Society, with the two psychologists responsible for designing it were given the Award for Excellence in Professional Practice by the Division of Occupational Psychology. We are now taking our next step to offer our middle management community a Leading with Heart intervention.

We are pleased to welcome Michael West to our Trust Management Team on the 29 January to support us in our continued leadership development.

Health and Wellbeing

The flu programme was launched mid-September and vaccination clinics commenced 1 October. Despite national challenges in supply of the vaccine leading to fewer clinics in the initial months, 74% of staff have been vaccinated to date against a target of 80%.

Communication and Engagement

During November, the Trust featured within a heavily covered pan-Hampshire story regarding patient and employee car parking charges at hospitals. Coverage on the story was seen in the Daily Echo, Andover Advertiser, Hampshire Chronicle and Romsey Advertiser. A statement was provided in response to the media enquiry.

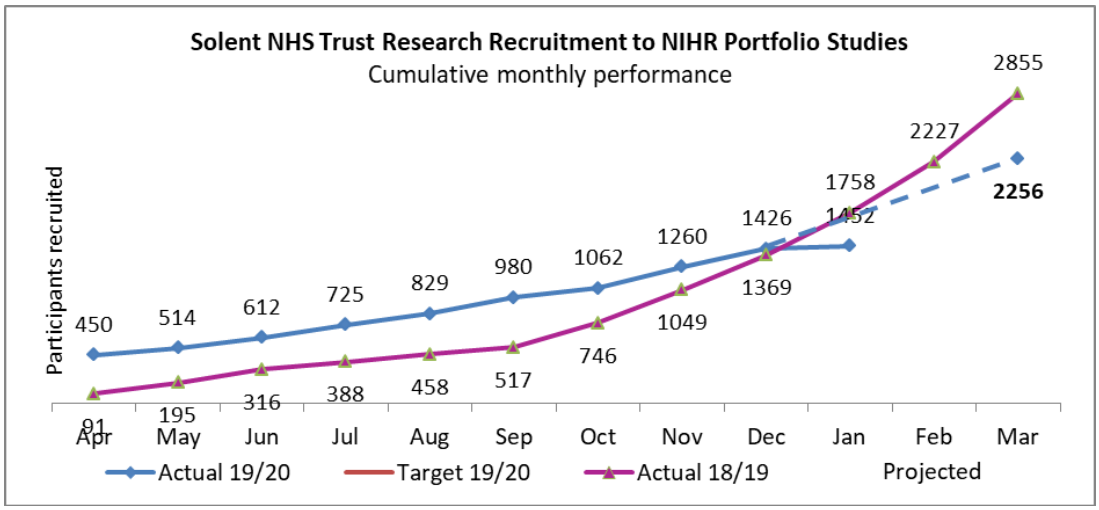
In December, in line with the Public Relations Strategy, the Communications Team led the campaign, #HomeforChristmas. The campaign, which linked to the Trust's purpose of keeping people safe and well at home, included a news piece on BBC South featuring the Portsmouth Rehab and Reablement Team. The campaign also included stories from nurses and AHPs in Solent sharing how they make a difference by helping people to return home; these were shared on the Trust's digital communication channels, including Instagram, Facebook and Twitter. The content on Facebook, in particular, received significant engagement (a combined reach of over 23k).

Internal communications campaigns continued to focus on the 2019 NHS Staff Survey which closed on 29 November. The Trust exceeded its target of 62% with a final response rate of 63%. The results from the survey will be published in mid-February.

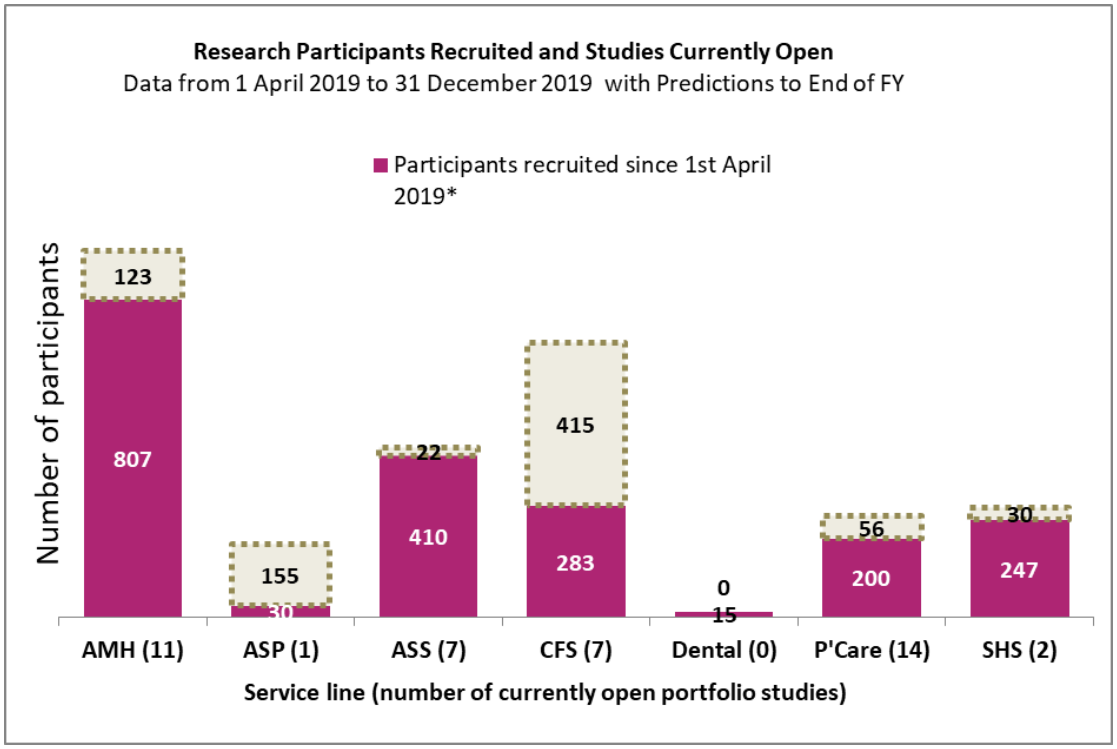
6.1 Research and Improvement Commentary

Research

As an NHS organisation, Solent's research performance is measured by the number of participants recruited into studies. Between April 1 and December 31 this year we have recruited 1452 participants into research studies which means we have exceeded our annual target. We are predicting recruitment of over 2000 participants by the end of the financial year.



There are open studies in each of our Service Lines, but the most research active are our Mental Health, Children's and Sexual Health Services.



Clinical Audit and Evaluation – Completion against Plan

April 1 - December 31 2019/20

We have seen significant improvements from audit and evaluation in the following examples:

- Overall completion compliance with GP discharge summary on Snowdon Ward (Adults Southampton).
- Documentation of bruising protocol for non-mobile infants due to new proforma (Childrens).
- ECHO health visiting use of Early Help or Step Down plans (Childrens).
- Documentation of clinical discussions regarding domestic abuse (Childrens).
- Annual appraisal for non-medical prescribers (Childrens).
- Outcomes from pain self-management programme (Primary Care/MPP)
- Self-referral into MSK physio reducing DNA rate (Primary Care/MPP)
- Use of trained assistants at inter-uterine coil fittings (Sexual Health)

	Local Projects 2019/20 – Q3		
	Number on Plan	Reports received	Completion rate
Adults Portsmouth	14	3	21%
Adults Southampton	40	13	33%
Childrens	39	12	31%
Mental Health	24	1	4%
Primary Care - GP	2	0	0%
Primary Care - MPP	32	13	41%
Sexual Health	26	10	38%
Specialist Dental	19	5	26%
Total	**196**	**57**	**29%**

Patient Participation

Solent won 2 national awards in December for patient participation – the winners were:

- Brooker Team for the plates and nutrition project – Excellence Teamwork Award
- Patients in QI co-design team – Patient Experience and Communications Award.

2 patient leaders attended to collect the awards, Mary Ramsay and Paula Tyler. Both also gave verbal presentations on working with patients in improvement.

Other highlighted activity includes:

- Collaboration with the University of Portsmouth Dental Academy and the family hubs in Portsmouth, working with families of pre-school children on oral health, experiences of going to the dentist and dental research priorities.
- Learning Disabilities services have co-produced a free e-learning training package available to staff, community organisations and the public on raising awareness of the needs of people with learning disabilities and their families.
- The second cohort of QI leaders now has patients as part of the programme, who working and learning alongside our staff.

Publications

Dr Cathy Price, Consultant in Pain Management and Clinical Director for Primary Care Services was awarded her Doctorate in Medicine in December. This was awarded for a series of four publications on a body of work establishing a national patient registry for those attending pain clinics. The work is being adopted across the UK.

Price CM, C. de C. Williams A, Smith BH, Bottle A**.** Implementation of Patient-Reported Outcomes (PROMs) from specialist pain clinics in England and Wales: Experience from a nationwide study. European Journal of Pain. 2019 ;23(7):1368-1377

Price C, de C Williams AC, Smith BH, Bottle A. The National Pain Audit for specialist pain services in England and Wales 2010–2014. British Journal of Pain. 2018 Dec 7:2049463718814277.

Hall, G. C., Bryant, T. N., Merrett, L. K**., Price, C**. Validation of the quality of The National Pain Database for pain management services in the United Kingdom. Anaesthesia 2008: 63: 11: 1365-2044

Griffiths, D. P. G., Mitchell Noon, J., Campbell, F. A., **Price, C.** M. Clinical governance and chronic pain: towards a practical solution. Anaesthesia 2003: 58: 3: 243-248

7.1 NHS Provider Licence – Self Certification 2019/20

Condition G6 – Systems for compliance with licence conditions:

Requirement

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Response

The Board is not aware of any departures or deviations with Licence conditions requirements. The effectiveness of internal control systems and processes are reviewed on an annual basis and documented within the Annual Governance Statement as presented to the Audit & Risk Committee and incorporated within the Annual Report. In addition, assurance to the Board is supported by opinions from Internal Auditors and External Auditors.

Annually the Trust declares compliance against the requirements of the NHS Constitution

Condition FT4 – Governance Arrangements:

Requirement

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.

Response

The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate.

Requirement

2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

Response

The Board is not aware of any departures from the requirements of this condition. The Board considers and adopts corporate governance standards, guidance and best practice as appropriate, including that issued by NHSI.

Requirement

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

Response

The Board is not aware of any departures from the requirements of this condition. On an annual basis the Trust has implemented a process of governance reviews (via the Governance and Nominations Committee) including;

- Reviewing composition, skill and balance of the Board and its Committees
- Reviewing Terms of Reference
- The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business conducted in year. A mid-year review of each Committee is also conducted.

The Composition of Committees is also kept under constant review to take into consideration and periods of unscheduled /planned leave, the impact of vacancies effecting quorarcy as well as any recommendations made following Internal Auditor (or other external review) – including the outputs of the Audit concerning the effectiveness of the Assurance Committee and Quality Improvement and Risk Group, and more recently the Mental Health Act and Scrutiny Committee. We have successfully recruited to our previous NED vacancy, and have proactively successfully recruited to the clinical NED role as part of succession planning. . We currently have an interim Medical Director in post and are looking to recruit to a substantive Chief Medical Officer role in the spring. The Trust's wider governance structure is also regularly considered and refreshed to ensure efficiency and clear lines of reporting.

Requirement

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.

Response

For 2018/19: We achieved a £1.4m surplus, against a stretch deficit plan of £0.4m; the original plan had a deficit of £1.0m. During 2018/19, Solent received £3.5m of Provider Sustainability Funding, as awarded from NHSI (£1.5m as per the original plan and an additional £2.0m for performing marginally better than plan).
Our efficiency target (Cost Improvement Plan) was £7.7m, of which £6.1m was delivered; the balance was achieved by other measures.

For 2019/20: We have a breakeven Control Target. The Trust has achieved the quarter 3 control total and therefore has earned £1,595k Provider Support Funding (PSF) and Financial Recovery Funding (FRF) income in the year to date result.

Internal control processes have been established and are embedded across the organisation as outlined within the Annual Governance Statement. The agreed annual Internal Audit programme deliberately focuses on key areas where testing may identify the need for strengthened controls.

The Board is not aware of any other departures from the requirements of this condition.

Risk and Mitigation actions: *Concerning CQC compliance - We continue to address actions and monitor compliance with requirements made following our CQC report (Feb 2019).*

Requirement

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.

Response

The Board is not aware of any departures from the requirements of this condition.

The Trusts' goals; Great Care, Great Place to Work and Great Value for money, demonstrate the organisations focus and emphasis on 'quality' being the overriding principle for everything we do.

The Board's agenda has a notable weight towards quality of care, supported by data and information owned and presented by the Executive Directors.

There is clear accountability for quality of care throughout the organisation from executive leadership by the Chief Nurse working with the Chief Medical Officer.

Concerning Board level capability – We have successfully recruited to our previous NED vacancy, and have proactively successfully recruited to the clinical NED role as part of succession planning.. We currently have an interim Medical Director in post and are looking to recruit to a substantive Chief Medical Officer role in the spring.

Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.

Established escalation processes allow staff to raise concerns as appropriate.

Requirement

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.

Response

The Board is not aware of any departures from the requirements of this condition. Details of the composition of the Board can be found within the public website. Qualifications, skills and experience are taken into consideration, along with behavioural competencies as part of any recruitment exercise for Board vacancies.

Item 8

NHS Solent NHS Trust

Board and Committee Cover Sheet

Item No.	8

Presentation to	*Public Board*			
Title of Paper	Information Governance Briefing Paper			
Purpose of the Paper	It is a requirement of the General Data Protection Regulations (2016) that the Board have oversight of and take accountability for Information Governance (IG).			
Author(s)	Angela Sumner (IG Specialist)	Executive Sponsor	David Noyes - SIRO	
Date of Paper	3rd February 2020	Committees/Groups previously presented		
Summary of key issues/messages	**Please Note:** It is a requirement of the General Data Protection Regulations (2016) that the Board have oversight of and take accountability for Information Governance (IG).			
Action Required	For decision?	N	For assurance?	Y
Recommendation	*The Public Board is asked to:* • *Consider the contents of the briefing*			

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient		Limited		None	
Assurance Level	Concerning the overall level of assurance the [X] is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

1. Purpose

1.1 The purpose of this report is to provide the Trust with a summary of the Trust's current Information Governance Compliance with Law, National Requirements and Mandatory NHS Requirements. Solent NHS Trust believes that it is essential to the delivery of the highest quality of health care for all relevant information to be accurate, complete, timely and secure. As such, it is the responsibility of all staff and contractors working on our behalf to ensure and promote a high quality of reliable information to underpin decision making. Information Governance promotes good practice requirements and guidance to ensure information is handled by organisations and staff legally, securely, efficiently and effectively to deliver the highest care standards. Information Governance also plays a key role as the foundation for all governance areas, supporting integrated governance within Solent NHS Trust.

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

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

2. Data Protection and Security Toolkit 2019/20

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

2.2 In March 2019 the Trust submitted its annual response to this toolkit and identified itself as fully compliant. The Trust was required to submit a Baseline Assessment covering the amended toolkit for 2019/2020 by the end of October, due to staff shortages this was submitted on the 15th November 2019. The toolkit was internally audited in November and the compliance report will be provided by PWC; identified actions will be taken into account for the full assessment submission by the 31st March 2020.

3. Summary of Information Governance's Legal Requirements Compliance

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

	2018/19	Q1 2019/20	Q2 2019/20	Q3* 2019/20	Year To date
Number of requests received	1115	308	338	279	925
Number of requests processed		249	272	165	686
Number of requests responded to within 21 days (best practice)	842	188	202	134	524
Number of requests responded to within GDPR (30 days) Or DPA (40 days), for all requests prior to GDPR	157	34	45	19	98
Total legal compliance	**999 (89.6%)**	**222 (89%)**	**247 (91%)**	**153 (93%)**	**622 (91%)**
Number of breaches	116	27	25	12	64

(10.4%)	(11%)	(9%)	(7%)	(9%)	

* Final figures are subject to change, as some requests are currently on hold or in progress

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

3.2 Freedom of Information Requests: Freedom of Information Act 2000 requires requests for information to be processed within 20 working days. Below is a breakdown of compliance. Please note that the Information Commissioner's Office require the Trust to be 95% compliant with this requirement. The December figures are subject to confirmation but are likely to breach the statutory timescales due to significant staff absence and the discovery of a number of requests in an unmonitored inbox. Steps have now been taken to deal with the requests as a matter of urgency.

Quarters	April to August	Sept	Oct	Nov	Dec
No. Requests	148	24	28	26	31
No. Breaches	25	1	3	1	TBC
% Compliance	83	96	89	96	TBC

3.3 Summary and Actions:

- Subject Access Request compliance has shown a gradual increase since Q1.
- Freedom of Information Request compliance was above target for Sept and Nov, December will show a lower compliance rate.
- Compliance monitoring and escalation processes are in place but it should be noted that whilst the team have coped well in very challenging circumstances due to the disruption in the service, issues have been identified that are subject to future improvement planning.

4. Information Governance Incidents/Security

Type of Incident	Q1	Q2	Q3	Q4	Total
Deliberate Breach By Solent Staff	4	0	1		5
ICT Failure	2	2	0		4
Lost Smart Card / ID Badge	15	9	12		36
PID Found In Public Place	3	7	5		15
PID In Wrong Record	35	32	23		90
PID Saved/Stored Insecurely	8	13	10		31
PID Sent To Wrong Address	23	16	13		52
PID Sent To Wrong Person	14	18	22		54
Printing Issues (Left On Printer / Wrong Printer)	3	3	4		10
Records Error	16	11	13		40
System Error	1	0	1		2
Post Issues (Way In Sent/received)	2	1	1		4
Other Information Governance Incident	17	20	9		46
NHS Mail Not Used For PID	12	5	14		31
Lost Notes / PID	5	2	5		12
no Breach (IG team use only)	0	4	1		5
Out of Our control (IG)	0	1	0		1
Cyber Security	2	0	1		3

Risk Item (Missing or Found)	0	0	0		0
TOTALS	**162**	**144**	**135**		**441**

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

Service line	Q1	Q2	Q3	Q4	Total
Adult Services - Portsmouth	6	14	9		29
Adult Services - Southampton	17	11	16		44
Childrens Services East	20	13	11		44
Childrens Services West	30	29	28		87
Corporate Services	14	11	14		39
Infrastructure	2	2	1		5
Mental Health Services	8	13	9		30
Primary Care	35	24	19		78
Sexual Health Services	16	24	15		55
Specialist Dental Services	14	3	12		29
Single Point of Access	0	0	1		1
TOTALS	**162**	**144**	**135**		**441**

4.1 The highest reported type of incident is “PID in Wrong Record”, this type of incident needs to be looked at in context, compared to the activity levels within the Trust e.g. number of record entries, compared to the number of incidents. Additionally the error is contained within the Health & Social Care setting, with records being amended as soon as the error is reported (removing the risk of a breach); therefore the risk to the patients data and the Trust is low. Though the Trust has planned to undertake a wider review of this type of incident and review the following;

- Number of entries that have been “marked in error” over the last 12 months, on SystmOne (similar assessments are to also be undertaken on Inform and R4) – the likelihood is that there are more incidents than that reported
- Number of entries made within medical records during the same period, to identify the percentage of this issue
- If there are any particular services areas, who identified entries as “PID in Wrong Record”.
- To work with the Information Systems Team and Governance Leads to assess the reasoning around why this type of incident are occurring and if there are any training needs that need to be address, or any cultural/environmental reasons for this occurring
- Devise a new process to enable the linking of reported breaches and requests for deletion of records or information in records

to date this work has not commenced due to a shortage of trained resources within the IG team, this is being addressed and we aim to commence this work from April 2020. onwards.

4.2 The second highest reporting category is PID sent to wrong address/person. This remains a highly reported category and is of a concern; however as per above this needs to be looked at in comparison with the number of letters sent each year, compared to the number of incidents (the occurrences are low). Actions taken within the Trust have significantly reduced the impact of these incidents however there has been one breach reported to the Information Commissioners Office (ICO) relating to the

sending of confidential information to the wrong recipient. This occurred due to steps taken to reduce the likelihood of address details being viewed through an envelope which led unfortunately to the sending of confidential information to two recipients but each received the others information. This is subject to a formal complaint to the Trust but the ICO have confirmed that they are not considering further action at this time.

4.3 In addition to the above and to allow the Trust to identify the root cause of these incidents and identify learning outcomes and training/awareness needs, the Information Governance Team are planning a deep dive review, to be commenced in April 2020 of all IG incidents to assess the following:

- Was the incident pure human error
- Was the incident a result of failure to follow processes and/or safeguards
- Was the incident a result of not being aware of processes and/or safeguards
- Was the incident a result of lack of training
- Was the incident a deliberate act

5. Summary

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

The service has experienced significant disruption for a number of months which has created difficult circumstances. This has given the service the opportunity to reflect, learn and re-focus the skills and capacity of the team and the following key priorities have been identified:

- The team will move towards a multi-skilled workforce and offer development opportunities to learn new skills and ensure coverage is available when absences occur. This will ensure that the Trust consider staff mental wellbeing.
- We intend to move all IG training back to online module (standard for most NHS Trust
- We intend to procure an online redaction tool (standard for most NHS Trusts)

Item 9.1

NHS Solent NHS Trust

Board and Committee Cover Sheet

Item No.	9.1

Presentation to	Board			
Title of Paper	Trust Risk Management Framework			
Purpose of the Paper	To seek the approval of the reviewed and updated Trust Risk Management Framework			
Author(s)	Ben Heaton, Head of Risk and Litigation	Executive Sponsor	Jackie Ardley	
Date of Paper	16/01/2020	Committees/Groups previously presented	Board Seminars	
Summary of key issues/messages	The Board have outlined their risk appetite and tolerance. This has set the parameters of Risk Management for Trust staff to operate within. The risk appetite and tolerance parameters will require changes to governance to ensure they are applied consistently. The Trust Risk Management Framework has been reviewed to include the requirements and changes agreed at the January Board Seminar.			
Action Required	For decision?	Yes	For assurance?	No
Recommendation	The Board is asked to: • Approve the latest version of the Trust Risk Management Framework.			

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	X	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature	JAArdley							

Item 9.2

Solent NHS Trust

Risk Management Framework

Version 0.6.0
DRAFT
17 January 2019

CONTENTS

1. Introduction

The Solent NHS Trust Board is committed to ensuring that effective risk management is an integral part of its management approach, underpinning all activities, performance and reputation. As such, the Trust's approach to risk management is one of proactive identification, mitigation, monitoring and review.

Effective risk management is an essential part of any successful organisation and must be integrated into the culture of the organisation and led by the Trust Board and senior management. It should address the risk surrounding delivery of the organisation's activities in the present and in the future to support the improvement of services and delivery of high quality care through continuous learning.

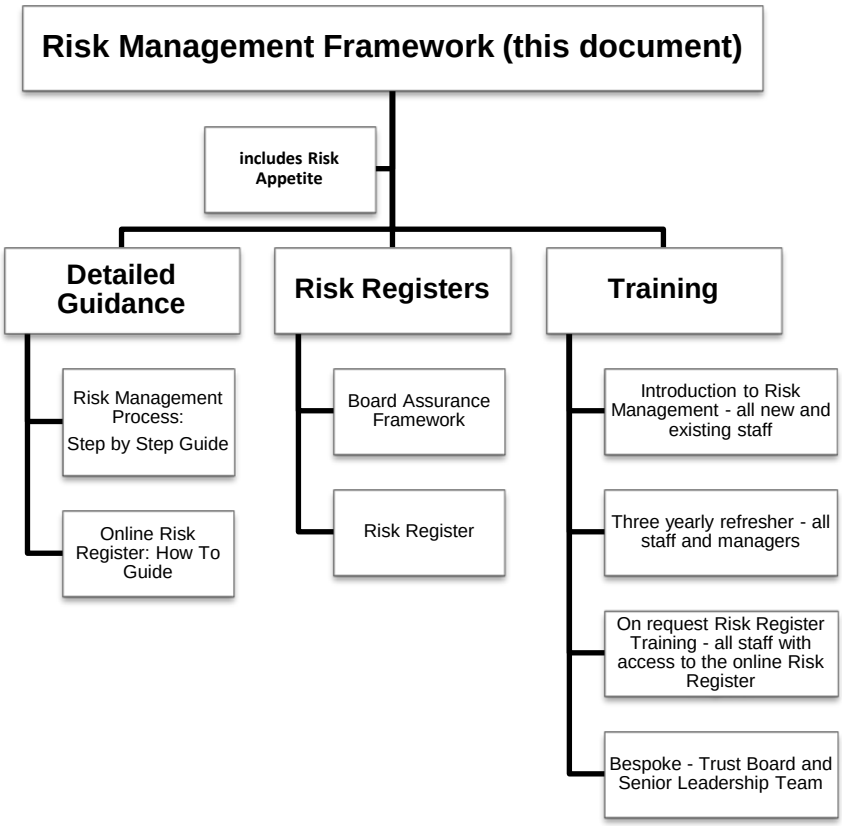
The delivery of healthcare will always involve a degree of risk however a positive risk management culture empowers staff to make sound judgement and decisions concerning the management of risk and risk taking.

2. Aim and Purpose

Risk management underpins the Trust's vision, goals and objectives which are reviewed and refreshed at least annually by the Trust Board.

This document provides a framework to assist staff in identifying risks to the achievement of the Trust's vision and goals, and summarises the processes to enable staff to effectively identify, analyse and control risk and make informed decisions about priorities for risk remedies and mitigation.

Framework components:



3. Scope

This Framework is Trust wide and applies to all directly employed staff and indirectly employed, substantive and temporary staff including contractors, bank staff, locums, agency staff, volunteers and non-executive directors.

4. Risk Management Terms & Definitions

The following terms are used throughout this document, in supporting documents and the Trust's risk management training programmes.

Accepted Risk	A risk that has been managed to achieve its target risk score
Action Owner	The person responsible for taking one or more of the actions needed to reduce and mitigate a risk
Action Plan	A document which sets out the activities that will address an identified gap in controls and reduce, eliminate or minimise the risk
Approving Manager	The person responsible for reviewing the risk assessment, approving the risk score and agreeing the action plan
Assurance	Evidence that control measures are working effectively to manage risk
Closed Risk	A risk that has been eliminated and no longer exists
Control	Process, system or activity to prevent risk or mitigate its potential impact
Consequence (also referred to as Severity or Impact)	Result of a particular threat or opportunity should it actually occur
Issue	A day to day operational situation that has occurred or is on-going and requires action to manage effectively. These should not be entered onto the Risk Register but in operational Issue/Action Logs.
Likelihood	Measure of probability that the threat will happen including a consideration of frequency with which it may arise
Operational Risk	A risk that has the potential to impact on the delivery of business, project or programme objectives
Risk	A potential future event or situation which, should it occur, will have an effect on the achievement of objectives and which could be avoided through pre-emptive action.
Risk Appetite	How much residual risk an organisation is prepared to seek in the pursuit of its objectives.
Risk Tolerance	The amount of residual risk an organisation is prepared to accept regarding aspects that could damage the achievement of its objectives.
Responsible Manager	The person accountable for ensuring that actions identified to mitigate and manage a risk on the Risk Register are taken within agreed timescales
Risk Assessment	The process used to evaluate a risk and determine whether controls are adequate or more should be done to mitigate the risk
Risk Management	The systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk
Risk Assessor	The person who has completed a risk assessment and entered it onto the Trust Risk Register
Risk Registers	A log of risks of all kinds and levels that may threaten the achievement of objectives. It is a living document which is populated through the organisation's risk assessment and evaluation process.
Strategic Risk	A risk that has the potential to impact on the delivery of the strategic objectives and is captured in the Board Assurance Framework

5. Risk Appetite and Tolerance

Risk appetite can be described as how much residual risk an organisation is prepared to seek in the pursuit of its objectives.

Risk tolerance is the amount of residual risk an organisation is prepared to accept regarding aspects that could damage the achievement of its objectives.

Solent NHS Trust Board accepts that risk is inherent in the provision of healthcare and its services and as such, is willing and has the capacity to seek and/ or tolerate calculated risks on a case by case basis in the delivery of its business goals.

The following defines the Boards approach to risk-taking and the thresholds which support the delivery of this Framework. Risks will be considered on a case by case basis; for consistency and simplicity, thresholds are aligned with the Trust's risk scoring protocols and with the approval, monitoring and oversight arrangements set out in this document.

	Seek (Appetite)	**Tolerate**
Can the Trust seek or tolerate any very high risks (15 to 25)?	**No, except when the alternative exposes the Trust to an equal or higher risk. Approved by Board.**	**No, except with justifications. Approved by Board Committees.**
Can the Trust seek or tolerate any high risks (8 to 12)?	**Yes, with justifications. Approved by Exec Director e.g. COO.**	**Yes, with justifications. Approved by Exec Director e.g. COO.**
Can the Trust seek or tolerate any moderate or low risks (1 to 6)?	**Yes**	**Yes**

Risks will have controls and mitigations in place.

If the current score is higher than the target score, there will be SMART actions in place to bring the scores in line.

Risks will not require further actions over and above their existing controls and mitigations when the existing and target scores align.

6. Roles and Responsibilities

The Risk Management Governance structure is set out in **Appendix 1.**

6.1 Trust Board

The Trust Board is responsible for determining the Trust's approach to risk management and approval of the Risk Management Framework and risk appetite and tolerance. As set out in its Terms of Reference, the Board oversees the effectiveness of processes for the identification, assessment, management and mitigation of risk. The Board will receive for monitoring and assurance, a report on the most significant operational risks on the Risk Register and the Board Assurance Framework.

6.2 Board Committees

Within the scope of their terms of reference, the Committees of the Trust Board are responsible for assuring the application of the Board's risk appetite and tolerance, approving proposals to tolerate risks scoring 15 and above and assuring the action plans for risks scoring 15 or above that are above their target risk score.

- Assurance Committee – clinical service risks
- Workforce and Organisational Development – people and OD risks
- Finance and Infrastructure Committee – ICT, finance and estates risks

- The *Trust Management Team* (TMT) oversees the appropriateness of risks included in the Board Assurance Framework and Risk Register and seeks assurance that plans are being executed to mitigate risks to the target/tolerable level. Specifically, Trust Management Team will:
    - Review the Trust Risk Pyramid
    - Review all individual risks on the Risk Register scoring 15 or higher (including those relating to the Sustainability and Transformation Partnerships (STP) work streams) to ensure that risk scores and mitigation plans are appropriate and being delivered
    - Ensure the sharing and triangulation of corporate service and clinical service risks.
    - Escalate risks appropriately to the Trust Board via the Chief Executive's Report.

- The *Audit & Corporate Risk Committee* assures the efficacy the Trust's risk management systems and processes. It will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives including effective use of the Board Assurance Framework.

6.3 Operational Management Groups

Operational management Groups and formal meetings are responsible for receiving, monitoring and reviewing relevant operational risks within the scope of their Terms of Reference.

- Quality Improvement and Risk Group - clinical service risks
- People and Organisational Development Group
- ICT Group
- Finance and Commercial Group
- Estates, Facilities and Sustainability Group
- Health and Safety Group – health and safety risks
- Performance Review Meetings (PRMs)

Their Terms of Reference will include:

- Reviewing operational risks, with a focus on those scoring >=12
- Identifying top three risks (PRMs only)
- Receiving assurance that risks are being appropriately managed and mitigated
- Escalating risks as appropriate to the appropriate Committee or TMT
- Escalating requests to tolerate risks scoring 15 or above to the relevant Committee

- The *Quality Improvement & Risk Group* seeks assurance from Clinical Service Lines that risks are being dealt with robustly and effectively at an operational level through appropriate governance structures, processes and controls, and that corporate services are working effectively and in a timely manner to support Service Lines in addressing risk. Compliance with statutory and regulatory obligations relating to risk is monitored and action plans arising from risk inspections and reviews are being progressed within timescales. The Group will escalate risks to the Assurance Committee as appropriate.

6.4 Clinical Service Governance and Corporate Service Meetings

Meetings that feed into the Trust Groups will review their; they will receive assurance that action plans are in place and risks are being appropriately managed and mitigated and will identify for escalation at the appropriate Group or TMT those risks which require additional oversight, monitoring and/or support.

6.5 Executive Directors

Executive Directors are responsible for the implementation of the Risk Management Framework and its assurance mechanisms bringing together the corporate, financial, workforce, clinical, information, research and governance risk agendas.

The Chief Operating Officers are responsible for ensuring Service Line Risk Registers are reviewed in Performance Review meetings and for escalating risks through the organisation and to the Trust Board via the Chief Executive as set out in this Framework.

Executive Directors will approve the seeking of and/ or acceptance of risks scoring 8 to 12 as appropriate.

6.6 Non-Executive Directors

The Non–Executive Directors are responsible for providing independent assurance to the Board through challenge and scrutiny of the risk management structure and processes.

6.7 Chief Executive

The Chief Executive is the Accountable Officer for effective risk management and the system of internal control within the organisation. The Chief Executive is also accountable for ensuring all statutory requirements including health and safety and risk management systems are met, implemented and maintained in accordance with organisational arrangements.

6.8 Chief Nurse

The Chief Nurse is responsible for ensuring that all risk and assurance processes are devised, implemented and embedded through the Trust and for reporting to the Chief Executive any significant issues arising from the implementation of the Framework including non-compliance or lack of effectiveness arising from the monitoring processes.

6.9 The Quality & Governance Team

On behalf of the Chief Nurse, the Quality & Governance Team leads risk management across the Trust and is responsible for:

- promoting a positive risk culture across the organisation
- ensuring that robust and effective infrastructure, systems, processes, training, technology and procedures are in place to deliver this Framework
- monitoring and reporting on compliance with Framework requirements
- carrying out analysis and surveillance on the Risk Register and reporting significant issues, themes and trends to the appropriate fora and senior managers
- undertaking quality control on the Risk Register and liaising with clinical and corporate services accordingly in order to maintain its integrity and validity
- maintenance of the Ulysses Safeguard system to ensure it remains fit for purpose

6.10 Director of Finance and Performance

The Director of Finance & Performance is the designated Executive Director responsible for internal financial control and sound financial governance.

6.11 Company Secretary

The Company Secretary is responsible for ensuring the Board Assurance Framework (BAF) is developed, reviewed and reported to the Trust Board and Audit & Corporate Risk Committee. The Company Secretary and the Quality & Governance Team will ensure the BAF is aligned to the Risk Register and the most significant operational risks from the Risk Register are reported to the Board and its Committees.

6.12 Service Line Leadership and Corporate Directorates

Service Line Clinical Directors and Corporate Associate Directors will provide leadership for the risk management agenda across their services and ensure that responsibilities to identify, record, analyse, control and communicate risk issues (via processes such as Risk Assessment, Incident Reporting and Risk Registers) are in place within their service lines and corporate directorates. They will be responsible for the identification, management and review of risks in line with their level of authority and areas of responsibility.

6.13 Managers

For the purposes of this document, a Manager is anyone who leads a team or department and has delegated responsibility for risk, and they are responsible for:

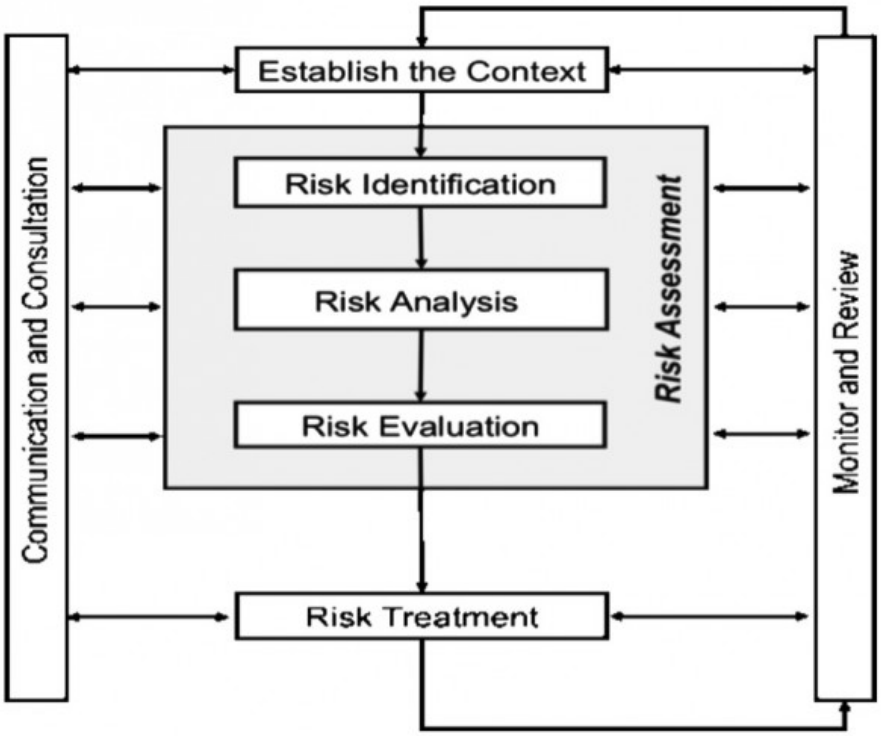
- The identification of risks and for implementing and monitoring any identified risk management control or assurance measures within their designated area and scope of responsibility
- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility and that all staff are aware of the significant and potential risks within their work environment and of their personal responsibilities
- Addressing risks as they arise and escalate in accordance with the procedures set out in this Framework
- Keeping the Risk Register up to date with progress
- Approving the seeking of and/ or acceptance of risks scoring 6 and below.
- Ensuring all their staff are provided adequate information, instruction and training to enable them to work safely
- Seeking advice on risk management issues as required, and liaising with relevant specialist advisors where necessary
- Ensuring risk management is integrated into all operational activities
- Ensuring all policies, protocols and guidelines pertaining to risk assessments and management are carried out within their services/departments, in liaison with appropriate identified relevant advisors where necessary e.g. Health & Safety, Infection Control and Safeguarding leads
- Implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, these are to be escalated
- Ensuring Health and Safety legislative requirements are complied with and that adequate resources are made available to provide safe systems of work and care for patients. This will include making provision for risk assessments to be completed and appropriate control measures put in place, ensuring staff know how to raise concerns, releasing staff to attend training, ensuring safe working procedures/ practices are in place and monitoring of these is in place. These responsibilities extend to anyone affected by the organisation's operations including sub-contractors, members of the public and visitors
- Ensuring staff receive risk management training in line with the requirements set out in this Framework.

6.14 All Staff

All staff are responsible for identifying and minimising risk, reporting and responding to risk, participating in training and carrying out any agreed control measures and duties as instructed.

7. Risk Management Process

The Trust's risk management approach is based on **AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines:**



Below is an overview of the Risk Management Process, a more detailed step-by-step guide is available on the Trust's staff intranet.

The key roles involved in the risk management process are:

- the **Risk Assessor** who is responsible for completing the risk assessment in full and entering details onto the Online Risk Register
- the **Approving Manager** is responsible for reviewing the risk assessment, approving the risk score and agreeing the action plan
- **Action Owners** are responsible for taking one or more of the actions needed to reduce and mitigate a risk
- the **Responsible Manager** is accountable for ensuring actions identified to mitigate and manage a risk on the Risk Register are taken within agreed timescales

Risk Assessors and Responsible Managers are usually managers but can be in any role and at any level of the organisation. The Approving Manager is dependent on the current risk score with the highest scoring risks being approved by the relevant Executive Director (see Risk Approval section below).

7.1 Establish the Context

To establish the context means to define the external and internal parameters that must be considered when managing risk. This includes external stakeholders, local and national, environment, as well as any external factors that influence its objectives. An internal context includes its internal stakeholders, its approach to governance, its contractual relationships, and its capabilities, culture, and standards.

7.2. Communicate & Consult

Communication and consultation is not a distinct stage in the management of risk, but runs through the whole process and comprises of:

- Ensuring the Trust's approach and infrastructure for risk management is communicated to all relevant internal and external stakeholders
- Ensuring that internal and external stakeholders are consulted about risks which may impact upon them and appropriately involved in the risk assessment and development of mitigation plans, monitoring and reporting arrangements
- Providing stakeholders with feedback on the effectiveness of the Trust risk infrastructure and framework.

7.3 Identify Risks

A risk is a set of circumstances or events which have not occurred and which could have positive or negative consequences on an organisations ability to meet its vision and goals.

When identifying a risk, consideration should be given to what could pose a potential threat to the achievement of objectives or otherwise impact on the success of the organisation. Risk can be identified from many sources of information. Some of these are reactive (e.g. incidents), proactive (risk assessments), internal (staff consultations) or external (inspections).

The table below gives example of sources of information for risk identification purposes:

Internal Proactive	Internal Reactive	External Proactive	External Reactive
• Risk Assessments • Organisational Objectives • Business Planning • Staff Consultation • Patient Consultation • Horizon Scanning • Internal Safety Alerts • Freedom to Speak Up • Data Analysis	• Internal Inspections • Complaints • Incidents • Claims • Audits and Reviews • Patient Feedback • Independent Reviews • Quality Impact Assessments	• Benchmarking • Mandatory Targets • National Confidential Enquiry Reports • Self-Assessments against national standards	• CQC Inspections • HSE Reports • NHS Safety Alerts

Risk identification should take place on a continual basis, but particularly during annual business planning when objectives are being set, where new activities or services are planned, new legislation or policy requirements have been identified, part of the Quality Impact Assessment (QIA) process, at the initiation of projects or when incidents or near misses have taken place.

The **Risk Management Process: Step by Step Guide** contains more information about risk identification and distinguishes between a risk and an issue; the latter should not be managed via the Risk Register but Service Line and Corporate Directorate Issue or Action Logs.

7.4 Assess & Analyse Risks

It is vital that all risks are assessed in an objective and consistent manner if they are to be managed effectively. Risks are firstly assessed on what could happen, then its impact should the risk occur and finally the likelihood of the risk occurring.

When assessing what the impact of the risk could be if it happened, the Risk Assessor will consider what the impact would be in most circumstances within the environment and what is reasonably foreseeable. When assessing how likely it is that the risk will occur, the Risk Assessor will take into account the current environment, the adequacy and effectiveness of the controls already in place and the likeliness of the risk being realised.

The total risk score is derived from multiplying the Likelihood score by the Consequence score:

Likelihood x Consequence = Total Risk Score

When completing a risk assessment the risk is scored three times using the descriptions above and this information is entered into the Risk Register:

- **Initial Risk Score** – this is level of unmitigated and unmanaged risk without any controls, process or actions in place to mitigate or manage it
- **Current Risk Score** – this is the level of risk taking into account any existing controls, processes or steps being taken to manage the risk (controls). This is also known as the current risk score.
- **Target Risk Score** – this is the level of risk that is considered acceptable and which should be reached if the actions identified to manage the risk are implemented. Target risks scores should be accompanied by a date by which the target should be reached to aid effective management and monitoring of the risk.

The Trust uses the Consequences and Likelihood Risk Scoring Matrix and definitions published by the National Patient Safety Agency (January 2008):

Consequence Score

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood Score

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Total Risk Score

The total risk score is derived by multiplying the consequence score by the likelihood score:

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Approval

Risks will be formally approved based on the current risk score as follows:

	Approval Arrangements
1-3 Low Risk	• Manager of the area where the risk exists
4-6 Moderate Risk	• Manager of the area where the risk exists
8-12 High Risk	• Clinical Director or Associate Director of Corporate Services depending on the nature of the risk.
15-25 Extreme Risk	• Relevant Executive Director

The Quality & Governance Team will be responsible for ensuring that approvals have taken place at the appropriate level and in a timely manner.

7.5 Risk Register

A Risk Register is a repository of risk assessments and includes a description of the risk, its initial risk score, current risk score and a target risk score and details of mitigation and preventative actions.

Solent has two Risks Registers – the Board Assurance Framework which is a repository of the risks to the Trust strategic objectives and the Risk Register, which is a repository of operational risks.

The Trust uses the Risk module of the Ulysses Risk Management System for its Risk Register. The Board Assurance Framework is managed by the Trust Company Secretary and the Risk Register is managed by the Quality & Governance Team.

Within the Risk Register, risks are grouped according to the level within the organisation that they impact upon and are being managed at:

Potential Risk Impact and Management Level	Risk Register Level
Risks which impact at Service, Locality, Team, Unit or Department level managed by the relevant local manager and monitored at Service, Locality, etc., Business Meetings	Service, Locality, Site, Team
Risks with Service Line or Corporate Directorate implications and managed by a Clinical or Operational Director or a Corporate Directorate senior manager and monitored at Service Line Boards and Performance Reviews	Service Line or Corporate Directorate
Risks with Trust-wide implications managed at executive or senior manager level and monitored at Trust Management Team	Trust-wide
Risks to delivery of the strategic objectives managed by the executives and monitored by the Trust Board through the Board Assurance Framework	Board Assurance Framework

The Board Assurance Framework may contain commercially sensitive information however the Risk Register is subject to Freedom of Information requests and extracts can be reported to the public in Trust Board meetings therefore risks must be described clearly and appropriately. The *Risk Management Process – Step by Step Guide* provides more detailed guidance for staff about how to clearly articulate a risk.

7.6 Manage & Act

After assessing the risk score, a decision on risk management should be made using the following criteria:

Accept	Low and minor risks can be accepted as requiring no further action. On reviewing this type of risk it may however be decided that some cost effective action would reduce the risk still further. Action on this risk is a lower priority. In many cases action can be taken to change the way activities are carried out in order to reduce the risk identified. It may be decided a particular risk should be avoided altogether. This may involve ceasing the activity giving rise to the risk.
Transfer or Share	This involves another party bearing or sharing some part of the risk e.g. through the use of contracts, insurance arrangements and organisational structures such as Service Level Agreements (SLAs).
Reduce	In many cases action can be taken to change the way activities are carried out in order to reduce the risk identified
Eliminate	It may be decided a particular risk should be avoided altogether. This may involve ceasing the activity giving rise to the risk.

Where the risk has been identified as requiring management to minimise the likelihood and/or impact of a threat, an action plan must be developed. The risk should then be reassessed and a post mitigation risk score identified as to what level of risk will remain once the action plan has been completed and additional controls have been put in place.

Controls are the precautions/processes/plans in place to assist in the prevention of risk occurring such as:

- Operational and business plans
- Statutory frameworks, for instance standing orders, standing financial instructions and associated scheme of delegation
- Actions in response to audits, assessments and reviews
- Workforce training and education
- Clinical governance processes
- Incident reporting and risk management processes
- Complaints and other patient and public feedback procedures
- Performance management systems
- Strategies/Policies/Procedures/Guidance
- Robust systems/programmes in place – what / how do you know?
- Objectives set and agreed at appropriate level
- Frameworks in place to provide delivery
- SLA/Contracts/Agreements in place

7.7 Monitor & Review

The monitoring of action plans and level of risk must be kept under review, along with the effectiveness of the controls (above). Internal and external evidence (assurance) will be sought that controls are working effectively as part of the monitoring process.

All risks must be reviewed on a monthly basis or sooner if actions/activities change.

The Responsible Manager is accountable for ensuring risks are reviewed and changes to a risk are captured, that actions are implemented and the risk is updated accordingly including:

- *Risk Description* – does it still reflect the current situation and potential/actual impact of the risk occurring? If the description is required to be changed significantly then the original risk should be closed and a new risk added
- *Controls* – are these up to date and still in place/ are there any additional controls to be added?
- *Actions* – are they now complete?
- *Assessment Scoring* - is the likelihood now reduced? is it the same as the Target Score or are more actions required in order to mitigate against the risk? Or has the likelihood increased and do actions need to be added?

Service Lines and Corporate Directorates will be responsible for providing assurance to the Quality Improvement & Risk Group that monthly reviews have been completed and onward assurance is provided to the Assurance Committee.

Where implementation of the action plan is not producing the anticipated results within the required time frame, the risk should be re-assessed and a revised action plan agreed as necessary.

Once all actions have been completed and the risk has been mitigated/minimised as far as possible, the risk can be accepted. These risks remain on the Risk Register and can be re-instated should circumstances change and there is a need to do so.

It is important risks are dealt with by the right people at the right level within the organisation and this will usually be the level of the organisation on which the risk is likely to impact should it materialise. However there are thresholds at which risks will have a higher level of oversight and this is based on the Residual (Current) Risk Score.

The higher the risk score higher the level of visibility, monitoring and support a risk may have within the organisation. A high risk score does not automatically transfer ownership and responsibility for managing the risk:

Level of Risk	Oversight Arrangements
1-3 Low Risk	• Annual monitoring by the Responsible Manager with the risk grading adjusted appropriately in line with any mitigating actions taken.
4-6 Moderate Risk	• Monthly monitoring by the Responsible Manager to ensure actions are being progressed, risks mitigated and the risk grading adjusted appropriately in line with any mitigating actions taken.
8-12 High Risk	• The Clinical Director or Corporate Department Associate Director (depending on the risk), is responsible for ensuring ensure actions are being progressed, risks mitigated and the risk grading adjusted appropriately in line with any mitigating actions taken.
15-25 Extreme Risk	• Risks will be reviewed by the Trust Management Team at each meeting and will seek assurance that actions are being progressed, risks mitigated and the risk grading adjusted appropriately in line with any mitigating actions taken.

Risk themes is where individual, but similar risks need to be considered jointly in order to gain a view of risk exposure. For example, many wards, teams, departments and services may face similar risks e.g. in-year cost pressures, recruitment problems, etc. which may be assessed as low scoring and locally managed. Taken individually these risks may not significantly impact on the organisation but collectively have the potential to threaten achievement of Trust's objectives.

The Ulysses system incorporates Risk Groups. This enables risks with similar aspects to be provided to the relevant Groups and Committees. For instance, Staffing risks are provided for the People and OD Group. This will include those risks owned by services as well as those owned by the People and OD Team.

Lessons identified from managing risks in one area and which may have a wider applicability will be shared as learning with other teams and services as part of the Trust's organisational learning framework.

8. Risk Analysis and Surveillance

The Quality & Governance Team is responsible for the continuous analysis and surveillance of all risks on the Risk Register; the Company Secretary is responsible for monitoring and analysis of the Board Assurance Framework.

Analysis and surveillance should support the identification and communication of:

- The Trust's top risks – these are the highest scoring and/or most prevalent risks on the Risk Register. They can be individual risks or groups of risk e.g. top 3 clinical risks, top scoring risks in a particular Service Line, etc.
- Themes – a prominent or frequently occurring Risk Group or risk subject e.g. staffing shortages, availability of wheelchairs, ligatures, etc.
- Trends – patterns of gradual change for example, are certain types of risk increasing or decreasing over time? are more/less of types of a certain risk being reported?

The findings from on-going analysis and surveillance should be included in Risk Management reports and be communicated to frontline staff through the staff intranet and newsletters/bulletins.

9. Risk Management Reporting & Risk Profiling

A Risk Profile examines the nature and levels of threats faced by an organisation. It examines the likelihood of adverse effects occurring, the level of disruption and potential resources associated with each type of risk and the effectiveness of the control measures in place. Solent NHS Trust's Risk Profile includes:

- the nature and level of the risks faced by the Trust
- the likelihood of adverse effects occurring and the level of disruption they could cause
- costs associated with each type of risk
- an assessment of the effectiveness of the controls in place to manage those risks

Risk Management reports to Trust Board, Board Committees and Management Committees should include risk profiling information and the following information about risks relevant to its Terms of Reference:

- Relevant findings from on-going Risk Register analysis and surveillance
- New risks added
- Risks where target score has been achieved
- Risks where score has increased
- Risks where score has decreased
- Risks for higher level oversight or monitoring
- Risks for closure

Evidence (assurance) that risk management systems and processes are working effectively should also be included in management reports such as:

- Number and % of risks reviewed within the past month and action plans updated
- Number and % of risks with action plans on track/off track
- Outcome of internal audits, independent reviews and internal reviews of risk management
- Relevant findings from compliance monitoring e.g. Peer Reviews, Quality Visits

The table below indicates the meetings at which risk must be discussed and the recommended frequency:

	Risk Register (every meeting unless indicated otherwise)	**Board Assurance Framework**
Formal Service Line Governance Meetings	• All risks and action plans reviewed monthly	• Not applicable
Clinical Service Performance Review Meetings	• All risks reviewed • Monthly – top three risks identified and action plan progress reviewed	• Not applicable
Operational Management Groups		
QIR	• Top clinical service risks reviewed in Service line reports. • Top medicines management risks reviewed every 2 months • Quarterly exception risk report • Annual risk report	• Not applicable
People & OD	• Review of People and OD risks at each meeting	• Not applicable
ICT	• Review of ICT risks at each meeting	• Not applicable
Finance & Commercial	• Review of Finance & Commercial risks at each meeting	• Not applicable
Estates, Facilities and Sustainability	• Review of Estates, Facilities and Sustainability risks at each meeting	• Not applicable
Health and Safety	• Review of Health and Safety risks at each meeting	• Not applicable

	Risk Register	Board Assurance Framework
Trust Management Team	• Review of risks scoring 15 or higher at each meeting • Review of the Trust Risk Pyramid	
Assurance Committee	• Every meeting – key quality risks issues/assurance/themes included in combined Chief Nurse/ COO Report and cross-referenced with Board Assurance Framework (includes Trust Risk Pyramid)	
Audit & Risk Committee	• 6 monthly Risk Report • Annual Governance Statement*	• Annual - BAF Effectiveness Review Report by Internal Audit
Executive Directors	• Not applicable – presented to Trust Management Team	• Monthly – all BAF entries reviewed with individual Executive Leads and collectively in Directors Meeting
Trust Board	• Every meeting – Chief Executive Report: BAF and Risk Register Summary – Public	• Every meeting – Chief Executive Report includes BAF and Risk Register Summary – Public Meeting • Quarterly – Full Board Assurance Report – Confidential Meeting

***Annual Governance Statement**

As Accounting Officer, the Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and NHS assets. The Chief Executive is required to give assurance about the stewardship of Solent NHS Trust in the Annual Governance Statement which is included in the Trust's Annual Report and Accounts. The statement draws together position statements and evidence on both corporate and quality governance, risk management and control.

10. Training

All staff must complete risk management training appropriate to their role; all training, except bespoke training, will be booked and monitored via the Trust Learning Management System via the Electronic Staff Record (ESR). Training is mandatory for staff as follows:

- All new staff will complete the e-learning *"Introduction to Risk Management"* training within one month of commencing employment with the Trust
- Existing staff will undertake the *"Introduction to Risk Management*" e-learning when this Framework is launched and every three years thereafter
- Managers responsible for assessing and managing risks can complete face-to-face Risk Register training on request.
- Additional bespoke training will be provided to Board members (e.g. Non-Executive Directors on appointment) and the Senior Leadership Team as required through Leadership and Board Development Programmes

Monitoring of training will be undertaken on a quarterly basis, and reported through the Workforce Report and the Quality Improvement and Risk Group.

11. Resources

The following documents and training materials are available to support staff with the implementation of this Framework:

- Risk Management Process – Step by Step Guide
- Online Risk Register – How To Guide
- Introduction to Risk Management training – booked via the Trust Learning Management System via the Electronic Staff Record (ESR).

Details are available on the Risk Management page of the staff intranet and from the Quality & Governance Team.

12. Communication and implementation

This Framework will be published on the Trust website and staff intranet and communicated to staff through risk management training programmes and staff and managers newsletters/bulletins.

Clinical service line and corporate service leads will be responsible for implementing across their areas and providing assurance of implementation to Quality Improvement & Risk Group.

13. Monitoring implementation

Assurance of implementation will be provided by clinical and corporate services and the Quality & Governance Team to the Quality Improvement Group and onwards to Assurance Committee.

The Trust's internal audit programme will include an audit of this Risk Management Framework and its implementation at corporate and clinical service level.

14. Review

This Framework will be reviewed every 3 years.

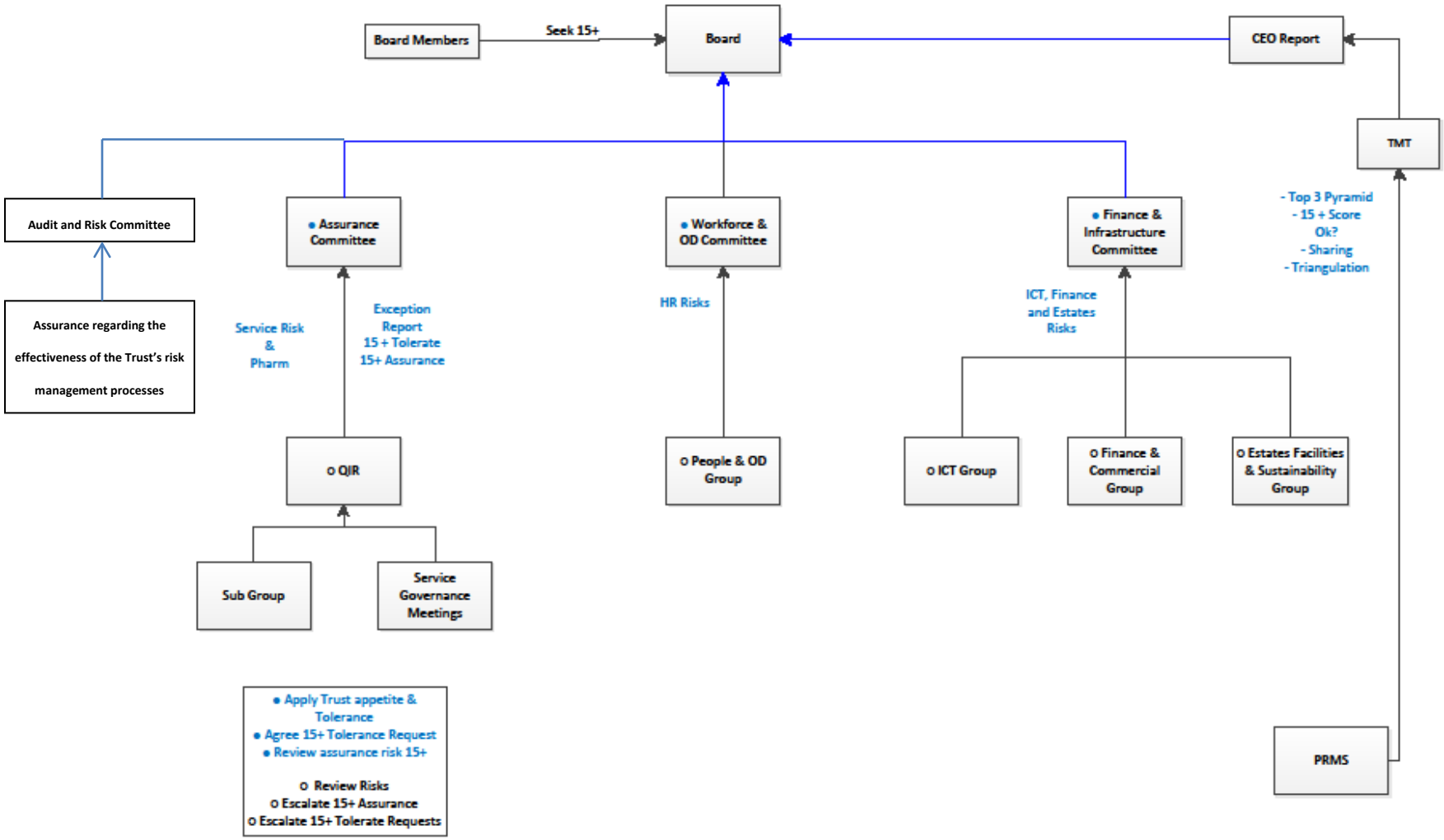
Version Control

Date	Version	Detail	Author/Contributors
27-11-2017	DRAFT v1	New Risk Management Framework to replace Risk Management Strategy & Policy (RK02) June 2015	Julie Jones, Project Manager
06-12-2017	DRAFT v2	Comments incorporated from Rachel Cheal, Company Secretary	Julie Jones, Project Manager
08-01-2018	DRAFT v3	Updated following development of draft Risk Management Process	Julie Jones, Project Manager
15-01-2018	DRAFT v4	Addition of Risk Appetite Statement & Governance Structure	Julie Jones, Project Manager
25-01-2018	FINAL v5	Revisions following feedback from members of the Trust Management Team, Quality Improvement & Risk Group, Quality & Governance Team, Chair of Audit & Corporate Risk Committee and Chair of Assurance Committee	Julie Jones, Project Manager
05-03-2018	FINAL V5.1	Amendments following feedback from Risk Process Workshop held on 28 January 2018	Julie Jones, Project Manager
17-05-2018	FINAL v5.2	Governance Structure chart updated to include People & OD Committee	Julie Jones, Project Manager
19-06-2018	FINAL v5.4	Training requirements updated in agreement with Ceri Connor, Associate Director of People	Julie Jones, Project Manager
07-01-2020	DRAFT V0.6.0	Updated risk appetite, roles and responsibilities, governance, meeting schedules and training. Updated governance diagram.	Ben Heaton, Head of Risk & Litigation

Approvals

Date Approved	Version	Meeting
5 February 2018	FINAL v5	Quality Improvement & Risk Group
8 February 2018	FINAL v5	Audit & Corporate Risk Committee
21 February 2018	FINAL v5	Trust Management Team
26 March 2018	FINAL v5.1	Trust Board

Appendix 1: Trust Risk Management Governance Structure



Item 10

Exception and recommendation report

Committee /Subgroup name	Workforce and OD (WOD) Exception Report	**Date of meeting**	30th January 2020
Chair	Mike Watts, Non-Executive Director	**Report to**	Board

Key issues to be escalated

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

The Committee received a Talent and Succession Planning paper and reviewed our management and leadership capability and effectiveness of our processes. It was noted that there are inconsistent processes below the senior leadership team which are creating some risks to workforce sustainability but also that there are areas of very good practice across the Trust, with clear examples of the difference made. The investment and changes in People Services has created a central coordination point for talent and succession planning and a clear set of recommendations will now be followed through and reported back to the Committee for assurance. The need for system partnership around talent management was noted and it was agreed that the Talent & Leadership Strategy would benefit from a review alongside the development of the new People & OD strategy and full National People Plan. A discussion took place on the success of our People & OD strategy to date, which has been rooted in a dialogic approach and the importance of holding a balance between structure and emergent change, participation and involvement.

A full review of Diversity & Inclusion (including WRES, WDES and organisational objectives) took place, which the Committee noted was the outcome of our new planned strategy and a much improved position. The risk around data quality and process was raised and asked for assurance that effective measurement is in place in order to drive improvement, e.g. the WRES finding on discrimination and disciplinary action. A discussion took place on our ambitions for community engagement, diversity and inclusion, which therefore went beyond the WRES target in order to ensure that our people practices and workforce were reflective of the ethnicity of our local populations. Privilege and intersectionality were also discussed and the need for awareness and knowledge building to help shape a compassionate and inclusive culture.

The updates to the Board Assurance Framework (BAF) were discussed. Due to significant shortages in key professional groups such as Mental Health nurses and doctors, Podiatrists, CAMHS practitioners, and GPs, it was noted that workforce sustainability could worsen (especially due to the education time needed for some of these roles). At present, Solent is holding the risk stable with mitigations. The Committee asked for our great place to work to be reinforced more strongly as risk mitigation. The Committee asked for assurance on whether all actions that could be taken were being taken to reduce our risk around workforce sustainability. Under-funding of Community services was highlighted as a barrier to action and a number of examples of possible workforce acquisition, development and deployment strategies were given. The development of the next People & OD strategy was also discussed (coming to Board workshop) and will include crowdsourcing participation to change ways of working that can save time and resource.

Michael West presented at the Portsmouth & South East Hampshire 2020 system leadership programme this week, which is being facilitated from Solent and is dedicated to improving the experience of people accessing mental health services. Michael also held a strategic roundtable discussion with our senior leadership team on compassionate and inclusive leadership. It was a powerful and though-provoking session and we were delighted that our leadership, culture and Annual Staff Survey results were recognised: 'a compassionate culture with a focus on improving lives.' We also discussed the issue of 'chronic excessive workload' within the NHS and the impact on health and wellbeing, which is captured within the BAF and being addressed through our new Health & Wellbeing Practitioner team.

The proposed Committee objectives were discussed and changes were suggested, which will be brought back to the next meeting.

The following standing items were discussed:

- Risk appraisal
- Escalations from People & OD Group
- STP/ICS Workforce & OD Programme Update
- Workforce Performance & Sustainability Report

Key matters arising:

- Triangulate workforce risks with those reported at other Committees and make recommendations which can be escalated to Committee Chairs as appropriate
- Recognise significant work undertaken within Solent to support the Hampshire & Isle of Wight Collaborative Bank
- People & OD Group feedback on financial sustainability, business and financial planning processes and impacts on workforce to be escalated to Finance Committee
- Progress against plan for the Workforce Optimisation Programme (and associated CIP) has paused due to the loss of the Programme Director. All steps are being taken to source a new Programme Director and improvement actions from the programme are being implemented with existing resources where possible

Decisions made at the meeting

Non-material amendments to the Terms of Reference have been made (see Appendix 1).

A decision was made to conduct a deep dive into Diversity & Inclusion employee data and processes in order to receive recommendations on data quality issues and process improvements. The documents presented were approved, subject to recommended changes below.

The proposed scores for internal and external risks for workforce sustainability on the BAF were agreed.

The planned agenda cycle for WOD was agreed, noting the effectiveness review to take place after 12 months.

As a matter of Any Other Business, the Committee agreed that the Chief People Officer could review, refresh and extend the People strategies as required. The new People & OD strategy will come back to this Committee for full scrutiny. In addition, an Action Plan for Tackling Bullying has been compiled from the updates previously given to the Committee on Improving People Practices, Employee Engagement and Diversity & Inclusion.

Recommendations

The new Workforce Performance & Sustainability Report was reviewed by the Committee and is recommended for inclusion in future Board papers (see Appendix 2). The draft has some final improvements to be incorporated and all suggestions are welcomed by the Board.

It is recommended that the Equality, Diversity & Inclusion objectives (under the Public Sector Equality Duty) and underpinning action plans incorporate additional focus on learning and development and workforce ethnicity of our local populations. These objectives will be brought to Board with the Annual Report in June.

The Committee recommend that a discussion take place on underfunding and the impact on workforce sustainability risk in the context of our total risk appetite as a Board.

Other risks to highlight (not previously mentioned)

Appendix 1

Solent NHS Trust Workforce and Organisational Development Committee

TERMS OF REFERENCE

1 Constitution

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

2 Purpose

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

3 Duties

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

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

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

- Workforce & OD risks recorded on the Board Assurance Framework
- The development and delivery of a people and organisational development strategy that supports the Trust plans and ensures an appropriate culture is in place.
- The creation and delivery of workforce plans aligned to Trust strategies and financial envelope to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users. We have the right people, in the right job, with the right skills, at the right place, in the right time and for the right cost (the 6Rs).
- The effectiveness of the Trust Communication strategy and workplans.
- The Trust's workforce performance and sustainability indicators, including but not limited to, ~~including~~ sickness absence, training, appraisal, employee relations, people practices and bank and agency usage and expenditure and monitor any necessary corrective plans and actions.
- Effectiveness of recruitment and retention processes to ensure that the Trust has the people to deliver its strategy.
- Meeting legal and regulatory requirements in relation to the workforce, ~~(~~to include Diversity & Inclusion~~)~~ such as WRES, WDES and Gender Pay Gap.
- Effectiveness of arrangements to understand and improve health and wellbeing.

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

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

4 Membership

4.1 The membership of the committee shall comprise the following:

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

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

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

5 Chair

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

6 Secretary

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

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

7 Quorum

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

8 Frequency

8.1 The Committee will meet bi monthly.

9 Notice of meetings

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

10 Minutes of meetings

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

11 Authority

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

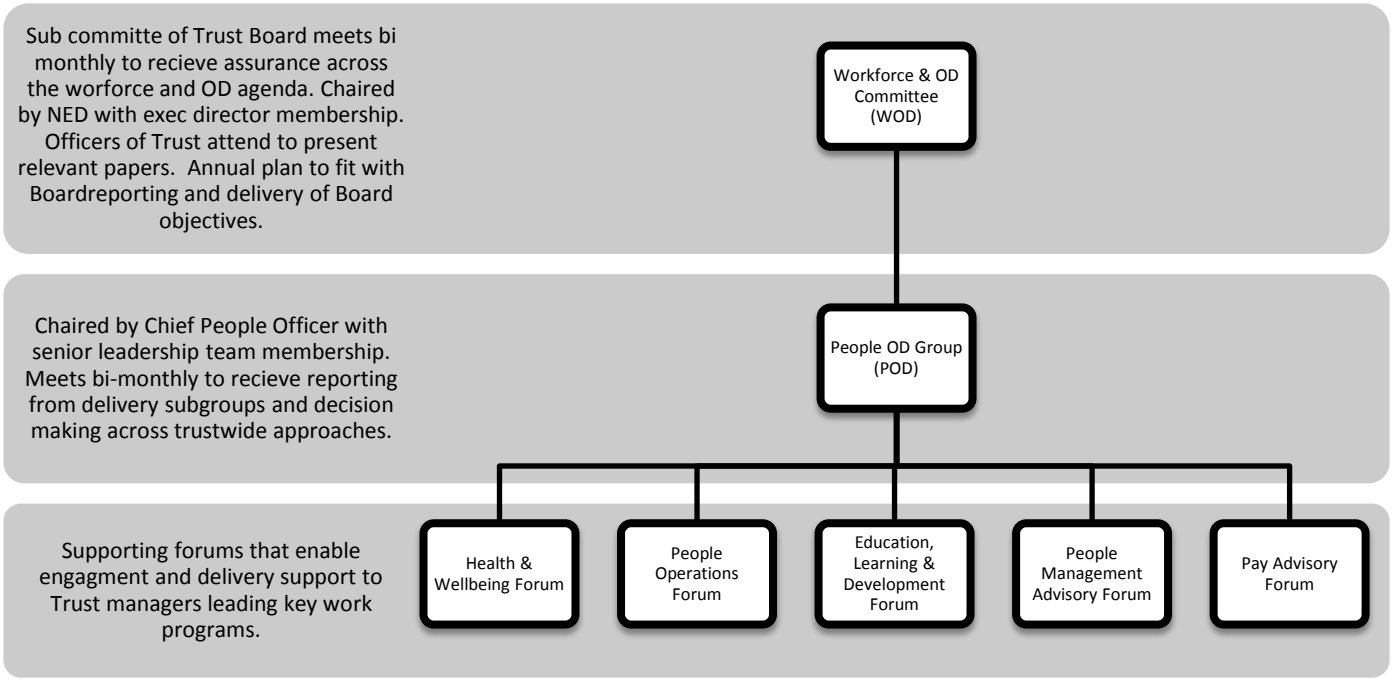
- To seek any information it requires from any employee of the Trust in order to perform its duties
- To call any employee to attend a meeting as and when required
- Seek external expertise where required

12 Reporting

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

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

Appendix 1 – Committee Structure



Version	1.1
Agreed at	WOD
Agreed at [insert name of the parent group/committee]	Date: 30.01.20
Date of Next Review	Date: Nov 20

Appendix 2

Board and Committee Cover Sheet

Item No.	10

Presentation to	***Workforce and Organisational Development Committee***		
Title of Paper	**Workforce Performance and Sustainability Report**		
Purpose of the Paper	Includes the M9 workforce data dashboards: • Workforce Dashboard • Scorecard • Agency spend tracker		
Author(s)	Ceri Connor/Kim Milne	Executive Sponsor	Helen Ives
Date of Paper	1 January 2020	Committees/Groups previously presented	NA
Summary of key issues/messages	*Data sets provide a summary of workforce metrics at the end of M9. Key metrics to note:* • *Staff in post – 2999.3 FTE an increase of 24 FTE since October (M6)* • *Sickness- 5% against a target of 4%* • *Turnover – 14.7% against a target of 14%* • *Vacancy rate – 2.6%* • *Agency costs - £336,487 M9, equal to M9 in 2018/19 financial year* • *Statutory and Mandatory Training – 85.6% against a target of 90%* *Plan is in place to increase Statutory and Mandatory training compliance to target via targeted service line action plans, communications, bespoke training delivery. Procurement for new Learning Management System is underway.* • *Appraisal compliance – 71%* *Plan is being implemented to align appraisal dates to Performance Appraisal section of ESR by end of March. ESR has been changed nationally to ensure appraisal date is linked to payroll, in 2020/21, as per requirements of NHS Pay deal. During February communications will be sent to advise those who have been unable to log appraisal date due to technical difficulties to send their appraisal information to a central email address for manual input.*		

Action Required	For decision?	N	For assurance?	Yes
Recommendation	*The committee is asked to review and note action being taken specifically in relation to Statutory and Mandatory training and Appraisal.*			

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	✓	Limited		None	

Assurance Level	Concerning the overall level of assurance the Workforce Committee is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)
Executive Sponsor Signature	Helen Ives

5.1 Workforce Performance & Sustainability Report

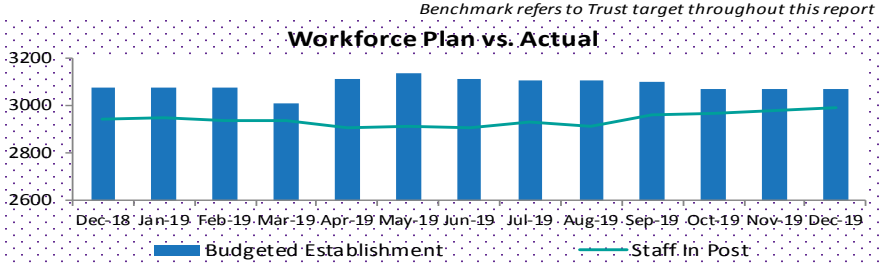
Month: Dec-19

Workforce Planning

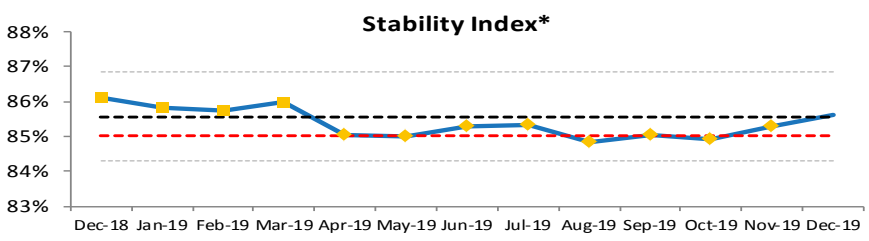
Key: Data | Benchmark | Mean | Upper / Lower Control Limit | 6 Points Above/Below Mean | Rising/ Falling Trend (6 points)

Benchmark refers to Trust target throughout this report

Actual vs. Planned

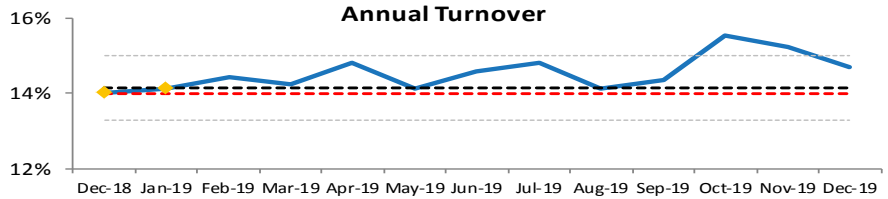


Stability Index

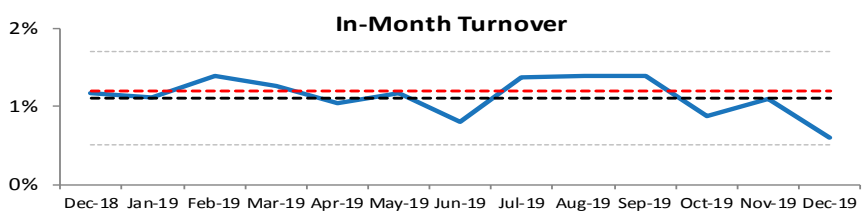


**no of staff in the group at both start and end of period divided by the no. of staff present at start of period*

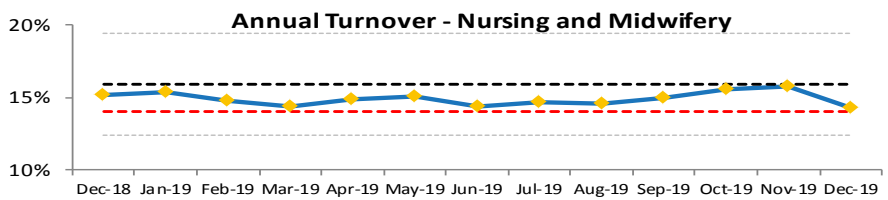
Turnover



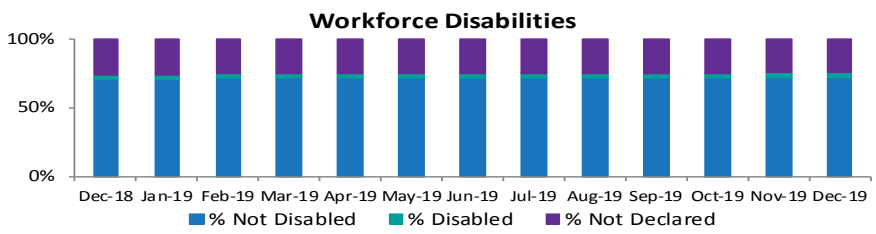
Turnover



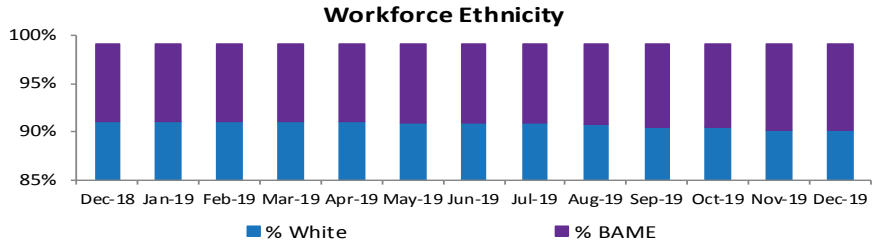
Turnover



WDES



WRES



Overall, we are close to the workforce plan and the stability index is improving. Full time equivalent (FTE) in post for December (M9) was 2,993.2 which is an increase of 83.1 FTE over the year.

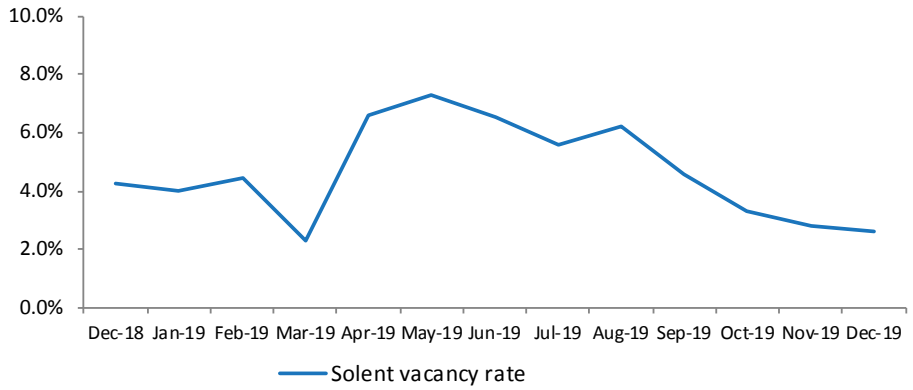
Stability been below the mean for most of the year, which indicates that retention of experienced workforce has fallen; we have seen 53 retirements YTD. Adults Southampton has been particularly impacted by this, with 11 retirements YTD. Although annual staff turnover had been rising but it is now returning toward the mean (14.7%, down from 15.2% in November). Nursing turnover has also decreased to 14.3%, down from 15.8% in November. Work-life balance is the largest reason given for leaving. WRES and WDES needs increased focus as outlined in the action plans shared at Board with the new diversity & inclusion objectives.

Workforce Acquisition

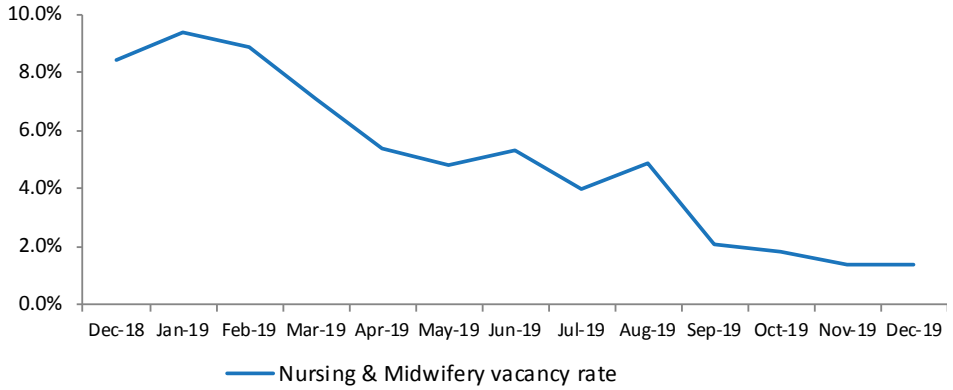
Month: Dec-19

Vacancy Rate

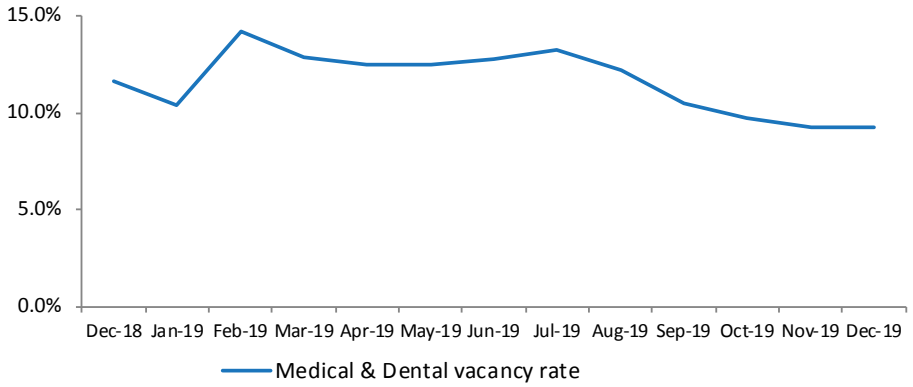
All Staff



Nursing & Midwifery



Medical and Dental

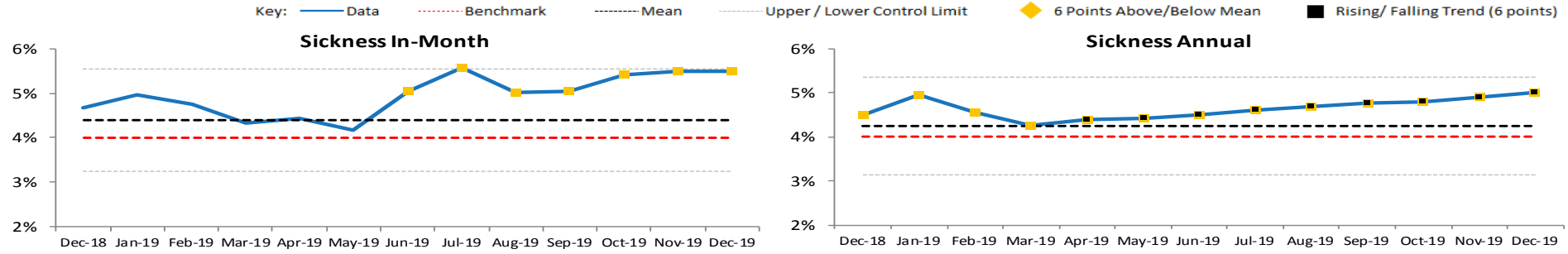


The vacancy rate for December was 2.6%, showing continued improvement since the Summer. This is due to a combination of effective recruitment campaigns and the planned reduction in workforce through the year. Our nursing vacancy rate is currently 1.4%, a significant reduction over the course of the year.
There are pockets across the Trust with higher vacancy rates and work continues on hard to fill posts and critical roles.

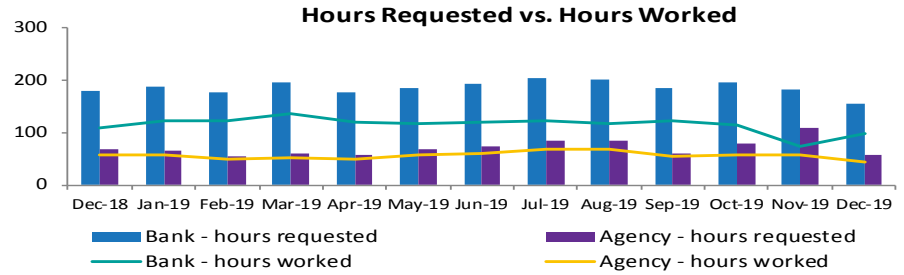
Workforce Deployment

Month: Dec-19

Sickness

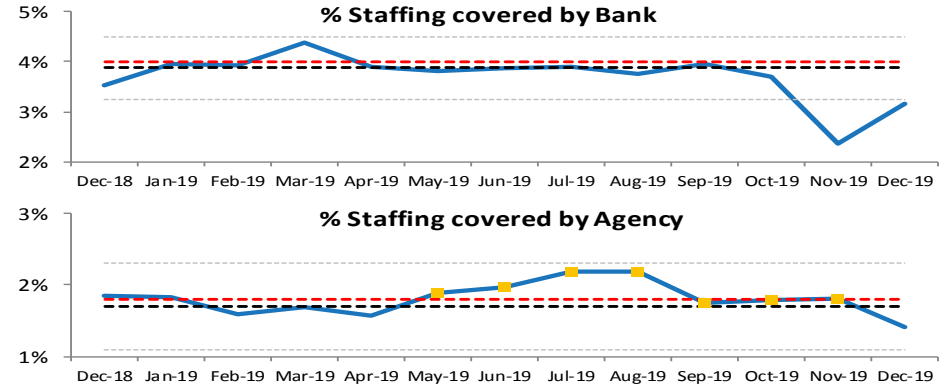


Bank & Agency



In Month Cost: Bank - £449,013 Agency - £336,487

These are actual costs are taken from the ledger and are not in-month.



Rostering

Current Position: 1

Additional rostering metric (completed on time) to be added

Sickness absence has been a rising trend. Detailed analysis showed a number of hotspots, which are being provided with additional support. Mental health related absence is a specific area that we concentrating on with our Wellbeing Practitioner team.

Agency usage has been impacted by sickness levels, although it has been steadily decreasing over the last three months. Agency staffing in month is 1.8% of the workforce but spend is exceeding the Agency ceiling. There were significant improvements over the Christmas period. Solent Bank continues to perform well and the HIOW Collaborative Bank continues its implementation. Benefits will not be seen from this project until later in 2020. The total additional staffing is 5.4%

The Roster Improvement Programme continues but only 36.8% of rosters were fully approved in December 2019.

We have a current position of 1 out of 4 against the national attainments. Work is now progressing on implementation of e-job planning. This will help us achieve a level 2.

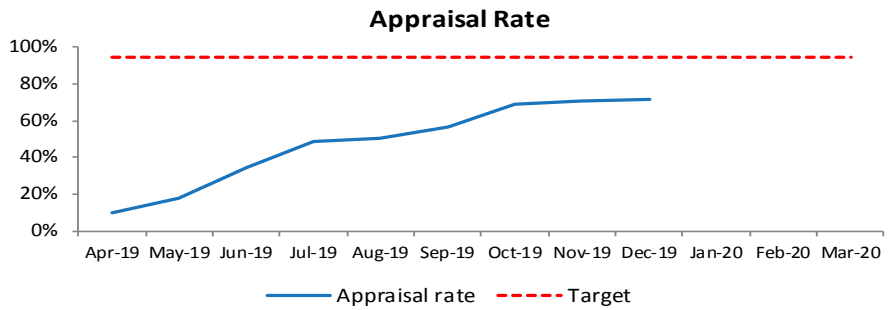
Flu vaccinations are 74% to date, against an 80% target

Additional Staffing (%)	E	6%	5.4%

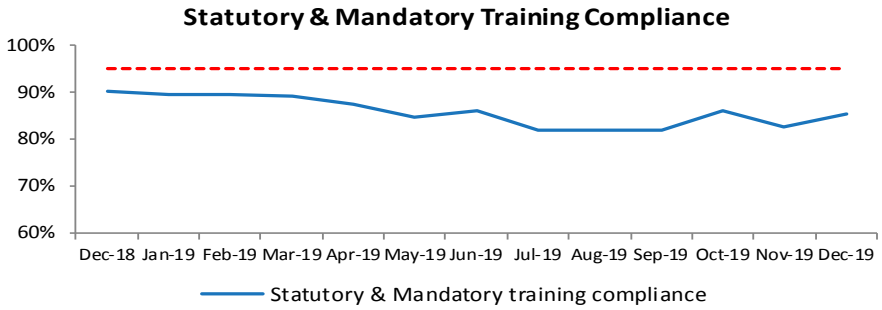
Workforce Development

Month: Dec-19

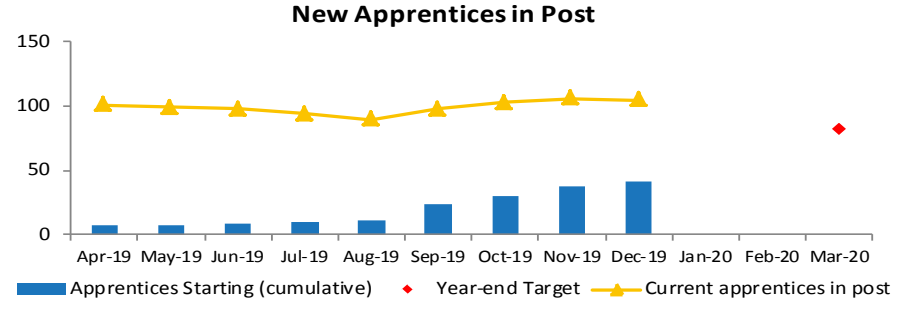
Appraisals



Stat & Mand Training



Apprentices



Engagement

Friends and Family Test

Percentage of Staff who would recommend Solent as an Employer

63%

Dec - 19

Staff Survey

Percentage of Staff who responded to the Staff Survey

63%

2018/19

The statutory and mandatory training rate in December was 85.4% against a target of 90%. A turnaround plan to achieve the 90% target is in place but there continues to be poor performance from the e-learning system. Additional support to increase compliance for IG training has been put in place. The Learning & Development team are supporting the input of paper-based records (necessitated by a system error). Appraisal compliance has been uploaded to ESR via a bulk upload, which will improve the compliance rate.

From April 2020, all staff working within the Agenda for Change NHS pay framework will be required to provide evidence of completion of their appraisal objectives to ensure they move to their next pay step point. Work to implement Manager Self Service in April 2020 will support this, ensuring staff can record appraisals effectively.

A new LMS procurement exercise has started and implementation will commence in early 2020. This will be a significant boost for staff morale, and will significantly strengthen our learning and development infrastructure.

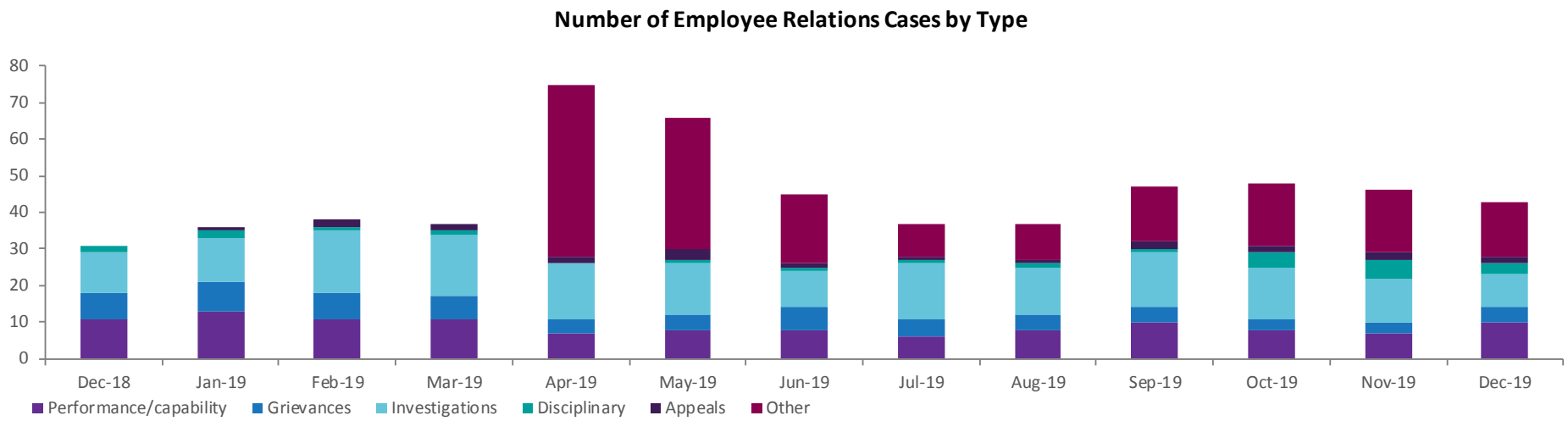
An Apprenticeship Academy model is due to launch in 2020 and we aim to increase the number of apprentices to 5% above target; we will be seeking to utilise apprenticeships for both new starts and as a path for career development.

Staff survey results, with national benchmarking, will be made available to us on 31st January, with full publication on 18th February 2020.

People Practices

Month: Dec-19

Employee Relations



Across the year we have seen a decrease in the overall cases form April to Dec 2019 (123 to 59). Whilst the numbers are decreasing we are still managing a number of complex cases and have 14 cases organisational change/ TUPE projects.

During December, we established the People Management Action Forum. This affords us the opportunity for plurality in decision making and exploration of a wide range of options for managing the issue whilst maintaining a person centred approach. This forum will also deal with issues relating to suspensions and terminations from the workplace.

In the context of policy reviews, we are looking to 'declutter' the policy landscape in order to be more progressive. We are moving to a 'Resolution Policy' along with procuring suppliers for external investigation and mediation. This approach will assist in resolving issues at the earliest opportunity and an attempt to reduce the number of cases requiring formal management. This is aligned to the work we are undertaking to establish a Just Culture, through our leadership development and manager skills programme. This programme will ensure that those involved in ER cases are appropriately equipped with the right skills to undertake the task.

The complex cases we manage are overseen by case managers assigned independently and where necessary, as is often the case, involve legal support. Lessons learnt from these cases are compiled and we will take action to reflect them in practice moving forward, where appropriate.

People & OD

Month: Dec-19

Learning

The Leadership and Development Strategy was agreed in December 2019. Resources within the team have been refocused to deliver on Leadership and development, working on the core leadership offer, embedding a culture of growth and development and ensuring this dovetails with the Just Culture we are embracing for people practices.
The inaugural Learning Innovation 'Unconference' will take place 16th March followed by the Annual Apprenticeship Awards. The event will be focused on sharing career development opportunities and will also be the launch of our new Learning & Development Strategy. We are delighted to welcome Charles Jennings as the keynote speaker.

Engagement

Once the staff survey results have been made available at the end of January we will be able to benchmark against previous surveys and culture programmes to evaluate their impact and identify any further issues to be addressed. The final response rate was 63%, which is an excellent achievement.
Having commissioned NHS Shared Business Services (SBS) to deliver our exit interview process, we have received our first quarter's data. Any immediate concerns from exit interviews will be reported into the People and OD Senior leadership team for direct action or consideration. In this first report we are seeing lack of personal development and career opportunities highlighted, the changes in POD to refocus resource on leadership and development will help to address these concerns

Leadership

The research we commissioned on the 'State of the Nation' review which is an independent look at our values, leadership and culture and will be reported to the next Workforce & OD Committee. Our Leading with Heart programme was recently recognised by the British Psychological Society when the two psychologists responsible for designing it were given the Award for Excellence in Professional Practice by the Division of Occupational Psychology. We are now taking our next step to offer our middle management community a Leading with Heart intervention.
We are pleased to welcome Michael West to our Trust Management Team on the 29th January to support us in our continued leadership development.

Inclusion

We welcomed the national WRES team to our Board workshop to discuss our WRES report and a new action plan has been presented. We also launch Black History month next month. All of our staff networks have continued to grow and develop.

Wellbeing

Our team of new Wellbeing Practitioners continue to develop and deliver a suite of interventions targeted at mental and physical health for our people. Our OWLES group focused on optimising wellbeing and lived experience will be bringing a range of recommendations forward in the next few months to further develop our health and wellbeing offer.

There will now be a separate report for Communications and PR activity.

Item 14

Board and Committee Cover Sheet

Item No.	14

Presentation to	Board			
Title of Paper	Charitable Funds Exception Report			
Purpose of the Paper	To summarise the business transacted at the last Charitable Funds Committee at their meeting 23rd January 2020			
Author(s)	Mick Tutt	Executive Sponsor	Sue Harriman, CEO Catherine Mason, Chair	
Date of Paper	24/01/2020	Committees/Groups previously presented	---------	
Action Required	For decision?	Y	For assurance?	N
Recommendation	The Board is asked to: • *Note the report from the Committee*			

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

Summary of business transacted:

We:-

- welcomed Gaurav Kumar; who would be assuming the role of chair and, in welcoming him, the outgoing chair remarked that Gaurav's background would, undoubtedly, assist the committee in the furtherance of its Purpose
- received the quarterly financial report – which demonstrated a modest 'spend' on activities which were intended, overwhelmingly, to enhance the experience of people accessing Solent services. This represented a first sign of the committee's renewed emphasis on *'the altered, and more inclusive, approach to accepting and approving bids'*; as reported in the last exception report
- received an up-dated briefing on potential Estate-focussed schemes, which could improve the environmental quality of experience for people
- received an up-dated communications plan, which would underpin the dissemination of the Purpose and activities of the committee

Decisions made at the meeting

We endorsed:-

- a Standard Operating Procedure; regarding the use of the fund for staff well-being

Item

Board and Committee Cover Sheet

Item No.	15.1

Presentation to	Trust Board			
Title of Paper	Complaints Scrutiny Panel			
Purpose of the Paper	To summarise the business transacted at the Complaints Scrutiny Panel on 3 December 2019			
Author(s)	Sarah Balchin, AD Community Engagement and Experience	Executive Sponsor	Jackie Ardley, Chief Nurse	
Date of Paper	24 January 2020	Committees/Groups previously presented	NA	
Action Required	For decision?	N	For assurance?	Y
Recommendation	The Board is asked to: To note the summary of the meeting and key messages			

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

Summary of business transacted:

The panel:

1. Welcomed the introduction of Mr R West, community partner and chair of PPG
2. Received presentations and reflections on 3 case studies of complaints: considered the learning from each, and critically evaluated the way in which each complaint was received, responded to and changes made.
3. Acknowledged that complex complaints were often difficult to resolve with families, and teams need support and development to address these concerns.
4. Agreed to focus on "difficult to resolve" complaints (those which required further investigation or were escalated to PHSO) at the next panel.
5. Received and reviewed PALS contacts and complaints activity for Q2: highlighting the workshop provided to increase awareness of changes in policy, acknowledging the low conversion of contacts to complaints, and recognising the need for plaudits to be formally recorded.
6. Discussed the proposed amendments to the terms of reference: agreeing a need to move to "Learning from Experience", to better reflect the Trust commitment to using experience feedback in the broadest sense as a tool to drive improvement.

Key additional messages:

1. Importance of co-ordinating learning from complaints across service lines and speciality groups and committees
2. The development of e-systems of communication should help information provision but needs to be Information Governance standards appropriate
3. The language we use about complaints and the people who have cause to raise a concern can be pejorative, have negative connotations needs to amended under advice of patients, families and carers.

Item 16.1

Board and Committee Cover Sheet

Item No.	16.1

Presentation to	Board			
Title of Paper	Assurance Committee Exception Report			
Purpose of the Paper	To summarise the business transacted at the last Assurance Committee at their meeting 23rd January 2020			
Author(s)	Mick Tutt	Executive Sponsor	Sue Harriman, CEO Catherine Mason, Chair	
Date of Paper	24/01/2020	Committees/Groups previously presented	-----	
Action Required	For decision?	Y	For assurance?	N
Recommendation	The Board is asked to: • Note the report from the Committee • Note the Safe Staffing – six monthly report			

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

Summary of business transacted:

We received:-

- Briefings, regarding **2 recent incidents raising important concerns regarding safety, in Portsmouth**:-
  - action taken by the landlords which severely restricted access on **the St James' site**
  - concerns regarding egress from **St Marys**, during an Alert

We received assurances, in both instances, of the mitigations now in place to reduce the likelihood of re-occurrence – but it may well be that Executive colleagues will have further detail and assurance to provide the Board at the meeting.

- The regular (6-monthly) **Safe Staffing report** – which is appended to this exception report, and took assurance regarding on-going action to ensure that (non-withstanding challenges arising from risks around recruitment and retention) people accessing services experienced interaction with sufficient, suitably qualified and experienced practitioners. We were also briefed regarding the intended participation, by the Associate Director (for Nursing), in National activity regarding benchmarking of safe staffing levels.

- A verbal up-date regarding the on-going risks posed to people who access our services, when attempting to secure appropriate services from **the 3rd party wheelchair provider**. This included current procurement activity, by the relevant Clinical Commissioning Groups; designed in part to address historic concerns raised, and a demonstration that our internal processes were now having a positive impact where concerns were raised.

  Whilst the Chief Nurse was able to provide assurance that the position was less-challenging than previously explored, she undertook to provide further, written, assurance or the next meeting of the committee.

We also received a revised version of the usual **exception report from the Quality Improvement & Risk group and our Chief Operating Officers**. 3 matters were of particular concern:-

- The residential **services based at the Orchards appear to be experiencing a period of increased challenge**; from people admitted who appear to be exhibiting

more florid acuity, and concurrent (and, perhaps, consequential) impact on management's attempts to staff the facility appropriately and proportionately.

These challenges would be familiar to any other significant provider of mental health services and we received assurances regarding action being taken which would be recognised by any of those other providers.

It is, generally, also recognised by other significant providers that any additional indication of support and encouragement – particularly from Board-colleagues; to both managers and front-line practitioners is perceived as valued at such times

It may well be that Executive colleagues will have further detail and assurance to provide the Board at the meeting.

- The concerns expressed at the previous meeting, regarding the **adequacy of parking at and adjacent to St Marys**, Portsmouth, remained a concern.

- A **shortage of Emerade** had been escalated as a Risk. Mitigating action was outlined – but the committee noted that monitoring of this risk should continue, at the next meeting.

Decisions made at the meeting

- Approved – and, indeed, commended the **End of Life strategy**; presented after some 2 years dedicated activity designed to engage with individuals and groups who had been, or could be, impacted by the consequences of this natural event
  we noted that the strategy, in itself, was not a 'stand-alone' document and we were briefed on the work now taking place to operationalise and implement its principles,
  fellow Board members should request copies of the strategy if they have not already seen it.

- Considered the implications of the **Committee Appraisal of its Effectiveness**, co-ordinated by the Assistant Company Secretary
  given the forthcoming change of chair we agreed that a period of time should elapse; to enable the new chair to fully assimilate the implications of the Appraisal and then take the necessary action.

Board and Committee Cover Sheet

Item No.	Item 16.2

Presentation to	Assurance Committee		
Title of Paper	Safe Staffing, 6 Monthly report		
Purpose of the Paper	To provide assurance that nurse staffing levels within wards/units are appropriate to meet the needs of patients and service users in line with national guidance		
Author(s)	Angela Anderson, Associate Director Professional Standards	Executive Sponsor	Jackie Ardley, Chief Nurse
Date of Paper	January 2020	Committees/Groups previously presented	Quality Improvement & Risk (QIR)
Summary of key issues/messages	• All inpatient areas have had staffing levels above plan of this reporting period • The Trust continues to work within National Quality Board Guidance through the monthly safe staffing meetings and the reporting processes • Additional data quality checks are required to ensure the Care Hours per Patient Day (CHPPD) are accurate and are clearly understood • Although the position relating to turnover has stabilised there remains a need to focus on recruitment and retention of staff • Services continue to focus on patient safety and delivery of safe, quality care when making decisions in relation to staffing levels and the use of temporary staffing • Work is continuing to identify an appropriate acuity and dependency tool for the inpatient areas • The monthly safe staffing meetings are in the process of changing to bring similar services across service lines together to enable sharing and support and challenge		
Action Required	For decision?	N	For assurance? Y
Recommendation	The committee is asked to: • Note the report • Support priorities identified		

For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient		Limited		None	
Assurance Level	Concerning the overall level of assurance the [X] is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

Safe Staffing Report, 1 June-30 November 2019

The purpose of this report is to provide the required six monthly update on the nurse staffing position within the inpatient wards/units directly provided by the Trust. The staffing position within the community teams is also reviewed within this report.

Introduction

This report aims to provide the Board with;

- Assurance that nurse staffing levels within each ward/unit are appropriate to meet the needs of patients and service users in our care and explain the approaches in place to monitor and manage staffing levels.

- The Board is asked to note the current reported position and endorse the action being taken to maintain and monitor safe staffing levels.

Background

The Trust is required, as outlined in the NQB Guidance, to report to Board on safe nurse staffing every Six months. The last report was presented in July/August 2019 covering the period December 2018 to May 2019. This report covers the time period June to November 2019.

The Trust continues to meet the requirements within the regulatory framework for publication of staffing levels. In-patient data is published via an upload to Unify each month and this now includes Care Hours Per Patient Day (CHPPD) data. In addition the monthly summary continues to be submitted to commissioners and uploaded to the Trust internet as required. Monthly safe staffing meetings continue to be held with the Chief Nurse and/or their delegated lead and in this reporting period we have provided a summary of themes from each meeting to the Chief Operating officers for discussion at the performance review meetings. Service Lines report by exception to the Quality Improvement and Risk, (QIR), group which reports in turn to the Assurance Committee and onto the Board.

Overview

Whilst Solent NHS Trust recognises that the national mandate for reporting relates to in-patient nurse staffing levels the Trust continues to include and acknowledge the contribution other disciplines make to ensure that clinical teams deliver safe, effective and high quality care in an increasingly complex environment. In line with the most recent NQB guidance in relation to CHPPD, the Trust has not identified any clinical inpatient teams where Allied Health Professionals should be included in the planned staffing levels, the criteria being that they are permanently part of the ward roster. This position is reviewed at the safe staffing meetings and will be amended should models of service delivery change in the future.

Safe Staffing Meetings:
Safe staffing meetings have continued during this reporting period and it should be noted that during this reporting period Oakdene ward closed and as they no longer admit patients their data will not be included in this report.

Following a review of safe staffing meetings and in an attempt to improve and share learning across teams some changes have been made to the meeting format. The meetings have changed from being service line focussed to bringing similar areas together. For example the in-patient areas of Maples, Hawthorns, Kite, Snowdon and Brooker meet as a group and community nursing for both Southampton and Portsmouth meet as a collective.

This new model was introduced in November 2019 and encourages effective support and challenge from peers. It also identified some variation in planned staffing levels in similar wards which will result in some focused work to understand the variance. It is intended to introduce data from the model hospital in these meetings to further understand the Trust variance both internally and with statistical neighbours.

The safe staffing discussions in this time period have identified concerns regarding some of the specialist roles and their sustainability in the longer term. Some individual clinicians have large caseloads and where treatment regimens become more sophisticated patients/ service users require more detailed and/or more frequent monitoring which impacts on the clinician's ability to continue to see patients at the required frequency. There is a significant risk that should there be a change, e.g. an individual leaves the Trust or is away from work for any period of time the patients/service users will not be receiving the expert advice, monitoring and support required. The majority of these roles are currently in Adults Southampton and the Head of Quality & Professions, with the service manager, is leading a detailed review which will report back to the Chief Nurse. The concerns have also been shared at the STP Quality Board as it is likely that this position is not unique to Solent. A safe staffing meeting bringing together all Solent specialist services across Portsmouth and Southampton is planned for early 2020.

The position in relation to reliance on temporary staffing in some service areas, particularly across mental Health services, remains a concern and discussions are underway between service and the Chief Nurse to plan an appropriate strategy to address this in order to ensure safe staffing levels continue to be monitored and to reduce reliance on bank and agency solutions.

The challenges with effective roster management remain and the themes identified through the safe staffing meetings have been:

- Concerns about low levels of annual leave allocated in the roster period which may adversely impact in the final quarter of the year
- Excessive net hours balances which need addressing
- Rosters not being approved within the timescales

To address these issues a number of services have in this reporting period recruited individuals to specifically manage/support roster management with an expectation that improvements will be realised early in 2020.

The work to identify a suitable acuity and dependency tool for inpatient wards continues with a national tool for mental health wards launched in December 2019. This may be appropriate for implementation across mental health inpatient areas, including Kite and Brooker. This tool will be reviewed in January safe staffing meetings. The Associate Director Professional Standards has been successful in securing a place on the 4th Cohort of the Chief Nursing Officer for England safe staffing programme. It is anticipated that this will provide the Trust with access to learning and innovation from across the country which will where appropriate be applied in Solent.

Whilst the trust has not adopted a formal acuity & dependency tool, the Board can be assured that Neurological wards are currently using a national tool & other services are using locally adapted tools, clinical judgement and other quality indicators such as incidents and patient experience to assess acuity & dependency. This will influence decision making in relation to agreeing the staffing levels to ensure care can be delivered safely.

The safe staffing meetings in November for in-patient areas compared CHPPD and as stated previously identified variance across the ward areas. CHPPD are calculated by adding the hours of Registered Nurses (RNs) and Health Care Support Workers (HCSWs) providing care during the 24 hours and dividing it by the numbers of patients on the ward at midnight. The CHPPD data is not

included in this report due to a need to complete data quality checks but will be included in future reports.

On reviewing the data it was noted that one area, Spinnaker ward, had a lower planned staffing level in comparison to its similar cohort of wards. It is necessary to understand this variance and a review is currently underway to understand the staffing model and recommend any changes which may be indicated. This review will report back to the Chief Nurse by end of January and a temporary increase to the HCSW numbers has been agreed. A further point of note is that during this reporting period all of the mental health wards, Maples, Hawthorns, Kite and Snowdon wee operating on CHPPD above their planned CHPPD. The safe staffing meeting discussed this and concluded that some data quality checks were needed but that it would reflect the dependency of patients across their wards with high numbers needing 2 or 3 to 1 nursing at times.

In-patient units

The Trust has continued to comply with the requirement to upload safe staffing data, via Unify, with details of the staffing position in each of the in-patient areas including uploading the reports onto the Trust internet site. To achieve this reports at ward level are reviewed monthly and they outline the actual numbers of staff on duty each shift and compare this with the planned levels awarding a RAG rating which has been nationally defined. For the unify report the information is presented as a percentage compliance against planned, the data for this reporting period is included in **appendix 1** for reference.

With the exception of June and July where some wards were under plan, the data shows that staffing levels were either on or above plan for this reporting period. Where services were below plan the gaps are filled either by moving staff flexibly across clinical areas, staff undertaking overtime shifts or use of bank or agency. The key priority is to ensure the clinical needs of patients are fully considered and decisions made on this basis. Where there is low bed occupancy or where acuity and dependency is lower than usual the clinical managers may take the decision that the below plan staffing levels are safe. This approach ensures that patients are safe and receive the appropriate care.

Significant changes took place in Jubilee House during July/August with a decision taken to reduce the number of beds provided to 14. This impacted on staffing levels and a need to adjust the planned staffing levels. This was reviewed by service and following discussion was signed off by the Chief Nurse in October 2019.

When considering safe staffing it is essential to consider other indicators in order to identify if there has been any adverse impact as a result on below planned staffing numbers. The table below summarises the incident reporting for in-patient wards in relation to key indicators which are considered when looking at safe staffing during this reporting period.

Table 1: Incident reporting

Ward	Assault - Non-Physical	Assault - Physical	Medication Errors / Management	Pressure Ulcers	Slips, Trips And Falls	Grand Total
ADP Spinnaker Ward	0	0	10	26	30	**66**
ADS Fanshawe Ward	0	1	11	11	50	**73**
ADS Lower Bramble Ward	3	1	9	14	17	**44**
ADS Snowdon Ward	1	2	9	3	27	**42**
ADS The Kite Unit	7	8	11	0	12	**38**
MHS The Limes (Brooker)	10	59	36	0	163	**268**

MHS Hawthorn	9	14	64	0	0	**87**
MHS Maples	44	60	27	0	3	**134**
ADP Jubilee House	2	0	21	5	13	**41**
Grand Total	**76**	**145**	**198**	**59**	**315**	**793**

The review of incident data shows a small increase in the numbers of incidents in comparison to the previous period where 753 incidents were reported. The most notable increase is in medication errors and slips, trips and falls compared to Assault- physical in the previous report. There has been a decrease in the reporting of these incidents but an increase in the Assault – non-physical which suggests verbal assault which in turn may link to the increased need for 2 or 3 to 1 staff to patient ratios due to patient dependency.

The highest levels of medications errors has been seen across the acute metal health wards, Maples and Hawthorns and a detailed review is scheduled for January 2020. An increase is also noted within Jubilee house and this in part will be due to improved reporting following an intensive staff development programme delivered during July-September. However this position will continue to be monitored as part of performance reviews and within safe staffing meetings.

There has been a reduction in the number of reported pressure ulcers which was expected following the introduction of the National Guidance introduced in April 2019.

***Footnote post Assurance Committee**: A detailed discussion was held regarding the increase in medicines errors and incidents of physical assault. The increase in medication incidents reported in Mental Health(MH) may be reflective of changes in how Pharmacy are logging medication incidents which are now logged to the service rather than Pharmacy. However, in the absence of full detail about when these changes took place it is not possible to fully attribute the increase to this or to staffing as all wards were above plan for the majority of this reporting period. Post meeting a further review of the data confirms the majority of incidents are near miss or no harm. The number of incidents reported in general is on an upward trend in MH but the number of moderate or above is in line with the previous year and there has been no medicines related high harm errors across the Trust year to date. A visit to the wards and discussion with the clinical managers on 24/1/2020 indicated the largest increase related to either incorrect storage (Brooker) or missed doses and prescribing errors (Maples & Hawthorns) and were identified and corrected before adversely affecting patients. The nature of the errors is consistent with busy clinical environments and actions have been put in place in all areas to address the issues. The impact will be monitored and reported in the coming months and reported in the next report to Board.*
The increase in the number of physical assaults was discussed and noted that approximately 39 assaults registered are related to assaults by one patient over a period of time. The increased assaults, seclusions are reflective of the increased acuity and demand/capacity issues which, whilst impacting on staffing, are not directly related to lower staffing numbers.

Table 2 summaries the complaints and services concerns received and the themes by in-patient ward for June – November 2019:

Ward	Number of Complaints	Number of Service Concerns	Themes
Jubilee House	1	1	The themes identified related to communication with families and CHC assessment process. The service concern related to an estates issue.
Spinnaker Ward (SMH)	1	0	The themes in this complaint related to the attitude and manner of a member of staff.
The Orchards Acute - Hawthorn	1	2	The themes identified from the complaint one of the service concerns relate to clinical treatment.

			The other service concern relates to the manner and attitude of staff.
The Orchards PICU - Maples	0	2	The themes identified relate to care received on the ward.
Fanshawe Ward (RSH)	0	2	Concerns raised regarding attitude of a member of staff towards patients and other concerns relating to general care, medications, and communication.
RSH – Lower Brambles	0	1	Concerns relating to care when discharged from ward.
Snowdon Ward (WCH)	0	1	Lack of communication regarding care when discharged from ward.
Total	**3**	**9**	

During the reporting period there were 3 formal complaints received which related to the inpatient wards. This is a further reduction from the previous two reporting periods. There has been a further increase in the number of service concerns raised from 7 in the last report to 9 in this period, continuing to show an upward trend. The complaints are equally spread across three of the wards and all wards have received service concerns with the exception of Spinnaker. The recurring theme in both complaints and service concerns continues to be staff attitude and communication.

On reviewing the unify data alongside the incidents and complaints data it is not possible to make a correlation between these and safe staffing levels. The wards as indicated have been on or above plan for staffing. Considering the themes of the complaints however it is possible that this reflects/links to the dependency levels on the wards and therefore the pressure experienced by staff during these periods.

Community Teams

The community teams across Southampton and Portsmouth continue to review the national and local information available to support safe caseload management and to identify safe staffing levels with no nationally recognised tools available at present. The safe staffing meetings from November have brought these teams together and it is anticipated this will enable more consistent approaches to be developed. The initial meeting of the teams in November identified some key learning in relation to roster management and ensuring all hours are accurately allocated prior to requesting temporary staffing.

The demand and capacity tool developed by community nursing service in Southampton continues to support the management of caseloads and is currently being reviewed and refined with a view to further roll out across all localities.

Both teams continue to experience staff turnover and challenges with recruitment which reflects the position nationally. In addition they are working consistently above capacity which creates pressures for staff. The teams triage patients to ensure visits are not missed and that all care is delivered safely and within an appropriate timescale.

Children's services continue to experience difficulties with recruiting experienced children's nurses which is in line with the national picture. Plans to replace the matron in the Portsmouth team are in place with recruitment planned for December 2019. This appointment will support the planned integration between the acute and community teams in the Portsmouth area.

Primary care services continue to be successful in recruiting to the Advance Nurse Practitioner roles and are currently exploring introduction of Consultant roles in some of their services such as MSK. They have also recruited practice nurse trainees and will continue to support this approach to attracting nurses into these difficult to recruit to areas. They are currently sharing their experiences with colleagues in Sexual Health.

Specialist Dental services have on-going challenges with recruiting registered dental nurses across their localities, particularly in the Portsmouth area. The progress and risks are monitored through the safe staffing meetings and at performance review meetings.

Sexual health services have on-going challenges attracting experienced sexual health nurses into their services due to a national shortage of nurses trained in sexual health. The service have successfully recruited band 5 nurses and provide an extensive training programme which will provide the individual with the required competencies for a band 6 role in the future. This is time intensive to deliver and retention rates will continue to be monitored to ensure it is a sustainable model for the future.

Bank and Agency Usage

Demand for Bank continues to remain static over the last 6 month period with internal bank cover remaining static at 70% of all requests. Community nursing across both Southampton and Portsmouth remains one of our key areas of usage. The national shortage of registered community nurses continues to affect the numbers we can recruit into these areas. Recruitment projects remain in place, with programmed attendance throughout the year at recruitment fairs and university open days for newly qualified students. This highlights Solent as a great place to work and encourages new recruits. Due to successful recruitment over the last 6 months for both Lower Brambles and Fanshawe wards at the RSH there has been a reduction in the number of shifts which are now escalated to bank staffing for cover, combined with an increase in available bank staff in this area agency costs have reduced significantly.

Demand continues to be high across Mental Health Services, which is attributed to high levels of RMN vacancies across all the ward areas. The addition of 3 extra beds in Maples and Hawthorn has contributed to the demand and we are currently seeing more 3:1 patient care levels required. Work is being undertaken to explore the introduction of Band 4 Mental Health practitioners, and focused recruitment remains in place.

Footnote post Assurance Committee: *The committee discussed the impact of reliance on temporary staffing on continuity of care for patients particularly in mental health settings. It was confirmed that the wards in the main have block booked agency staff so they are working in the same way as substantive staff having full induction, appraisal and supervision. This means that patients have continuity of care in the main.*

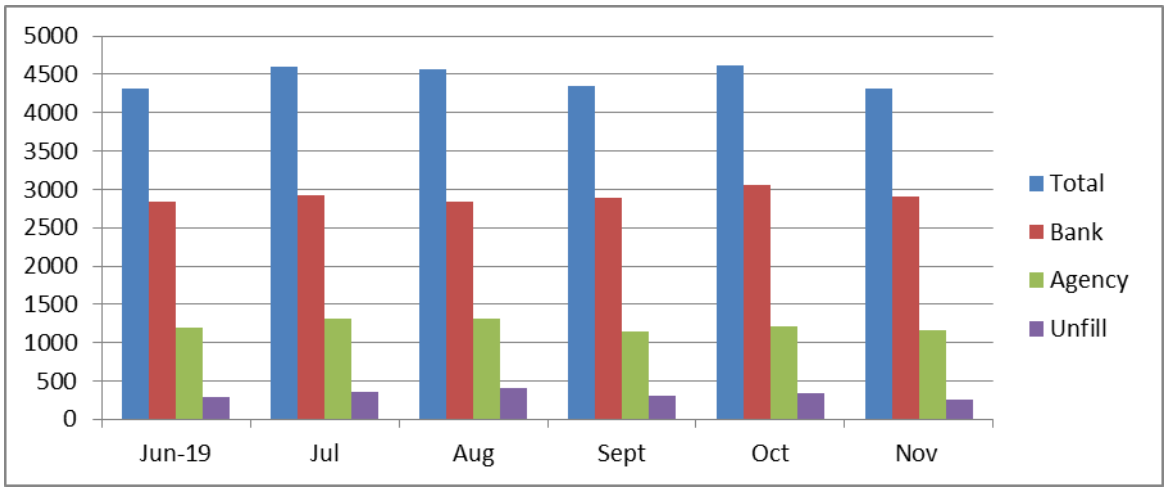
Focus has been on the scrutiny of rosters and staffing levels with a programmed Roster improvement plan currently being rolled out across all services. The aim is to help services to achieve a better understanding of their roster, to ensure all staff hours are assigned and accurate rosters produced which in turn will to a reduction in the need for temporary staffing.

Table 3 highlights level of Bank & Agency requests for clinical areas for June 2019 – November 2019.

Clinical June 19 - Nov 19	Req	Bank	%	Agency	%	Unfilled	%
MHS SERVICES	5273	2656	50%	2249	42%	348	8%
PORTSMOUTH ADULT SVS	6337	3243	51%	2570	40%	524	9%
PORTSMOUTH CHILDREN SVS	114	114	100%				
SOUTHAMPTON ADULT SVS	2433	1764	73.00%	525	21.00%	144	6%
PRIMARY CARE	31	31	100%				

SOUTHAMPTON CHILDREN SVS	133	133	100%				
DENTAL SERVICES	651	567	87%	84	13%		
SEXUAL HEALTH SERVICES	52	52	100%				
TOTALS	15024	8560	57.00%	5428	36.00%	1016	7%

Table 4 demonstrates level of Bank/Agency requests over last 6 month period.



Conclusion/Next Steps

The Board can be assured that positive progress continues to be made in strengthening the approach the Trust is taking in relation to understanding the staffing position across the organisation. Although seeing a reduction in turnover across the Trust, concern remains regarding the on-going challenges in both recruiting and retaining staff. This is a particular concern across mental health services and the continued reliance on temporary staffing to ensure safe staffing levels remains a pressure.

Based upon the data and information available it is evident that services are considering patient safety and the need to deliver safe, quality care when making decisions in relation to staffing levels and the use of temporary staffing. They remain diligent and are continuing to work with professional and workforce leads to focus on retaining staff with the necessary skills and competence to meet the increasingly complex patient needs whilst also developing new roles such as Nursing Associates, Degree Nurse Apprenticeship's, Advanced and Consultant Practitioners.

The work on agreeing the appropriate acuity and dependency tool for services will continue including learning from the national safe staffing programme. It is also hoped that the current roster improvement programme will continue to show improved performance across the organisation.

The planned changes to the safe staffing meetings will enable teams to share knowledge and to better understand variance in similar clinical areas. They will foster learning from good practice and performance.

Key Priorities for the next six months:

- To embed the new approach to safe staffing meetings
- To Introduce a Red flag/safe staffing dashboard to reflect the NQB guidance requirements and enable more sensitive analysis of safe staffing to inform workforce and business planning

Board Recommendation

The Board is asked to note this report and support the priorities identified

Appendix 1

			Jun-19				Jul-19				Aug-19			
			Day		Night		Day		Night		Day		Night	
Ward Name	Main two specialties		Fill Rate		Fill Rate		Fill Rate		Fill Rate		Fill Rate		Fill Rate	
	S1	S2	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff
AMH Orchards - Hawthorn	710 - ADULT MENTAL ILLNESS		100.8%	151.7%	110.0%	114.4%	150.4%	104.0%	106.5%	125.8%	124.1%	173.5%	122.2%	125.9%
AMH Orchards - Maples	710 - ADULT MENTAL ILLNESS		87.2%	129.2%	106.7%	116.7%	148.1%	109.4%	112.9%	146.0%	111.1%	137.5%	125.9%	132.4%
The Limes	715 - OLD AGE PSYCHIATRY		85.0%	118.3%	103.3%	105.0%	139.2%	101.6%	89.2%	111.3%	93.2%	138.6%	111.1%	125.0%
Jubilee House	315 - PALLIATIVE MEDICINE		91.0%	121.4%	90.0%	131.7%	133.5%	146.3%	72.0%	104.8%	108.9%	157.4%	120.4%	225.9%
Spinnaker	314 - REHABILITATION		90.7%	111.3%	101.7%	136.7%	122.8%	134.4%	101.6%	141.9%	114.8%	137.8%	111.1%	118.5%
Lower Brambles	314 - REHABILITATION		98.7%	98.1%	100.0%	100.0%	99.5%	100.0%	98.4%	100.0%	114.8%	110.3%	114.8%	114.8%
Fanshawe	314 - REHABILITATION		98.0%	98.3%	100.0%	98.3%	100.3%	98.3%	100.0%	96.8%	111.9%	116.0%	114.8%	111.1%
Snowdon Ward	314 - REHABILITATION		103.3%	131.3%	101.7%	98.3%	127.1%	96.7%	98.4%	106.5%	127.8%	149.6%	114.8%	124.1%
Kite	314 - REHABILITATION		107.5%	96.3%	100.0%	150.0%	89.5%	150.0%	100.0%	167.7%	114.8%	115.3%	114.8%	164.8%

			Sep-19				Oct-19				Nov-19			
			Day		Night		Day		Night		Day		Night	
Ward Name	Main two specialties		Fill Rate		Fill Rate		Fill Rate		Fill Rate		Fill Rate		Fill Rate	
	S1	S2	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff	Registered	Care Staff
AMH Orchards - Hawthorn	710 - ADULT MENTAL ILLNESS		129.8%	172.4%	132.7%	132.1%	132.7%	193.6%	125.0%	157.7%	126.0%	214.1%	119.2%	187.2%
AMH Orchards - Maples	710 - ADULT MENTAL ILLNESS		124.4%	133.7%	123.1%	130.8%	132.1%	155.8%	136.5%	166.3%	134.6%	156.3%	134.6%	164.4%
The Limes	715 - OLD AGE PSYCHIATRY		103.8%	136.5%	114.1%	120.2%	106.4%	140.7%	116.7%	121.2%	113.5%	132.1%	119.2%	114.4%
Jubilee House	315 - PALLIATIVE MEDICINE		119.2%	151.9%	119.2%	169.2%	122.3%	143.3%	121.2%	215.4%	120.8%	144.2%	121.2%	169.2%
Spinnaker	314 - REHABILITATION		122.3%	118.5%	111.5%	138.5%	113.8%	146.2%	123.1%	223.1%	111.5%	122.3%	113.5%	234.6%
Lower Brambles	314 - REHABILITATION		114.6%	110.7%	113.5%	109.6%	118.5%	116.7%	117.3%	119.2%	116.9%	113.2%	121.2%	115.4%
Fanshawe	314 - REHABILITATION		120.0%	113.5%	115.4%	113.5%	119.2%	119.9%	117.3%	119.2%	119.2%	113.5%	115.4%	111.5%
Snowdon Ward	314 - REHABILITATION		117.3%	141.5%	113.5%	115.4%	122.2%	163.7%	109.3%	118.5%	121.2%	145.4%	115.4%	140.4%
Kite	314 - REHABILITATION		124.0%	114.9%	115.4%	171.2%	127.9%	119.2%	115.4%	180.8%	113.5%	160.1%	180.8%	223.1%

Item 17.1

Board and Committee Cover Sheet

Item No.	17.1

Presentation to	Board			
Title of Paper	Governance and Nominations Committee exception report			
Purpose of the Paper	To summarise the business transacted at the last Governance and Nominations Committee at their meeting 13th December 2019			
Author(s)	Rachel Cheal, AD Corporate Affairs and Co. Sec	Executive Sponsor	Sue Harriman, CEO Catherine Mason, Chair	
Date of Paper	17th December 2019	Committees/Groups previously presented	-----	
Action Required	For decision?	Y	For assurance?	N
Recommendation	The Board is asked to: • Note the report from the Committee • Approve the Committee's Terms of Reference (Appendix 1), and • Approve the Standing Orders (Appendix 2)			

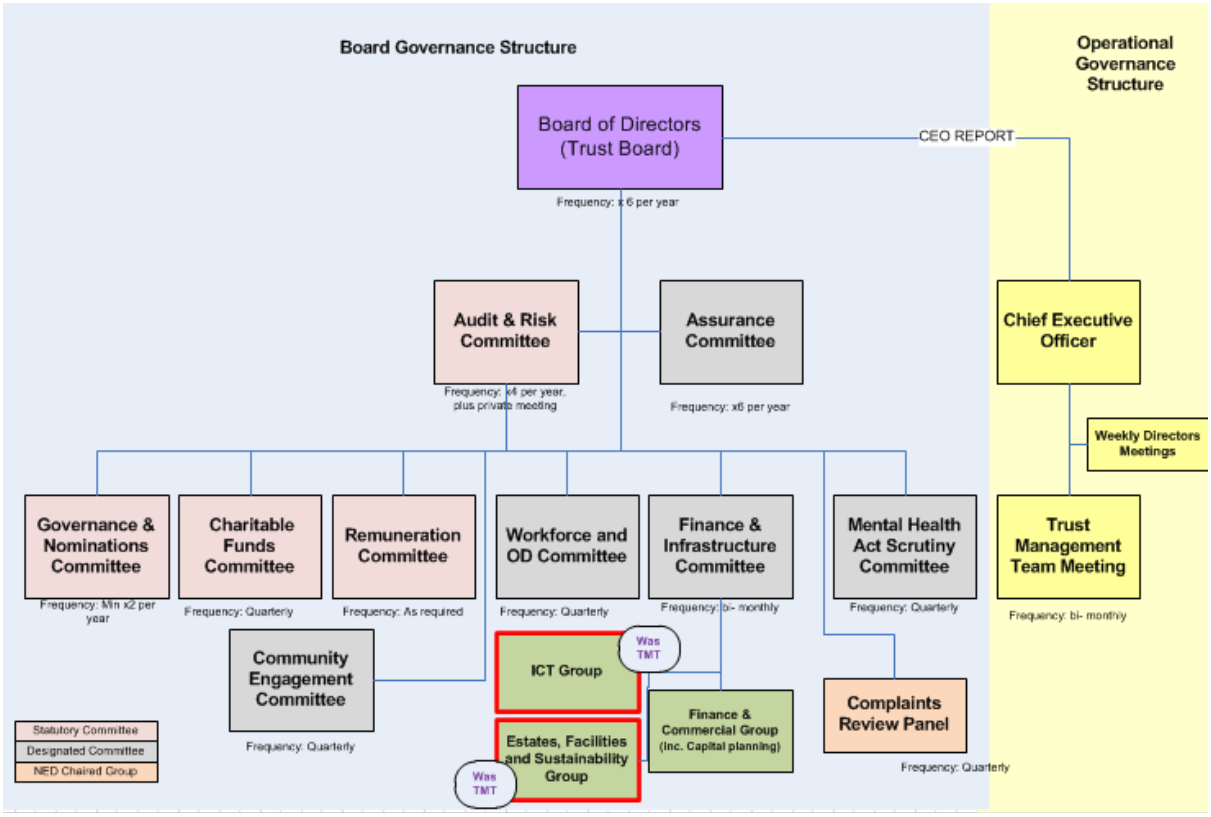
For presentation to Board and it's Committees: - To be completed by Exec Sponsor

Level of Assurance *(tick one)*	Sigificant		Sufficient	x	Limited		None	
Assurance Level	Concerning the overall level of assurance the Board is asked to consider whether this paper provides: Significant, sufficient, limited or no assurance And, whether any additional reporting/ oversight is required by a Board Committee(s)							
Executive Sponsor Signature								

Summary of business transacted:

The committee:

- Were briefed on the latest position regarding **Associate Hospital Managers in post** and were informed that appraisals will take place ahead of Mick Tutt, NED retiring at the end of January 2020 and a recommendation paper will be presented to the next Governance and Nominations Committee
- Approved the **Committee's mid-year review** of its objectives
- Reviewed the **composition of the Board and its committees** and in doing so
    - **Ratified the updated Committee governance structure**, as below:



    - **Ratified the current NED lead roles**, as agreed at the July 2019 meeting, as below:

Role	Designated NED
Deputy Chair	Mick Tutt
Senior Independent Director	Jon Pittam
Patient Safety - Learning from Deaths	Mick Tutt
FTSU / Whistleblowing	Jon Pittam
Emergency Planning	Stephanie Elsy
Assisting in Medical Fitness to Practice cases	Mike Watts

- **Ratified the current NED Committee membership** – including formalising Stephanie Elsy as Chair of the Finance & Infrastructure Committee, as below (key changes highlighted in yellow):

		Statutory Committees				Designated Committees					NED Chaired Group	
Director	Board	Remuneration Committee	Audit and Risk Committee	Governance and Nominations Committee	Charitable Funds Committee	Assurance Committee	Finance & Infrastructure Committee	Workforce and OD Committee	MHA Scrutiny Committee	Community Engagement Committee	Complaints Review Panel	Committee Charing / membership
Catherine Mason	Chair	Member	-	Chair	-	-	-	-	Member (AHM)	-	-	1 Chair 2 member
Mick Tutt	Member	Member	-	Member	Chair	Chair	-	-	Chair	-	-	3 Chair 2 member
Jon Pittam	Member	Member	Chair	Member	-	As appropriate/ available	-	-	Member (AHM)	-	-	1 Chair 3 member
Mike Watts	Member	Chair	Member	-	-	Member	Member	Chair	-	-	-	2 Chair 3 member
Stephanie Elsy	Member	Member	Member	-	-	-	Chair	Member	-	Chair	Chair	3 Chair 3member
Gaurav Kumar	Member	Member	-	-	Member / future chair	-	Member	Member	-	-	-	4 member
Quorum (NEDs)	At least 2 NEDs inc. Chair or nominated Deputy	NED Chair + 2 other NEDs	NED Chair + 1 other NED	NED Chair + 1 other NED	1 NED	NED Chair + 1 other NED	NED Chair + 1 other NED	NED Chair + 1 other NED	NED chair +1 other NED	1 NED	----	
Exec Sponsor	CEO	Chief People Officer	Chief Finance Officer	CEO / CoSec	COO S'ton	Chief Nurse	Chief Finance Officer	Chief People Officer	Chief Medical Officer	Chief Nurse	Chief Nurse	
Exec Members	All	On invitation : CEO, CPO	On invitation : CFO CEO, CN, CoSec	CEO, CoSec	COO S'ton, CoSec	CEO/DOF, CN, CMO, COOs, CoSec	CEO, CFO, Regular attendees : COOs	CPO, CMO, CN, COOs, CFO, CEO	COOs, CN, CMO	CN	CN	
Quorum (Execs)												
Frequency of meeting	Every 2 months	At least 1 per year + as req[d]	Quarterly + private meeting	At least twice per year	Quarterly	6 times per year	Every 2 months	Every 2 months	Quarterly	Quarterly	Quarterly	

  - And, acknowledge the **NED Tenure log**
- in recognition of Mick Tutt's (NED) forthcoming retirement and of Thoreya Swage joining, it was agreed that a meeting be held in early February 2020 to consider the roles and membership that Mick Tutt held and that of our new NED colleague
- approved the updated **Terms of Reference** (see Appendix 1) and noted the associated agenda cycle
- received the **Associate Hospital Manager Governance Report** as presented to the recent Mental Health Act Scrutiny Committee, which details arrangements including recruitment, appointment, expenses and oversight of tenure
- reviewed the amendments to the **Standing Orders**, for onward presentation for approval by the Board (presented as Appendix 2)
- received an update regarding proposed **Board Development activities for 2020** (dates to be confirmed) in acknowledgement of new Board members joining, and
- **formally thanked Mick Tutt**, NED for his contribution to the Committee.

Solent NHS Trust

Governance & Nominations Committee Terms of Reference

Reference to "the Committee" shall mean the Governance & Nominations Committee
Reference to "the Board" shall mean the Trust Board

1. Constitution

1.1 Solent NHS Trust Board resolves to establish a Committee of the Board to be known as the Governance & Nominations Committee (the Committee). As a Committee of the Board, the Standing Orders of the Trust shall apply to the conduct of the working of the Committee.

2. Purpose

The Committee make recommendations to the Board as appropriate regarding the following matters;

- the governance arrangements for the Trust including Committee structure,
- the composition and Terms of Reference,
- consideration of skills and experience of Board members
- succession planning of Board members
- Associate Hospital Manager appointments

3. Duties

3.1 The Committee will:

<u>Governance arrangements</u>

- Consider and keep under review governance arrangements, making recommendations to the Board as appropriate, including:
  - committee structure
  - membership and composition – including nominations of NEDs and Executive members to Board Committees and in consideration of balance of skills/experience
  - Terms of Reference of the Board and its Committees
  - nominations of key roles
  - overseeing appraisals of the Board and its committees
  - fit and proper person arrangements
- be mindful of the role of the Audit & Risk Committee in providing assurance to the Board regarding the effectiveness of governance arrangements
- Consider and review key governance documentation – including updates to the Trust's Standing Orders and Scheme of Delegation
- Consider the timing of and outcome of Well Led preparation – including the; '*Developmental reviews of leadership and governance using the Well- Led Framework: guidance for NHS Trusts and NHS Foundation Trusts'*
- The Committee will conduct an annual appraisal of its effectiveness

<u>Succession Planning and NED Tenure</u>

- Consider and keep under review succession planning arrangements for Board members, including:
  - ensuring there is a full, rigorous and transparent procedure for appointments

For NEDs:

- Reviewing tenure of NEDs and considering skills and experience when planning for future appointments
- Reviewing recruitment documentation for NED vacancies in conjunction with NHS Improvement

For Executives:

- ensuring the leadership of the organisation remains appropriate in consideration of the evolving system developments , collaborative working, talent pool and market forces – working with the Chief People Officer and Workforce and OD Committee as appropriate
- Provide support to the Chief People Officer in the appointment process of executive team members as required
- Reviewing the annual executive succession plan

- Acknowledge that it is for the NEDs to appoint and remove the Chief Executive, and that the appointment of the Chief Executive requires Board approval.
- Be informed of any matters of concern regarding the continuation in office of any Director including the suspension or termination of service of an Executive Director as an employee of the Trust subject to the provisions of the law and their service contract.

<u>Associate Hospital Managers (AHM)</u>

- consider recommendations made by the Chair of the Mental Health Act Scrutiny Committee and Mental Capacity Act and Mental Health Act Lead regarding the appointment and tenure of Associate Hospital Managers
- seek assurance regarding the governance arrangements regarding AHM appointments

<u>Board Development</u>

- In conjunction with the Chief People Officer, consider and recommend Board Development activities in light of feedback and analysis of skill mix analysis, appraisals of Committees/Boards and other feedback mechanisms

4. Membership

4.1 Members of the Committee shall be appointed by the Board and shall comprise;

- Chair
- Chief Executive (or Deputy CEO in their absence)
- Chair of Audit & Risk Committee (Non Executive Director)
- Chair of Assurance Committee (Non Executive Director)

4.2 The Chief Executive and Chair will not be present when the Committee is considering the succession or appointment of their respective roles.

5. Attendance

5.1 The Associate Director of Corporate Affairs and Company Secretary shall be invited to attend every meeting. Other attendees, such as the Chief People Officer and external advisers may be invited to attend for all or part of any meeting, as and when appropriate.

6. Quorum

6.1 The quorum necessary for the transaction of business shall be 3 members – including:

- At least 2 NEDs (including the Chair or their designated deputy) and
- The CEO

7. Frequency of meetings

7.1 The Committee will meet at least twice a year. Additional meetings can be called by the Chair.

8. Meeting administration

8.1 The Associate Director of Corporate Affairs and Company Secretary or their nominee shall act as the Secretary of the Committee.

8.2 Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated promptly to all members

9. Reporting

9.1 An exception report will be provided to the Board via the Committee chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

Version	9 (Dec 2019)
Date of Next Review	Date: Dec 2020
Agreed at Board	Date:

Item 17.3

Solent NHS Trust

Solent NHS Trust

Standing Orders

V9

Version	Approved by	Date	Amendment summary	Date of next review
V4	Board of Directors	Jan 2017	Document review and updated to reflect new terminology. Amendments presented to Dec 2016 Governance and Nominations Committee.	Nov 2018
V5	Chairs action	14th March 2017	Amended 4.8.5: Mental Health Act & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee (MHA & DoLSSC)	Nov 2018
V6	Acting Chairs action	5th February 2018	Amendment to Section 2.10 regarding Fit and Proper Person requirements and restrictions on an individual's ability to become /continue to be a director	Nov 2018
V7	Chairs Action	30th April 2018	Inclusion of People and OD Committee section 4.8.8	Nov 2018
V8	Board of Directors – via Audit & Risk Committee (Nov '18)	Nov 2018	Logo change. Clarification re: voting /non-voting membership section 2.1, minor amendments re: FPPT requirements 2.10, inclusion of Community Engagement Committee section 4.8.9	Nov 2020
V9			Updated	Nov 2022

Contents

The Standing Orders, Standing Financial Instructions and Scheme of Delegation, provide a regulatory framework for the business conduct of the Trust. Each is a separate document, but should be read in conjunction with one another.

All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Failure to comply with Standing Orders and Standing Financial Instructions is a serious disciplinary matter

Section One Interpretation and Definitions

Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board)

"Accountable Officer" means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive

"Board of Directors" (also known as the Trust Board) means persons formally appointed to site on the Board of Directors (including the Chairman, Non-Executive Directors and Executive directors of the Trust)

"Chief Executive" means the chief officer of the Trust

"Committee" means a committee or sub-committee created and appointed by the Board of Directors

"Committee members" means persons formally appointed by the Board of Directors to sit on or to chair specific committees

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets

"Deputy Chairman" means the non-officer (Non-executive) member appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason

"Director of Finance & Performance" means the Director of Finance & Performance of the Trust

"Employee" means an employee of the Trust or any other person holding a paid appointment or office with the Trust

"Executive member" means an executive member of the Board of Directors who is either an executive member of the Board of Directors or is to be treated as such by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, and now contained under Schedule 2, paragraph 12; Schedule 6, paragraph 8; and Schedule 5, paragraph 8 of the NHS Act 2006, as amended. Such funds may or may not be charitable.

"Member" means an executive or non-executive member of the Board as the context permits. Member in relation to the Board does not include its Chairman.

"Membership and Procedure Regulations" means National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) and subsequent amendments.

"Nominated employee" means an employee charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-executive member" means a non-executive member of the Board of Directors and is not to be treated as an officer by virtue of the Membership, Procedure and Administration Arrangements Regulations 2000 (as amended).

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"Officer member" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

"Assurance Committee [Safety and Quality Committee]" means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the Trust has responsibility

"SFIs" means Standing Financial Instructions

"SOs" means Standing Orders

"Trust" means Solent NHS Trust

Section Two Standing Orders

1.1 Statutory Framework

1.1.1 Solent NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2011 under The Solent National Health Service Trust (Establishment) Order 2011 No 804.

1.1.2 The principal place of business of the Trust is:

Solent NHS Trust Headquarters,
Highpoint Venue,
Bursledon Rd,
Southampton,
SO19 8BR

1.1.3 NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the National Health Service Act 2006.

1.1.4 The functions of the Trust are conferred by this legislation.

1.1.5 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

1.1.6 The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and as now contained under Sections 256 and 257 of the NHS Act 2006 (and Health & Social Care Act 2012), to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

1.1.7 The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.8 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

1.2.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.2.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Codes of Conduct make various requirements concerning possible conflicts of interest of Board members.

1.2.3 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS and should be considered in conjunction with the Freedom of Information Act 2000.

1.3 Delegation of powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (Section 5) the Trust's Board of Directors is given powers to "make arrangements for the exercise, on its behalf, of any of its functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit (or as the Secretary of State may direct)". Delegated powers and Schemes of Delegation are available separately.

2. Board of Directors: composition, tenure and role

2.1 Composition of the membership of the Board of Directors

In accordance with the Membership and Procedure Regulations the composition of the Board shall be:

(i) Up to 6 non-executive members, including the Chair appointed by NHS Improvement[1].

(ii) The Chairman of the Board of Directors appointed by NHS Improvement.

(iii) Up to 5 executive members (but not exceeding the number of non-executive members) including:

- Chief Executive;
- Director of Finance & Performance;
- Chief Medical Officer;
- Chief Nurse.

(iv) Solent NHS Trust is established with 11 (voting) members in total; 5 executive members (below), a Chairman and 5 non- executive members

- Chief Executive
- Director of Finance & Performance and Performance
- Chief Medical Officer
- Chief Nurse
- Chief People Officer

The Board of Directors shall have not more than 12 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State). In addition to the voting members previously listed within section 2.1; the Chief Operating Officer Southampton and County Services and Chief Operating Officer Portsmouth Services are also (non-voting) members.

[1] previously the Trust Development Authority and the Appointments Commission.

The Board of Directors shall, at its discretion, appoint a Deputy Chief Executive Officer at which point the voting arrangements will be considered.

2.2 Appointment of Chairman and members of the Board of Directors

Appointment of the Chairman and Members of the Board of Directors - paragraph 3 of Schedule 3 to the NHS Act 2006, provides that the Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the Membership and Procedure Regulations. The Terms and Conditions of the Chairman and Non-Executive members are set out by the NHS Improvement[2].

2.3 Terms of office of the Chairman and members of the Board of Directors

The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in the Membership and Procedure Regulations. The terms of office of the Chairman and Non-Executive members are available via the NHSI document referenced above.

2.4 Appointment and Powers of Deputy Chairman

2.4.1 Subject to Standing Order 2.4.2 below, the Chairman and other members of the Board of Directors may appoint one of their number, who is not also an officer member, to be Deputy Chairman, for such period, not exceeding the remainder of his term as a member of the Trust.

2.4.2 Any member so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Chairman and other members of the Board of Directors may thereupon appoint another member as Deputy Chairman in accordance with the provisions of Standing Order 2.4 1.

2.4.3 Where the Chairman of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chairman.

2.5 Role of the Board of Directors

2.5.1 The Board of Directors provides proactive leadership of the Trust towards achievement of corporate objectives and oversight of the framework of sound internal controls, risk management and governance in place to support their achievement.

The purpose of the Board is as follows:

- The purpose of the Trust Board is to govern the organisation effectively and ensure that the Trust is providing safe, high quality, patient-centred care.
- The Board is responsible for ensuring Solent is a value based organisation which provides; Great Care, is a Great Place to Work and provides Great Value for Money, where everyone counts and contributes.
- The Board leads the Trust by undertaking the following key roles:
  - Ensure the management of staff welfare and patient safety
  - Formulating Strategy, defining the organisations purpose and identifying priorities

[2] previously the Trust Development Authority and the Appointments Commission

- Ensuring accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
- Seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- Shaping a positive culture for the board and the organisation.

2.5.2 All members of the Board of Directors have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not affect the particular responsibilities of the Chief Executive as the Trust's Accountable Officer. All directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the Board of Directors and help develop proposals on priorities, risk mitigation, values, standards and strategy.

2.5.3 Executive members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.5.4 **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.5.5 **Director of Finance & Performance**

The Director of Finance & Performance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.5.6 **Non-executive members of the Board of Directors**

The non-executive members of the Board of Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.5.7 **Chairman of the Board of Directors**

The Chairman shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with the Appointments Team of NHS Improvements over the appointment of non-executive members of the Board of Directors and, once appointed, shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.7 Corporate role of the Board

2.7.1 All business shall be conducted in the name of the Trust.

2.7.2 All funds received in trust shall be held in the name of the Trust as corporate trustee and accountability for these funds is to the Secretary of State for Health

2.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in paragraph 3 of these Standing Orders.

2.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.8 Schedule of Matters Reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board'. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.9 Lead roles for members of the Board of Directors

The Chairman will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health/regulators or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

2.10 Fit and Proper Person Requirements (FPPT)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 5) and NHS Provider License (Condition G4) places a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or a Non-Executive Director (NED) under given circumstances.

The Trust is required to ensure that directors and equivalents are 'fit and proper' for the role and make every reasonable effort to assure itself by all available means. The Trust has developed a 'Fit and Proper Person Test- Standard Operating Procedure' which sets out the Trust's systems and processes in place to ensure that all new directors and existing directors are, and continue to be, fit, and that no appointments meet any of the unfitness criteria set out in the 2014 Regulations.

A number of restrictions apply in relation to the individuals' ability to become or continue as a director.

A person may not become of continue as a director of the Trust if[3]:

- a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.
- a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;
- a person who, in the case of a non executive director other than the initial non-executive directors, no longer satisfies paragraph 29 (if applicable);

[3] *The list is taken from Monitor's Model Constitution for Foundation Trusts which, whilst the Trust is not an FT is considered applicable*

- a person whose tenure of office as a chairman or as a member or Director of a health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

- a person who has had their name removed from a list maintained by a direction under any NHS act or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable), and due to such reasons is considered by the Trust to be unsuitable to be a Director;

- a person who by reference to information revealed by a disclosure and barring service (established under section 87 of the Protection of Freedoms Act 2012) check is considered by the chief executive to be inappropriate on the grounds that their appointment may adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

- a person who has, or has been in the last five years prior to their application to be a member, been involved as a perpetrator in a serious incident of assault or violence, or in one or more incidents of harassment, against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust (including volunteers), and following such behaviour has been asked to leave, has been removed or excluded from any hospital, premises or establishment, in accordance with the relevant Trust policy for withholding treatment from violent / aggressive patients;

- a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

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

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

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

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

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

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

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

Directors are required to complete a pre-employment and annual declaration in respect of FFPT considerations, in accordance with the Trust's Standard Operating Procedure. A full list of the considerations/requirements can be found within the self-declaration form and Board Code of Conduct.

3. Meetings of the Trust

3.1 Calling meetings

3.1.1 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board may determine.

3.1.2 The Chairman of the Trust may call a meeting of the Board of Directors at any time.

3.1.3 One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of meetings and the business to be transacted

3.2.1 Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under paragraph 3.6 of these Standing Orders.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.5 Before each meeting of the Board of Directors (In Public meeting) a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting (section 1(4)(a) Public Bodies (Admission to Meetings) Act 1960).

3.3 Agenda and supporting papers

The Agenda will be sent to members no later than five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than four clear days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of motion

3.5.1 Subject to the provisions of paragraphs 3.7 and 3.8 of these Standing Orders, a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least fifteen clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and

permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: procedure at and during a meeting

3.7.1 **Who may propose**

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

3.7.2 **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(i) The reception of a report;
(ii) Consideration of any item of business before the Board of Directors;
(iii) The accuracy of minutes;
(iv) That the Board of Directors proceed to next business;
(v) That the Board of Directors adjourn;
(vi) That the question be now put.

3.7.3 **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 **Rights of reply to motions**

(i) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(ii) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

(i) An amendment to the motion;
(ii) The adjournment of the discussion, or the meeting;
(iii) That the meeting proceeds to the next business;
(iv) That the question should be now put;
(v) The appointment of an 'ad hoc' committee to deal with a specific item of business;
(vi) That a member/director be not further heard;
(vii) A motion under section 1(2) or section 1(8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to rescind a resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Board of Directors it shall not be competent for any director/member other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of meeting

3.9.1 At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairman and Deputy-Chairman, if there is one, are absent, such member (who is not also an Officer Member of the Trust i.e. a Non-Executive Director) as the members present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman presiding at the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting of an NHS trust unless the following are present:

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

3.11.2 A senior employee in attendance for an executive member of the Board of Directors but without formal acting up status may not count towards the quorum.

3.11.3 If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

3.12.1 Save as provided in paragraphs 3.13 and 3.14 of these Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote).

3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a member so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A senior employee who has been formally appointed to act up for an executive member of the Board of Directors during a period of incapacity or temporarily to fill an executive director vacancy shall be entitled to exercise the corresponding voting rights.

3.12.7 A senior employee attending a meeting of the Board of Directors to represent an executive member during a period of incapacity or temporary absence without formal acting up status may not exercise the corresponding voting rights. Their status of such attendees shall be recorded in the minutes.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the provisions of these Standing Orders with respect to a quorum, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (at least 8 including at least one member who is an executive member and one member who is a non-executive member) and that at least two-thirds of those members present signify their

agreement to such suspension. The reason for the suspension shall be recorded in the minutes of the meeting.

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit and Risk Committee shall be advised of and review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

(i) Upon a notice of motion under paragraph 3.5 of these Standing Orders;
(ii) Upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
(iii) that two thirds of the Board members are present at the meeting (i.e at least 8 members) where the variation or amendment is being discussed, and that at least one half of the Trust's non-executive members vote in favour of the amendment; or
(iv) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Minutes

3.15.1 The nominated secretary shall record the minutes of every meeting.

3.15.2 The secretary shall submit the draft minutes to the Board of Directors in advance of its next meeting for agreement, confirmation or otherwise.

3.15.3 The record of the minutes shall include:

(i) The names of:

(a) Every member present at the meeting;

(b) Any other person present; and

(c) Any apologies tendered by an absent member;

(ii) The withdrawal from a meeting of any member on account of a conflict of interest; and

(iii) Any declaration of interest.

3.15.4 Minutes shall record key points of discussion. They shall not, however, attribute comments to specific members unless this is specifically required by the Chairman presiding at the meeting. Where personnel, finance or other restricted matters are discussed, the minutes shall describe the substance of the discussion in general terms.

3.16 Admission of public and the press

3.16.1 **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows:

“that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'” (Section 1 (2), Public Bodies (Admission to Meetings) Act 1960)

3.16.2 **General disturbances**

The Chairman (or Deputy Chairman if one has been appointed) or the person presiding at the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

“That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public” (Section 1(8) Public Bodies (Admissions to Meetings) Act 1960)

3.16.3 **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in 3.16.1 and 3.16.2 above shall be confidential to the members of the Board.

Members of the Board of Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.16.4 **Use of mechanical or electrical equipment for recording or transmission of meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board of Directors or Committee thereof. Such permission shall be granted only upon resolution of the Board of Directors.

3.17 Observers at meetings of the Board of Directors

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors’ meetings and may change, alter or vary these terms and conditions as it deems fit.

Requests from personnel to observe the meeting must be made to the Company Secretary, and where appropriate sponsored by an Executive member. All requests will be referred to the Chairman and CEO for consideration and wider Board as appropriate.

4. Appointment of Committees and sub-Committees

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Secretary of State for Health, the Board of Directors may appoint committees of the Board of Directors.

4.1.2 The Board of Directors shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires to, receive and consider reports of such committees.

4.2 Joint Committees

4.2.1 Joint committees may be appointed by the Board of Directors by joining together with one or more other Trusts consisting of, wholly or partly of the Chairman and members of the Board of Directors or other health service bodies, or wholly of persons who are not members of the Board of Directors or other health bodies in question.

4.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Board of Directors or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings of, and any committees established by the Board of Directors. In which case the term "Chairman" is to be read as a reference to the Chairman of other Committees as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. There is no requirement to hold meetings of committees established by the Board of Directors in public.

4.4 Terms of reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-Committee unless expressly authorised by the Board of Directors.

4.6 Approval of appointments to Committees

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted (via the Governance and Nominations Committee concerning NED and Exec membership). Where the Board determines, and regulations permit, that persons, who are neither non-executive nor executive members, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Secretary of State. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for statutory functions

Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board of Directors, such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Committees established by the Board of Directors

The committees, established by the Board are:

4.8.1 Audit and Risk Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, an Audit and Risk Committee will be established and constituted to provide the Board of Directors with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis. The duties of the Committee will include Governance, Risk Management and Internal Control, Internal Audit, External Audit, Other Assurance Functions, Management and Financial Reporting.

4.8.2 Remuneration Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Remuneration Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

In accordance with Standing Orders the Board shall establish a Remuneration Committee with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Remuneration Committee make decisions on behalf of Solent NHS Trust Board and where necessary make recommendations to NHS Improvement about appropriate remuneration, allowances and terms of service for the Chief Executive and other executive directors, to include:-

- Salary
- Performance related pay
- Provision of other contractual terms and benefits
- Approval of compromise agreements/severance pay or other occasional payments to individuals and out of court settlements, taking account of national guidance

The Committee will also receive and note decisions of the Clinical Excellence Awards (CEA) panel.

4.8.3 Charitable Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Board of Directors will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charity Commission. The provisions of this paragraph must be read in conjunction with paragraph 2.7 above and Standing Financial Instruction, Section 18.

4.8.4 Assurance Committee

The Board shall establish an Assurance Committee responsible for providing the assurance on all aspects of quality of care, including patient safety; governance systems, risk issues for clinical, corporate, workforce, information and research & development and regulatory standards of quality and safety. In particular providing assurance to the Board regarding :

- Regulatory compliance (including Safeguarding) and the provision of services in accordance with statute, best practice and guidance
- High standards of healthcare governance and high quality service provision.
- Risk – ensuring that risks are identified, prioritised and appropriately managed as highlighted via the Chief Nurse and Chief Operating Officers report to the Committee.
- a culture of continuous improvement across the Trust exists and learning is shared and embedded

4.8.5 **Mental Health Act & Deprivation of Liberty Safeguards (DoLS) Scrutiny Committee (MHA & DoLSSC)**

A MHA&DoLSC will be established and constituted to oversee the implementation of the Mental Health Act 1983 and DoLS functions within Solent NHS Trust.

The Scrutiny Committee has primary responsibility for seeing that the requirements of the Act and the Code of Practice regarding DoLS are followed within the Trust. In particular, to seek assurance that patients are detained only as the Mental Health Act 1983 or the DoLS Code of Practice allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights. In addition, the remit of the MHA&DoLSSC has been expanded during 2016 to include oversight and scrutiny of training for practitioners; to enable them to, competently, discharge their relevant responsibilities.

4.8.6 **Governance & Nominations Committee**

A Governance & Nominations Committee will be established and constituted to lead on the identification, nomination and recommendation of appointments (in accordance with their Terms of Reference) to the Board. The Committee will also keep under review the corporate governance arrangements for the Trust including Committee Structure, membership and Terms of Reference, making appropriate proposals and recommendations to the Board as appropriate.

4.8.7 **Finance & Infrastructure Committee**

The Finance & Infrastructure Committee will be established and constituted to ensure appropriate financial frameworks are in place to drive the financial strategy, and provide assurance to the Board on financial and infrastructure matters as directed. Specifically the Committee will make recommendations to the Board in relation to its duties of;

- strategic financial planning
- annual budget setting and monitoring
- Treasury management
- business management
- Financial Recovery Programme and financial control and
- Infrastructure (Estates and IT)

The Committee will also receive an 'exceptions and recommendation' report from the Finance and Commercial group, and may on request from the Board review specific aspects of financial performance where the Board requires additional scrutiny and assurance.

4.8.8 **Workforce and Organisational Development (OD) Committee**

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

4.8.9 **Community Engagement Committee**

The Committee is responsible for assuring the Board on delivery and development of the engagement strategy. In particular the Committee shall be concerned with assuring the Board that the Trust is fulfilling the three aims of the engagement strategy:

1. To improve our internal capacity, understanding and expertise on engagement.
2. To develop positive and constructive relationships with local community and voluntary sector organisations so that they can become equal partners in service design and delivery.
3. To develop the Trust's reputation as a system leader for engagement.

4.8.10 **Other Committees**

The Board of Directors may also establish such other committees as required to discharge their responsibilities.

As well as operating to the Trust's Code of Conduct, Committees will operate under the following principles[4]

- observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the trust's affairs and stewardship of public funds
- maximise value for money through ensuring that services are delivered in the most efficient and economical way, within available resources, and with independent validation of performance achieved wherever practicable;
- be accountable to Parliament, to users of services, to individual citizens, and to staff for the activities of the Trust, for their stewardship of public funds and the extent to which key performance targets and objectives have been met;
- comply fully with the principles of the Citizen's Charter and the Freedom of Information Act 2000, in accordance with Government policy on openness; and
- bear in mind the necessity of keeping comprehensive written records of their dealings, in line with general good practice in corporate governance.

5. Arrangements for the exercise of Trust functions by delegation

5.1 Delegation of functions to Committees, Executive Directors or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board of Directors may make arrangements for the exercise, on its behalf, of any of its functions by a committee, sub-committee appointed by virtue of Section 4 of these Standing Orders, or by an Executive Director or senior employee of the Trust, or by another body as defined in paragraph 5.1.2 below, in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

5.1.2 Where a function is delegated to another Trust in accordance with the respective provisions of the NHS Act 2006, (and subsequent amendments) and Health and Social Care Act 2012, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or Executive Directors or senior employees of the Trust, the Board of Directors delegating the function retains full responsibility.

[4] *Taken from the Department of Health Guidance (concerning best practice of Remuneration Committees)*

5.2 Emergency powers and urgent decisions

The powers which the Board of Directors has reserved to itself within these Standing Orders (see paragraph 2.8 of these Standing Orders) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman. A proposal will be recommended by the Chief Executive and approved under 'Chairs action' and noted at the next formal meeting of the Board of Directors in public session.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors in respect of its sub-committees.

5.3.2 When the Board of Directors is not meeting in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Board of Directors in public session.

5.4 Delegation to Executive Directors and senior employees

5.4.1 Those functions of the Board of Directors which have not been retained as reserved by the Board of Directors or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive.

The Chief Executive shall determine which functions they shall perform personally and shall nominate officers to undertake the remaining functions for which they shall still retain accountability to the Board of Directors.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance & Performance to provide information and advise the Board of Directors in accordance with statutory or Department of Health requirements. Outside these statutory requirements the Director of Finance & Performance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers

The arrangements made by the Board of Directors as set out in the Schedule of Matters Reserved to the Board and Scheme of Delegation of powers

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or approval. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Overlap with other Trust policy statements/ procedures, regulations and Standing Financial Instructions

6.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of staff employed by Solent NHS Trust. The decisions to approve such policies and procedures will be recorded in the minutes of the Board meeting in question and will be deemed, where appropriate, to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific policy statements

Notwithstanding the application of paragraph 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following policy statements:

(i) the Code of Conduct Appendix 2 to these Standing Orders

(ii) the staff disciplinary and appeals procedures adopted by the Trust, both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the provisions of section 6.1, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

(i) Caldicott Guardian Report 1997 (and all subsequent guidance);
(ii) Human Rights Act 1998; and
(iii) Freedom of Information Act 2000.

7. Duties and obligations of members of the Board of Directors and senior employees under these standing orders

7.1 Declaration of Interests

7.1.1 Requirements for declaring interests and applicability to members of the Board of Directors

The NHS Code of Accountability requires members of the Board of Directors to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

(d) A position of authority in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for NHS services;

(f) Research funding/grants that may be received by an individual or their department; and

(g) Interests in pooled funds that are under separate management.

(ii) Any member of the Board of Directors who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in paragraph 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, shall declare his/her interest by giving notice in writing of such fact to the Chairman of the Board of Directors as soon as practicable.

7.1.3 **Advice on Interests**

(i) If members of the Board of Directors have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Board of Directors, the Chief Executive or the Company Secretary.

(ii) Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 **Recording of interests in minutes of meetings of the Board of Directors**

(i) At the time Board members' interests are declared, they should be recorded in the minutes of the Board of Directors.

(ii) Any changes in interests should be declared at the next meeting of the Board of Directors following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report and on the Trusts website in accordance with the Trusts Managing Conflicts of Interest Policy. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a meeting, of the Board of Directors if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 **Register of Interests**

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in paragraph 7.1.2 above) which have been declared by members of the Board of Directors.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members of the Board of Directors in proceedings on account of pecuniary interest

7.3.1 **Definition of terms used in interpreting 'pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "Contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(a) he, or his nominee, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(b) he is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:

(a) Neither he or any person connected with him has any beneficial interest in the securities of a company of which he or such person appears as a member; or

(b) any interest that he or any person connected with him may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him in relation to considering or voting on that contract; or

(c) those securities of any company in which he (or any person connected with him) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with paragraph 7.1.2 (ii) of these Standing Orders.

7.3.2 **Exclusion in proceedings of the Board of Directors**

(i) Subject to the following provisions of this paragraph, if the Chairman or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this paragraph in any case in which it appears to him in the interests of the National Health Service that the disability should be removed.

(iii) The Board of Directors may exclude the Chairman or a member of the Board of Directors from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chairman or member of the Board of Directors by virtue of paragraph 11 of Schedule 4 to the National Health Service Act 2006 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this paragraph.

(iv) This paragraph applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such Committee or sub-Committee (whether or not he is also a member of the Board of Directors) as it applies to a member of the Board of Directors.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(i) <u>Power of the Secretary of State to make waivers</u>

Under the Membership, Procedure and Administration Arrangements Regulations 1990 and subsequent amendments ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver shall be agreed in line with sub-paragraphs (ii) to (iv) below.

(ii) Definition of 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3 (iii) below, the "relevant chairman" is:

(a) At a meeting of the Board of Directors, the Chairman presiding at the meeting;

(b) At a meeting of a Committee:

- in a case where the member in question is the Chairman of that Committee, the Chairman of the Board of Directors;
- in the case of any other member, the Chairman of that Committee.

(iii) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to a member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:

(a) services under the National Health Service Act 2006; or

(b) services in connection with a pilot scheme under the National Health Service Act 2006;

For the benefit of persons for whom the Trust is responsible.

Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

- are members of the same profession as the member in question; and/or
- are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(iv) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (ii) (b) above, except where that member is the Chief Executive;

(c) in the case of a meeting of the Board of Directors:

- the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
- may not vote on any question with respect to it.

(d) in the case of a meeting of the Committee:

- the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
- may vote on any question with respect to it; but
- the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board of Directors.

7.4 Standards of Business Conduct

7.4.1 **Trust policy and national guidance**

The Board of Directors and all employees must comply with the Trust's Code of Conduct. Full requirements are set out Appendix 2

7.4.2 **Interest of executive directors and employees in contracts**

(i) Any executive member of the Board of Directors or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he or any person connected with him (as defined in paragraph 7.3 above) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or the Company Secretary as soon as practicable.

(ii) An executive director other than the Chief Executive or a senior employee should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(ii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and recommendations by, members of the Board of Directors in relation to appointments**

(i) Canvassing of members of the Board of Directors or of any Committee of the Board of Directors directly or indirectly for any appointment by the Trust shall disqualify the candidate for such appointment. The contents of this paragraph shall be included in application forms or otherwise brought to the attention of candidates.

(ii) Members of the Board of Directors shall not solicit for any person any appointment by the Trust or recommend any person for such appointment; but this paragraph shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

(i) Candidates for any staff appointment by the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member of the Board of Directors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(ii) The Chairman of the Board of Directors, every member of the Board of Directors and senior employees shall disclose to the Board of Directors any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

(iii) On appointment, non-executive members of the Board of Directors, and in the case of executive members of the Board Directors, prior to appointment, should disclose to the Board of Directors whether they are related to any other member or holder of any office in the Trust.

(v) Where the relationship to a member of the Board of Directors is disclosed, the provisions of paragraph 7 shall apply.

8. Custody of seal, sealing and signature of documents

8.1 **Custody of seal**

The common seal of the Trust shall be kept by the Chief Executive or a manager nominated by him in a secure place.

8.2 **Sealing of documents**

Where the Trust (or supplier) decides that a document shall be sealed, the senior authorised person recommending the sealing shall make sure appropriate checks are made and the documents are correct.

The common seal shall be affixed under the management of the Chief Executive or their nominated manager and with appropriate signatories, as stipulated.

The signatories must be different to the senior authorised person recommending the sealing.

Appendix 3 summarises when the Company Seal should be used.

8.3 **Register of sealing**

The Chief Executive shall ensure that a register is maintained in which he, or another manager authorised by him, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by:

- the Chief Executive or any other executive member of the Board of Directors.

In land transactions, the signing of certain supporting documents will be delegated to senior employees and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer, for example, sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed. The Commercial Team maintain a register of signatures.